

Application for ESRA Abstract Prizes: I don't wish to apply for the ESRA Prizes

Background and Aims Short-term hypertension (HT) after Interscalene block (ISB) has been reported in quite few studies (1). In addition to the known side effects of HT, increased surgical hemorrhage may disrupt visual clarity. Therefore, the present study aimed to review the incidence and associated risk factors of hemodynamic changes after ISB using 15 mL of 0.375% bupivacaine for arthroscopic shoulder surgery in the lateral decubitus position.

Methods The follow-up forms of anesthesia, medical records of adult patients without HT were evaluated retrospectively. Systolic and diastolic pressure, heart rate, and peripheral oxygen saturation (SpO₂) were recorded before and at five-minute intervals after block performance and during surgery.

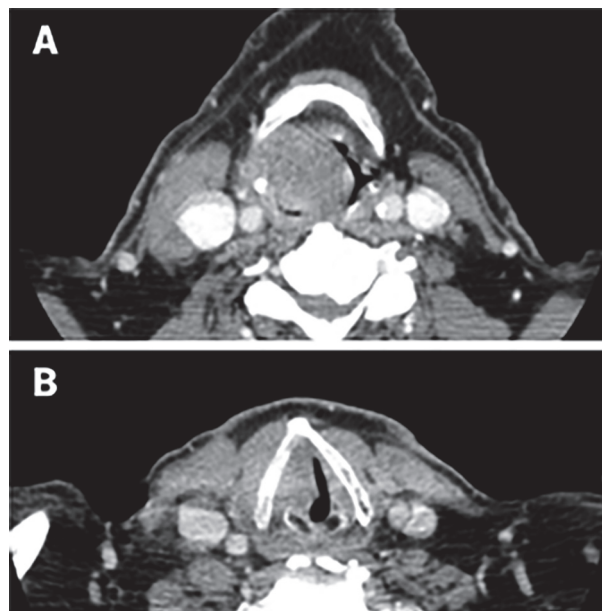
Results A total of 99 patients were recruited, and all of them were sedated with midazolam and fentanyl prior to needle insertion. At the 30th minute after ISB before surgery, a 20% increase was observed in 12.1% of patients, compared to the baseline blood pressure (BP). Systolic arterial pressure was found to be >140 mmHg in 7.07% and >180 mmHg in 2.02% of the patients. No differences in heart rate and SpO₂ were noted. Antihypertensive medication was administered to 2.02% of patients despite sedation with dexmedetomidine/remifentanyl infusion. Such features as age, comorbidities, duration of surgery, and gender had no statistically significant effect on HT ($p>0.05$).

Conclusions Some spread of local anesthetic after ISB would cause a blockade of carotid sinus baroreceptors leading to an increase in BP. This should be considered in patients with cardiovascular diseases or poorly controlled HT, especially in awake patients under regional anesthesia.

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ropivacaine 0,75% in each side. 100 µg of fentanyl, 1 mg midazolam and 15 mg of ketamine were administered for conscious sedation.

Results 10 minutes after BICPB we obtained sensory block in dermatomes C2-C4. After cannulation of trachea, patient was put under general anesthesia, maintained with sevoflurane. The surgery was performed without complications and the postoperative period was uneventful and painless. He was then transferred to the reference hospital in treatment of head and neck cancer after 3 days.



Abstract #36188 Figure 1 Cross-sections of cervical CT images. A. Supraglottic zone B. Glottic zone

#36188 HOW TO GET AWAY FROM THE AIRWAY IN URGENT TRACHEOSTOMY

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Background and Aims Urgent tracheostomy is needed to treat upper airway obstruction in patients with head and neck cancer. It sometimes constitute an anesthetic challenge, especially for causing obstruction and distortion of the airway's anatomy. Bilateral intermediate cervical plexus block (BICPB) allows anesthesia of the anterior neck, allowing the performance of superficial neck surgery. This abstract aims to demonstrate the effectiveness and safety of regional anesthesia in patients undergoing urgent tracheostomy.

Methods A 62-year-old man, ASA IV, with history of alcohol abuse and basaloid squamous cell carcinoma (cT3N2bM0) presented to the emergency room with stridor and worsening dyspnoea at rest. He was proposed for urgent definitive tracheostomy, in which induction of general anesthesia had a high risk of airway loss, because the mass was causing glottis obstruction with a maximum diameter of approximately 4 mm. We performed an ultrasound-guided BICPB with 4 mL

Conclusions BICPB is an effective alternative anesthetic approach for patients undergoing urgent tracheostomy in whom general anesthesia carries a high risk. It provides complete anesthesia and long-lasting analgesia of the anterior cervical region.

#36325 A CASE REPORT OF PATIENTS WITH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA RECEIVING HUMERAL NECK REPAIR SURGERY USING SUPERIOR TRUNK BLOCK

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Background and Aims Paroxysmal nocturnal hemoglobinuria (PNH) is a rare acquired hematopoietic stem cell disorder characterized by the presence of abnormal red blood cells and an increased risk of hemolysis.

