

end of the surgery, acetaminophen and parecoxib were administered. In the post-anesthesia care unit, the patient complained of no pain and no rescue analgesia was needed. During the first 24h post-surgery, the pain remained controlled with conventional intravenous analgesia with acetaminophen and non-steroidal anti-inflammatory drugs.

Conclusions In our case report, we decided to combine clavipectoral fascial plane block and superficial cervical plexus block. Together, these blocks can provide complete sensory anesthesia for surgical procedures involving the clavicle, providing a safe and reliable alternative to general anesthesia.

#36395 TREATMENT OF PURULENT ENDOPHTHALMITIS WITH PARS PLANA VITRECTOMY UNDER PERIBULBAR BLOCK AND CONSCIOUS SEDATION

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Background and Aims Endophthalmitis is a severe intraocular inflammation that can occur following surgery or eye trauma. Wound infection has been described as a primary foci of infection in endogenous endophthalmitis. We present a case of purulent endophthalmitis treated with immediate pars plana vitrectomy (PPV) under peribulbar block and conscious sedation.

Methods A 75-year-old male patient, with multiple cardiovascular risk factors, underwent open aortic valve replacement, and was readmitted one month later with sternal wound infection. He received antimicrobial treatment. Four months later, the patient presented with purulent endophthalmitis. PPV ensued under peribulbar block and conscious sedation with a propofol perfusion. Peribulbar block was performed with two injections of Ropivacaine 1%: inferior-temporal (5mL) and superior-nasal (3mL), to ensure adequate spread within the intraconal and extraconal spaces.

Results Peribulbar anaesthesia allowed akinesia and good surgical conditions with respiratory and hemodynamic stability. The surgical procedure was performed successfully without perioperative complications.

Conclusions Peribulbar anaesthesia is a feasible anaesthetic technique for PPV, as it allows akinesia during surgery, better hemodynamic stability, and fewer postoperative complications, especially in older fragile patients with comorbidities. PPV performed under peribulbar block can be considered a reliable approach in managing purulent endophthalmitis, offering a safe alternative to general anaesthesia.

#36014 AWAKE CRANIOTOMY WITH SCALP BLOCK IN A HIGH-RISK PATIENT WITH SEVERE COVID-19 PNEUMONIA, CASE REPORT

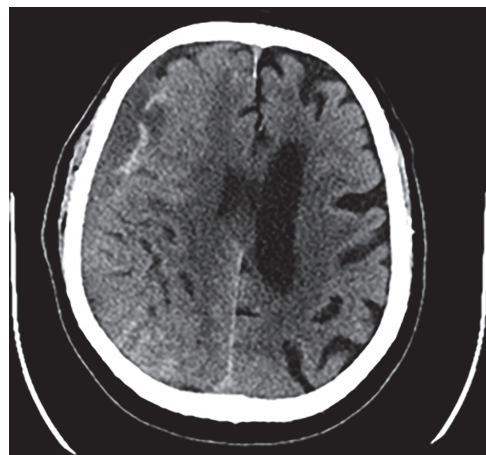
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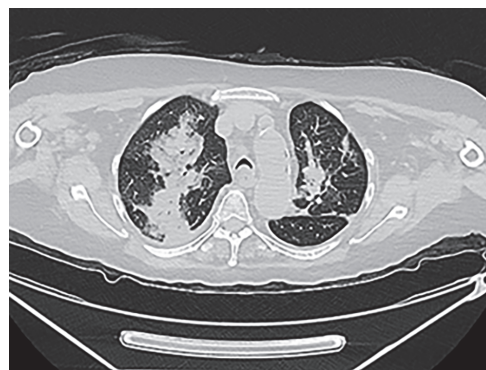
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Background and Aims Awake craniotomy is most commonly preferred in tumor resections that may cause neurological sequelae, arteriovenous malformation surgery, and deep brain stimulation applications such as Parkinson's disease. This case report describes an awake craniotomy performed with a monitored anesthesia care method in a high-risk patient with severe COVID-19 pneumonia.

Methods A 61-year-old male patient with known hypertension, diabetes, and coronary artery disease was isolated at home and diagnosed with SARS-CoV2 infection. The patient had a subdural hematoma due to head trauma as a result of sudden loss of consciousness (figure-1). He was unconscious (GCS:10 points). Due to his hypoxic condition and severe pneumonia (figure-2), operation was considered high-risk, and awake craniotomy was planned. He had respiratory rate of 46/min; heart rate of 88/min; blood pressure of 160/69mmHg, and oxygen saturation 86% with 4lt/min oxygen. Initially, a loading dose of dexmedetomidine was given as 1mcg/kg/100cc IV infusions for 15 minutes. Then, invasive blood pressure monitoring and bilateral scalp block with 0.5% bupivacaine were performed. The patient was sedated with dexmedetomidine infusion until end of operation. The operation, without any complications, was completed in 40 minutes.



Abstract #36014 Figure 1 Preoperative patient's brain tomography axial section image



Abstract #36014 Figure 2 Preoperative patient's lung tomography axial section image