CLAVIPECTORAL FASCIAL PLANE BLOCK AS SOLE ANESTHETIC TECHNIQUE FOR CLAVICULAR FRACTURE SURGERY – IS IT ENOUGH? A CASE SERIES REPORT

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Background and Aims The clavipectoral fascial plane block (CPB) is a recent regional anesthesia technique that has been utilized for clavicular fracture surgery. Although the sensory innervation of the clavicle is controversial, CPB seems to be effective since many of the sensory nerves pass through the plane between the clavipectoral fascia and the clavicle itself. We describe 3 cases where general anesthesia and airway manipulation were avoided with the use of CPB as sole anesthetic technique.

Methods We present 3 patients with closed, complete midshaft fractures of the clavicle, submitted to open reduction and fixation. The first case was a 74-year-old patient with history of heart failure (Ejection fraction <20%). We performed a CPB with 20 mL ropivacaine 0,5% and minor sedation with midazolam. The second case was a 19-year-old patient victim of trauma with multiple rib fractures and pneumothorax. We did a CPB with 30 mL ropivacaine 0,5% under sedation with 0,5-0,7 mcg/kg/h of dexmedetomidine. The third case was a 54-year-old patient with history of difficult airway. We used CPB with 30 mL ropivacaine 0,5% combined with dexmedetomidine sedation.

Results In all cases, there were no registered complications and pain scores were low (VAS score of 1-2/10) in PACU.

Conclusions This technique may provide benefits to patients with difficult airways and in trauma. Comparing with interscalene block, CPB can avoid adverse events such as ipsilateral phrenic nerve palsy, vocal cord paralysis, vertebral artery injection, total spinal anesthesia and pneumothorax. However, loss of the fascia’s integrity during trauma may compromise the spread of the local anesthetics.

AN UNOPTIMISABLE PATIENT: A CASE REPORT OF ANAESTHETIC MANAGEMENT FOR A SEPTIC JOINT

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Background and Aims Prosthetic joint infections can be challenging to treat and often require surgical intervention. We present a case of arthroscopic knee washout performed under peripheral nerve blocks due to the high risks of general and neuraxial anaesthesia.

Methods A 75 year old lady presented with an infected prosthesis, two years post total knee arthroplasty. She had a BMI of 40, hypertension, TIA one year ago (currently on Clopidogrel), moderate obstructive spirometry (FEV1 72% predicted), ASD repair 40 years ago and suspicion of pulmonary hypertension on CT thorax. She was positive for COVID-19 on admission. Surgical debridement was delayed due to the risks of both general and regional anaesthesia given her COVID status and anti-platelet medication. Clopidogrel was stopped and she was treated with IV antibiotics. After two days she was at risk of deteriorating; she had significantly elevated inflammatory markers and was repeatedly spiking temperatures. Given her ongoing anaesthetic risks we consented her to have a joint washout under awake peripheral nerve blocks. Ultrasound guided femoral and popliteal nerve blocks were performed with 16ml and 20ml 1% Prilocaine respectively. Aliquots of alfentanil were required intermittently during the procedure to a total of 800mcg, and the patient was reassured throughout.

Results Arthroscopic washout was successfully performed in this patient under femoral and popliteal nerve blocks using 1% Prilocaine, with supplemental intravenous analgesia.

Conclusions Peripheral nerve blocks can be used for washout of infected knee joints, allowing time for optimisation before definitive surgical intervention under neuraxial or general anaesthesia.