

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 clavicular 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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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 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

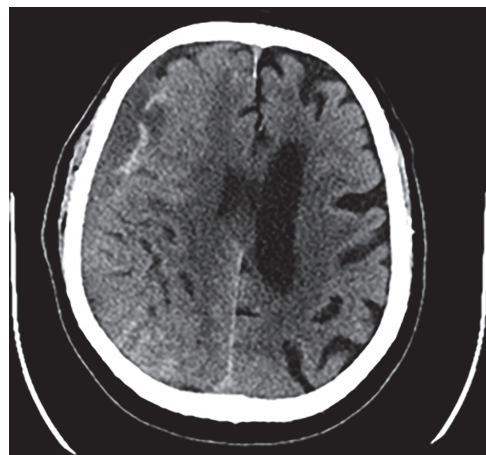
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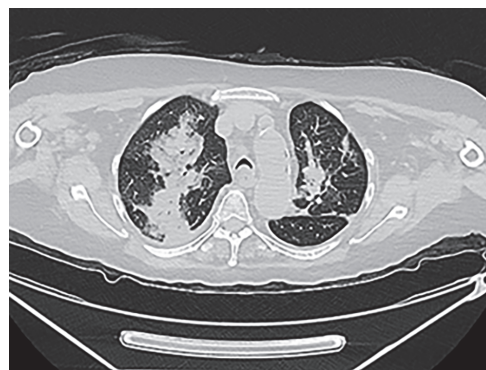
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Background and Aims Awake craniotomy is most commonly preferred in tumor resections that may cause neurological sequelae, arteriovenous malformation surgery, and deep brain stimulation applications such as Parkinson's disease. This case report describes 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

Results Scalp block takes first place in craniotomy analgesia and also provides hemodynamic stability. It is known that dexmedetomidine is an excellent alternative to propofol for sedoanalgesia. Therefore, the main reason for preferring the awake craniotomy method is that the patient has severe pneumonia.

Conclusions Awake craniotomy requires multidisciplinary teamwork and personal experience. Dexmedetomidine remains an indispensable agent of awake craniotomy with its anxiolytic and analgesic properties and minimal respiratory depression effect.

#36416 SCIATIC POPLITEAL BLOCK VS SCIATIC POPLITEAL COMBINED WITH SAPHENOUS BLOCK FOR ANKLE FRACTURE SURGERY – A RETROSPECTIVE STUDY

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

Background and Aims Surgical treatment of ankle fracture (AF) is associated with significant postoperative pain. The two peripheral nerve blocks (PNB) used more frequently to provide complete anesthesia/analgesia to the ankle are the sciatic popliteal nerve block (SPNB) and saphenous nerve block (SNB). These PNB may be used as de only anesthesia technique or may be combined with spinal or general anesthesia. The main objective of this study was to compare the postoperative pain scores of patients treated with SPNB and SPNB combined with SNB.

Methods We reviewed retrospectively 51 patients surgically treated to ankle fractures with PNB through the first 5 months of the year of 2023. Thirty-two had SPNB and 19 SPNB plus SNB. The primary outcomes were pain scores at day 1 (D1) and day 2 (D2) postoperatively using the visual analog scale (VAS) score.

Results Pain scores did not vary significantly when comparing the use of SPNB and SPNB plus SNB. The mean VAS score of SPNB group at D1 was 0.59 +/-

1.16 and of SPNB plus SNB group 0.42 +/- 1.02 (p=0.29). At D2 the mean VAS score of SPNB group was 0.81 +/- 1.44 and the SPNB plus SNB group 0,95 +/- 1.43 (p=0.62).

Conclusions When combined with spinal anesthesia or general anesthesia SPNB may be sufficient to provide postoperative analgesia after AF surgery. The SNB may not add any postoperative analgesic benefit into this group of patients. The combination of SPNB plus SNB may be advantageous when surgery is performed only under regional anesthesia with PNB.

#35737 USE OF CONTINUOUS SACRAL PLEXUS BLOCK IN A PARTURIENT WITH TRAUMATIC PELVIC FRACTURES

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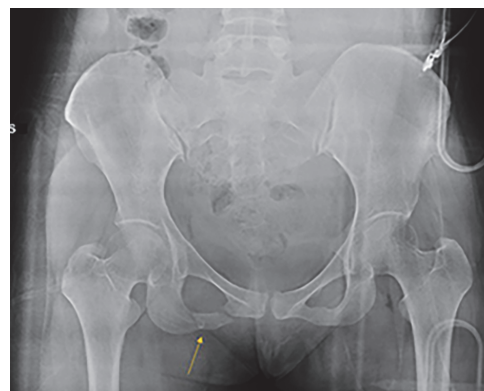
10.1136/rapm-2023-ESRA.518

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Background and Aims Background: Severe pain from sacral fractures can be difficult to treat especially in the parturient where systemic analgesia options are limited by its maternal and fetal side effects. Regional anaesthesia can be especially useful in providing analgesia due to its minimal side effects. Aims: We postulated that a sacral plexus catheter can help achieve our goals of 1) long-lasting pain control without need for repeated procedures, 2) minimal maternal and fetal side effects, 3) facilitating physiotherapy and rehabilitation, and 4) early home discharge.

Methods We detail the case of a 30-year-old 16-week parturient with traumatic sacral fractures. Despite optimal multimodal analgesia, our patient experienced debilitating pain affecting her breathing, sleep, and rehabilitation. As analgesia options were limited, regional anaesthesia techniques including a sacral plexus catheter, caudal and lumbar epidural block were offered. A right sacral plexus catheter was eventually inserted for pain relief, using the parasacral parallel shift approach under ultrasound guidance. An initial local anaesthetic bolus of 15mL Lignocaine 1.5% with adrenaline 1:200,000 was injected, followed by a continuous infusion of Ropivacaine 0.2% at 5ml/h. She was followed up daily by the Acute Pain Service team.

Results With the sacral plexus catheter, our patient experienced significant pain relief and rehabilitated well. She reported improvement in pain with from a Numeric Rating Scale of 10 to 2 post-procedure and recovered sufficient function for home within 1 week.



Abstract #35737 Figure 1 Plain radiograph of the pelvis showing mildly displaced fracture of the right inferior pubic ramus. Site of fracture indicated by yellow arrow