Methods The case involved an 83-year-old man with a left humeral neck fracture who had been diagnosed and treated for PNH for 10 years. The patient was a high-risk patient with a history of both hemolytic and thrombotic symptoms, which were suppressed by treatment with the monoclonal antibody eculizumab. Surgery was performed with an intramedullary nail through the proximal end of the humerus. Given the exacerbation of PNH, light sedation with midazolam and a superior nerve trunk block with 5 mL of 0.5% levobupivacaine was performed. No significant exacerbation of PNH symptoms or hematoma formation was observed. He was discharged from the hospital on postoperative day 2.

Results There are no reports of surgical experience with peripheral nerve blocks in patients with PNH. Anesthetics or high-dose opioids for surgical management should be a risk factor for an episode of hemoglobinuria by sleep induction, as nocturnal exacerbation of hemoglobinuria has been attributed to carbon dioxide retention and blood acidosis leading to complement activation. Because the superior nerve trunk block is a superficial technique among brachial plexus blocks, the risk of hematoma formation was considered low. Treatment with monoclonal antibody could have facilitated the management of the disease and avoided perioperative problems.

Conclusions We experienced a case of PNH patient who underwent humeral head fracture surgery under regional anesthesia and light sedation.

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#36011 **ULTRASOUND-GUIDED SUPERIOR LARYNGEAL NERVE BLOCK FOR DIAGNOSIS AND TREATMENT OF NEUROGENIC COUGH IN A PATIENT POST-ESOPHAGECTOMY: A CASE REPORT**

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Background and Aims Chronic cough is cough lasting for more than 8 weeks, with a multifactorial cause including a hypersensitivity of the internal branch of the superior laryngeal nerve. Cough following esophagectomy in patients with esophageal carcinoma has been commonly associated with gastric reflux in 20-80% of patients. However, very few literature has described cough secondary to superior laryngeal nerve irritation as a complication of esophagectomy. Recent literature described the use of superior laryngeal nerve block using lidocaine and steroids for patients presenting with neurogenic cough. This paper presents a case of a 48 year-old male post-esophagectomy with gastric pull-up, complaining of persistent cough unrelieved by medical management.

Methods Trigger points of cough were identified. Superior laryngeal nerve block using lidocaine with dexamethasone was done, which resulted to immediate relief. However, symptom recurred in less than 24 hours. Six days after, the procedure was repeated using lidocaine with epinephrine and triamcinolone acetamide.

Results Cough severity index score of patient decreased from 40 to 20, with 70% decrease in the frequency of symptom.

However, patient also noted a transient difficulty in swallowing.

Conclusions Superior laryngeal nerve block using lidocaine and steroids is a possible modality in the diagnosis and treatment of neurogenic cough as a complication of esophagectomy. Its effect is, however, temporary and should be done repeatedly to achieve significant results. Further studies should be done to determine the most effective combination of local anesthetic and steroid to achieve a desirable prolonged relief. One of the possible complication of the procedure is dysphagia.

#36516 **SINGLE INJECTION POSTERIOR INTERCOSTAL BLOCK. CAN IT BE AN ALTERNATIVE BLOCK FOR SMALL BREAST SURGERIES? CASE REPORT**

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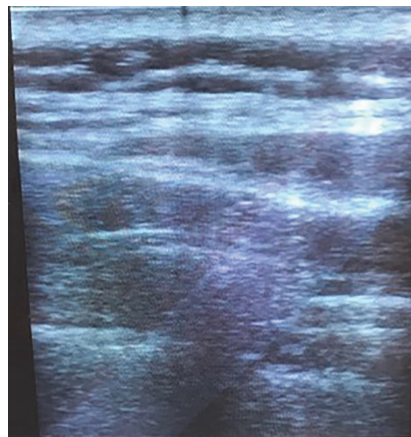
10.1136/rapm-2023-ESRA.500

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Background and Aims Multiple Intercostal nerve blocks had their role in the clinical scenario for small breast procedures. Agreeing with all new evidence of intercostal space spread of local anesthetic, we present a safe technique to block intercostal nerves by a single injection in the posterior intercostal space.

Methods We aimed to describe two case reports from two Middle-aged Women, one with a diagnosis of breast abscess and the other with a breast expander rejection. After signing the informed consent, both patients underwent the anesthetic procedure with standard monitoring, received light IV sedation, positioned in lateral decubitus with the up arm lying in front of them. A perpendicular line between the scapulae's spine and the vertebral column was marked and the point of injection was placed 7 cm from the vertebral column. After local anesthesia, a Tuohy needle was inserted into this point at the superior angle of the rib, and a syringe with 4ml of saline was placed to test the loss of resistance (LOR) technique.



Abstract #36516 Figure 1 Us image – Posterior IC block