

**Results** Surgery and anaesthesia were uneventful. In the post-operative period leading to hospital discharge (5 days later), the VAS at rest or movement remained low (0-1), and no rescue analgesia was needed. The child showed an extreme degree of satisfaction with the management of postoperative pain, and no complications with the cFNB were reported during the hospital stay.

**Conclusions** In the present case report, a Continuous FNB was found to be a safe and effective analgesic technique for the management of pain associated with pathological fractures in paediatric cancer patient with thrombocytopenia. Consequently, cFNB should also be considered for these patients also preoperatively, to ensure adequate pain management and improved overall patient experience.

### #36488 THORACIC PARAVERTEBRAL BLOCK (TPVB) FOR TREATMENT OF ELEVATED HEMIDIAPHRAGM DUE TO PHRENIC NERVE INJURY AFTER INTERSCALENE BLOCK

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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)

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

**Background and Aims** A 50 years old, male patient, was scheduled for surgical repair of rotator cuff injury. An interscalene approach to the brachial plexus was selected to provide analgesia and was combined with general anaesthesia (TIVA). During the immediate post-operative period, the patient developed shortness of breath and complained for easy fatigue, which, after a detailed examination, were attributed to a paralysis of the right phrenic nerve, resulting in the elevation of the right hemidiaphragm and causing the symptoms. This was considered a complication of the interscalene block.

**Methods** After six months with no improvement, a restoration of the diaphragm with thoracoscopic technique was decided. The patient was scheduled for diaphragm plication. The anaesthesia was performed with paravertebral block and general anaesthesia (TIVA). Throughout the 6 hours long surgery, the patient remained hemodynamically stable, while he didn't present any other analgesic demands. After the operation, the patient was extubated and his level of analgesia was assessed, based on NOL (15) and VAS (2) scales.

**Results** Throughout the 6 hours long surgery, the patient remained hemodynamically stable, while he didn't present any other analgesic demands. After the operation, the patient was extubated and his level of analgesia was assessed, based on NOL (15) and VAS (2) scales.

**Conclusions** Paravertebral block is an attractive regional anaesthetic technique, as it can provide excellent unilateral analgesia, with a low rate of hypotension compared to epidural anaesthesia for thoracic and abdominal procedures. In our case,

paravertebral block was proved an efficient analgesic technique for a long and laborious time operation.

### #35531 WEATHERING THE STORM: AMPUTATION IN A PATIENT WITH SEPSIS INDUCED MULTIORGAN DYSFUNCTION UNDER NERVE BLOCKS – A CASE REPORT

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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** Lower limb amputation is a procedure usually performed under general or neuroaxial anaesthesia. However, in certain cases as patients in multiorgan failure, peripheral nerve blocks are the only viable alternative for anaesthesia.

**Methods** A 68-year-old male presented with an acute limb ischemia complicated by an infected ulcer leading to sepsis and multiorgan failure. The patient had a history of diabetes, myocardial infarction and triple vessel disease waiting for CABG. Considering the patient's cardiac condition, septic status, acute kidney injury, acute liver failure, general and spinal anaesthesia was deemed high risk. Therefore, a combination of iliac fascia, subgluteal sciatic and obturator blocks was proposed for anaesthesia to a life-saving transfemoral amputation. The procedure was carried out under sedation with dexmedetomidine and ketamine.

**Results** The patient had adequate anaesthesia and remained hemodynamically stable throughout the surgery and the post-operative period. Sedation in this procedure was required for the comfort of the patient and analgesia adjuvant.

**Conclusions** Sepsis induced multiorgan dysfunction is a challenge for the anaesthesiologist due to general and spinal anaesthesia side effects. Nerve blocks with sedation could be a safe alternative for anaesthesia in septic patients proposed for limb amputation.

### #36407 REGIONAL ANESTHESIA TECHNIQUES VERSUS NEURAXIAL TECHNIQUES FOR LOWER LIMB PERIPHERAL VASCULAR SURGERY AT HIGH-RISK PATIENTS

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**Please confirm that an ethics committee approval has been applied for or granted:** Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

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

**Background and Aims** Peripheral vascular disease (PVD) is a major cause of morbidity and mortality globally, with significant financial burdens on critical healthcare resources. Regional blocks is a widely used anaesthesia techniques for high-risk patients with severe coexisting diseases and use of anticoagulants in which general anaesthesia and neuraxial blocks is harmful and should be avoided. The aim of this study is to

serve as a reminder of its significant value of regional anesthesia blocks in patients who are not appropriate for other type of anesthesia

**Methods** 120 patients underwent a peripheral vascular reconstruction of lower limbs which were performed under either spinal anesthesia I group (30 patients) or regional block II group (n.femoralis, n.ischiadicus, n.obturatorius)with local infiltration at the site of dissection as needed(30 patients)or combined spinal-epidural anesthesia III group (30 patients). Outcomes will include longer-term mortality;major adverse cardiovascular,pulmonary,renal and limb events;delirium;neuraxial or regional anesthesia–related complications;graft-related outcomes;length of operation and hospital stay;costs;and patient-reported or functional outcomes.

