of phrenic nerve paralysis. There are few cases in literature, without clear uniformity in volume and concentration of local anaesthetic, the most performed by neurostimulator. We describe a clinical case of echoguided bilateral analgesic interscalenic block for total shoulder arthroplasty, to control intense postoperative pain.

Methods We performed an interscalenic bilateral block in a 52 years old patient, ASA 2 with bilateral dislocation and fractures of proximal epiphysis of humerus. He did not have any respiratory comorbidities. The surgery was started under balanced general anesthesia, using remifentanil for analgesic management. At the end of surgery, we perform bilateral block using low volume of anaesthetic, 7 ml each side of ropivacaine 0.375%, visualizing echographically plexus roots and the spread between c5-c7.

Results The patient did not show any respiratory complication after extubation. The study of diaphragm excursion did not show any phrenic dysfunction. We administered multimodal analgesia without opioids needing. His Numeric Rating Scale was 0 at extubation, 3 at 12 and 24 hours from surgery. The patient had never showed signs of respiratory failure, and never had a saturation lower than 98%.

Conclusions After surgery, we only could approach brachial plexus in interscalenic site, avoiding suprascapular block because of difficult posterior approach. The use of echography leads to reduction of volume and concentration, and could lead to deep change in classic absolute contraindications of peripheral anaesthesia.

RESULTS

The patient was breathing spontaneously the whole time. Total blood loss during surgery was 300 ml. On the ward, she was disoriented and angry in the postoperative period due to alcohol withdrawal but had no opioid requirements. In 48 hour postoperative period she was given ketoprofen 100mg and metamisol 2.5g two times on the first and second postoperative day.

INTERSCALENE BRACHIAL PLEXUS BLOCK IN CHRONIC ALCOHOLIC PATIENT WITH HYPOTHYROIDISM FOR DISTAL HUMERUS FRACTURE

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Background and Aims Many important anaesthetic considerations are present in patients with hypothyroidism. Patients suffering from chronic alcohol misuse can present with acute deterioration, with or without concurrent illness, and necessitating intensive care. Recovery may be complicated by alcohol withdrawal. We wanted to present a case of a chronic alcoholic female patient with hypothyroidism who had to go under emergency surgery of the distal part of the humerus.

Methods A 63- year-old woman, a chronic alcoholic with poorly treated hypothyroidism was scheduled for emergency surgery due to comminuted fracture of the right distal humerus region. On the day of surgery her TSH level was 169.39 mIU/L. Also, she had surgery performed on the same arm and shoulder before already. Because of her medical anamnesis we chose to perform an interscalene brachial plexus block with light sedation. Patient was given 50mcg of fentanyl and 3mg of midazolam and 600mg of propofol intravenously in total for surgery of three hours. For the block we used 10 ml of 0.5% Levobupivacaine, 5 ml of 2% Lidocaine and Dexamethasone 4 mg using ultrasound guidance.

RESULTS

The patient was breathing spontaneously the whole time. Total blood loss during surgery was 300 ml. On the ward, she was disoriented and angry in the postoperative period due to alcohol withdrawal but had no opioid requirements. In 48 hour postoperative period she was given ketoprofen 100mg and metamisol 2.5g two times on the first and second postoperative day.

Abstract #36079 Figure 1 Radiography scan of the distal humeral region before surgery

Abstract #36079 Figure 2 Radiography scan of the distal humeral region after surgery

Abstract #36079 Figure 3 Surgical field
Conclusions Peripheral nerve blocks are preferable for emergency surgery maintaining cardiovascular stability.

Background and Aims The Erector Spinae Plane (ESP) block is paraspinal fascial plane block that targets both ventral and dorsal rami of the thoracic and abdominal spinal nerves. It has been used to provide analgesia for a range of surgical procedures and painful conditions. Spontaneous cough-induced rib fractures are a rare but recognised phenomenon in term parturients. Patients who experience rib fractures near term often undergo elective caesarean delivery, due to the recognition that thoracic pain may limit patient effort in the second stage of labour. We present a case of ESP catheter managed rib fracture pain, facilitating labour and vaginal delivery in a term parturient with a cough-induced rib fracture.

Methods A 38-year-old woman, para 1, presented at 37+6 weeks gestation with left-sided pleuritic chest pain, following a lower respiratory tract infection, which was associated with intense bouts of coughing. The presumptive diagnosis was an atraumatic rib fracture and she was initially discharged with analgesia. She re-presented the following day with 10/10 pain despite paracetamol, oxycodone and a lidocaine patch. A mid-thoracic ESP catheter was inserted under ultrasound guidance with immediate relief. She received 4-hourly clinician administered boluses of 20ml of 0.125% levobupivacaine for 5 days with a maximum pain score of 4 on coughing.

Results With adequate analgesia attained and following multidisciplinary input, she underwent induction of labour, resulting in an instrumental vaginal delivery undercombined ESP and epidural analgesia.

Conclusions ESP blocks could be considered for pregnant patients presenting with rib fracture pain near term, who wish to attempt labour and vaginal delivery.

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Background and Aims Total knee arthroplasty (TKA) is one of the most common orthopedic procedures and is associated with significant postoperative pain. We present a case report of a TKA performed exclusively on peripheral nerve block (PNB) anesthesia.

Methods A 61 year old female, ASA IV, presented for revision of a TKA due to primary arthroplasty infection. She had a history of hypertension, morbid obesity, mitral and aortic valvuloplasty. Most recent echocardiogram showed aortic valve with severe obstruction and indication for future repair. She was hypocoagulated with warfarin (INR preoperative 1.5). The following PNB were performed under ultrasound-guidance to obtain surgical anesthesia: femoral nerve, lateral cutaneous femoral nerve, obturator nerve, sciatic nerve (popliteal), with a total of 300 mg of ropivacaine (60 mL of 0.5% ropivacaine). Before incision a perfusion of propofol for light sedation was started and tourniquet inflated. Surgery proceeded during 2.5 hours uneventful. Patient reported a high level of satisfaction in the postoperative ward. In the following days the patient remained with a good analgesic control.

Results The standard anesthetic technique for TKA is neuroaxial anesthesia or general anesthesia. However, there are situations where those two techniques can impose increased risks and become an anesthetic challenge. As we had an urgent surgery and patient had a high INR level neuroaxial anesthesia increased risk for complications. Additionally, her valvular disease imposed an increased risk or hemodynamic stability that could be affected by general anesthetics.

Conclusions We performed an exclusive PNB anesthetic technique that was tailor-made for this patient, surgery and pain control.

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Background and Aims The clavicular fascia block described by anaesthesiologist Dr Luis Valdés in 2017.

Methods About 10 cases of clavicle fractures. Patients aged between 28 and 42 years, ASA I except for one ASA II patient due to type I obesity. All cases were scheduled surgeries for open osteosynthesis for acromioclavicular fracture-dislocation. Balanced general anaesthesia combined with CPB block at the mid-clavicular level along with ultrasound-guided superficial cervical plexus block was performed under standard monitoring and standard premedication.

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