

Conclusions Peripheral nerve blocks are preferable for emergency surgery maintaining cardiovascular stability.

#36450 MAJOR ORTHOPEDIC SURGERY IN A PATIENT WITH VALVULAR DISEASE AND HYPOCOAGULATION: CAN PERIPHERAL NERVE BLOCKS ANESTHESIA BE THE ANSWER FOR THIS CHALLENGE?

Mariana Dias, Luisa Coimbra*, Carolina Ribeiro, Joana Silva, Filipe Rodrigues. *Anesthesiology, CHVNG/E, Porto, Portugal*

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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.

#36291 CONTINUOUS ERECTOR SPINAE PLANE BLOCK AND CATHETER INSERTION FOR RIB FRACTURE PAIN IN A PERIPARTUM PATIENT: A CASE REPORT AND REVIEW OF THE LITERATURE

Shane Kelly*, Jesse Connors, Ryan Howle. *Dept. of Anaesthesiology, The Coombe Hospital, Dublin, Ireland*

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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 under combined 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.

#36477 CLAVIPECTORALIS FASCIA BLOCK (CPB) COMBINED WITH SUPERFICIAL CERVICAL PLEXUS BLOCK. 10 CASE SERIES FOR CLAVICLE FRACTURE SURGERY

Adrian Santos*, Javier Nieto Muñoz, Maria Paz Fernandez Lara, Inmaculada Luque Mateos. *Anesthesiology, Hospital Costa Del Sol, Marbella, Spain*

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Application for ESRA Abstract Prizes: I apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims Clavicle fractures are a pathology with a relatively low incidence (2-3% of all fractures). Only a percentage of cases require surgical treatment. Among the different anaesthetic approaches, general anaesthesia associated with locoregional techniques is generally the gold standard. Classically, the regional block of choice has been the interscalene block. However, the development of ultrasound-guided peripheral blocks allows more interesting analgesic options, such as the clavipectoral 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.