**Results** Operations included femoral-femoral,femoral-popliteal bypass grafting.Average age of patients 72.7 years.ASA score III-IV.The intra-operative events showed that the mean time needed to perform the block and dose of analgesics and sedatives needed during surgery was greater in group II and III, compared to group I.Local infiltration in the area on the dissection with 5 ml 1%lidocaine was required in patients in group II vs none in the spinal group and combined spinal-epidural technique.

**Conclusions** Lower limb vascular reconstruction can be done under regional anesthesia(n.femoralis,n.ischiadicus,n.obturatorius blocks)what can allow to avoid hard complications at patients with high-risk diseases and optimize pain relief for them.

### #36367 ANAESTHETIC MANAGEMENT OF A PATIENT WITH PURE AUTONOMIC FAILURE: A CASE REPORT

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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** Pure Autonomic Failure (PAF) is a rare neurodegenerative disease of the autonomic nervous system. The etiology is unknown but its pathophysiology involves the accumulation of a protein, called Lewy bodies, in the cells of autonomic nerves, leading to reduced norepinephrine production and release. Therefore, the main symptom of PAF is orthostatic hypotension, but it can also present bladder dysfunction, constipation, anhidrosis and sleep disorders. We describe the successful anesthetic management of a patient with PAF.

**Methods** A 68 year old man, ASA physical status III, was scheduled for unicompartmental knee prosthesis surgery. He was diagnosed with PAF 5 years before due to orthostatic hypotension, neurogenic bladder, erectile dysfunction, hypsomia and REM sleep behavior disorder. An arterial line and central venous catheter were placed. We performed regional anesthesia with femoral, sciatic, obturator and lateral cutaneous nerve blocks guided by ultrasound and neurostimulation.

**Results** The surgery took about 1 hour and went out uneventfully with no need to administer vasoactive drugs. The patient was transferred to the intermediate care unit and was discharged home on post-operative day 4.

**Conclusions** PAF is a rare disease that can present challenges to the Anaesthesiologist. General management must focus on ensuring hemodynamic stability perioperatively. In this clinical case, we demonstrate that regional anesthesia with peripheral nerve blocks can be an effective and safe anesthetic option. Further considerations include: exaggerated or unpredictable response to vasopressors, decreased clearance of drugs with liver metabolism (such as amino amide local anesthetics) and avoidance of prolonged postoperative inactivity.

### #35936 EXTERNAL OBLIQUE INTERCOSTAL BLOCK FOR NEPHRECTOMY: A CASE REPORT

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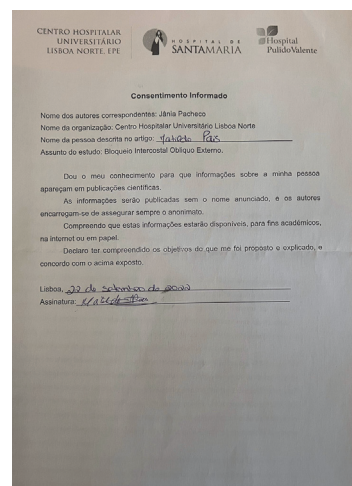
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**Background and Aims** The recently described external oblique intercosteral (EOI) plane block might be a good alternative to neuraxial analgesia for upper abdominal incisions, since it is a superficial nerve block that can be performed in the supine position and has easily identifiable ultrasound points, providing upper midline and lateral abdominal wall analgesia.

**Methods** A 57-year-old female patient, ASA-PS III, presenting with left emphysematous pyelonephritis, was submitted to urgent left total nephrectomy through an oblique subcostal incision. The surgery was performed under general anaesthesia combined with an ultrasound-guided injection of 20 mL of levobupivacaine 0.25% (50mg) and dexamethasone 4mg in the EOI fascial plane. Multimodal Intravenous analgesia with paracetamol 1g and tramadol 100mg were also administered.

**Results** Before emergence from anaesthesia, a catheter in the EOI plane was placed and 20mL of ropivacaine 0.2% (40mg) was given. Upon awakening, the patient reported no pain. The postoperative pain management regimen involved intravenous paracetamol 1g every 8 hours and 20ml of ropivacaine 0.2% (40mg) through the EOI plane catheter every 4 hours. No additional analgesia was required.



Abstract #35936 Figure 1 Patient consent