

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?

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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

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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 multi-disciplinary 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

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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.

Results No adverse effects or anaesthetic complications were reported. The dose administered was 15 ml bupivacaine 0.5% for CPB and 5 ml bupivacaine 0.5% for the superficial cervical plexus block. There was no evidence of motor block of the operated limb. Immediate postoperative VAS was 0 in all cases and no rescue analgesia was required in the first 24 hours, only the usual multimodal analgesia.



Abstract #36477 Figure 1 IMAGEN 1

Conclusions CPB associated with superficial cervical plexus block is an effective analgesic alternative for clavicular surgery. It is a safe ultrasound-guided block, which makes it a valid alternative to multimodal intravenous analgesia. Further studies are needed to demonstrate the efficacy, advantages and complications associated with this locoregional technique.

#35895 REGIONAL ANESTHESIA AS AN ALTERNATIVE IN HIGH ANESTHETIC RISK PATIENTS, A REPORTED CASE

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Background and Aims A 59-year-old ASA IV patient with stage IV lung adenocarcinoma who suffered a pathological fracture of the distal right humerus. It was decided to do a closed reduction and internal fixation by traumatology with a T2 nail of the humerus. This patient was at a high anesthetic risk due to a history of bilateral PTE and pulmonary neoplasia that caused chronic respiratory failure with the need for oxygen therapy at home.

Methods In this case, regional anesthesia was performed under ultrasound control and neurostimulation: Interscalene block with 25ml of 0.375% levobupivacaine. Superficial cervical block with 10ml of 0.375% levobupivacaine. Suprascapular block with 10ml of 0.25% levobupivacaine. Intravenous sedation was performed in spontaneous breathing with nasal cannulas with capnography with: Remifentanyl 0.05mcg/kg/min Propofol 3mg/kg/h

Results Throughout the intervention the patient remained hemodynamically stable and with oxygen saturations of 97-

98%. Postoperative pain was well controlled without the need of opioids.

Conclusions This case wants to demonstrate the importance of having regional anesthesia in fragile patients with high anesthetic risk. We see how even in surgeries where general anesthesia is usually required, with a good anesthetic plan we can avoid it and perform the surgery safely and with excellent postoperative pain control, also avoiding the abuse of opioids in these patients.

#34642 CASE REPORT: ULTRASOUND-GUIDED COMBINED SUPERFICIAL CERVICAL PLEXUS BLOCK, CLAVIPECTORAL FASCIAL PLANE BLOCK AND DEXMEDETOMIDINE PERFUSION FOR SURGERY AFTER CLAVICULAR FRACTURE

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Background and Aims In thoracic trauma with pneumothorax, mechanical ventilation should be avoided whenever possible. Regional anesthesia can be an attractive alternative anesthetic approach in this setting. In clavicular surgery, regional anesthesia requires the block of various nerves that conduct nociceptive information of the skin over the incision area and the clavicular periosteum.

Methods A 66 year-old male patient was scheduled for open reduction and internal fixation of the right clavicle. He had a closed, displaced fracture in the middle third shaft of the right clavicle (car crash). The pre-anesthetic patient assessment revealed a significant medical past: ischemic stroke in 2016 and controlled arterial hypertension. The patient also presented a small right hemopneumothorax and bilateral rib fractures. The anesthesia plan included a regional anesthesia combined with dexmedetomidine perfusion. The regional anesthesia of the surgical field was achieved with a superficial cervical plexus block, combined with a clavipectoral fascial plane block.



Abstract #34642 Figure 1 Anesthesia distribution of peripheral's nerves blocks: superficial cervical plexus block and clavipectoral fascia plane block

Results The surgery lasted 2 hours, during which the patient remained comfortable, with total sensory block. Towards the