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

Catarina Tiago, Ana Marques*, Carmen Pereira. *Anesthesiology, Centro Hospitalar Vila Nova de Gaia/Espinho, Vila Nova de Gaia, Portugal*

10.1136/rapm-2023-ESRA.550

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, hyposmia 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

Rita Barbosa, Marco Dinis*, Alexandra Resende. *Anesthesiology, Centro Hospitalar Universitario Lisboa Norte, Lisbon, Portugal*

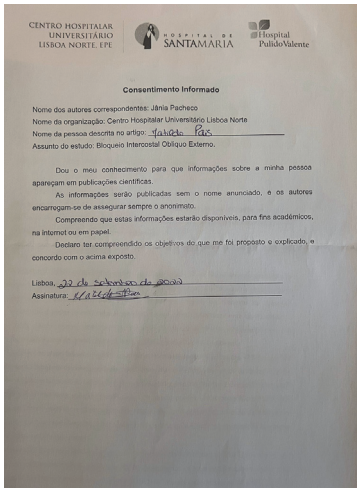
10.1136/rapm-2023-ESRA.551

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

Background and Aims The recently described external oblique intercostal (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 administrated.

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.


CENTRO HOSPITALAR UNIVERSITÁRIO LISBOA NORTE, EPE
HOSPITAL DE SANTA MARIA
Hospital Pulido Valente

Consentimento Informado

Nome dos autores correspondentes: Jânia Pacheco
Nome da organização: Centro Hospitalar Universitário Lisboa Norte
Nome da pessoa descrita no artigo: Yolanda Paes
Assunto do estudo: Bloqueio Intercostal Oblíquo Externo.

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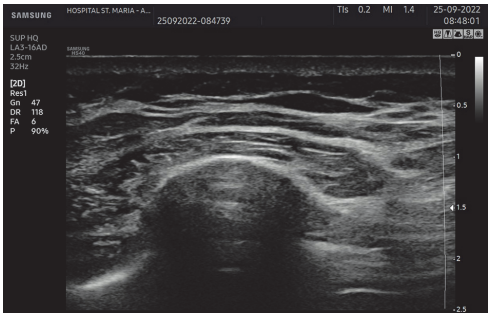
Abstract #35936 Figure 1 Patient consent

Abstract #35936 Figure 2 External Oblique Intercostal Block



Abstract #35936 Figure 3 External Oblique Intercostal Block

Conclusions The EOI plane block shows promising results in targeting upper abdominal wall analgesia, an anatomic region not sufficiently addressed by other fascial plane blocks, such as the subcostal Transversus Abdominis Plane block or the Rectus Sheath block.

#36086 PATIENT PERCEPTIONS AND RECALL OF THE CONSENT PROCESS FOR REGIONAL ANAESTHESIA WITHIN OUR DEPARTMENT

Emma Lennon*, Sheriff El Mahgoub, Shanika Wijayaratne, Abigail Walsh. *Anaesthetics, SVUH, Dublin, Ireland*

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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 There are well established procedures for obtaining and documenting informed consent for surgical procedures. Anaesthetic procedures, lack the same standardized approach. This has safety implications for patients and clinicians. We sought to evaluate the patient experience of those who underwent regional anaesthesia (RA) within our department.

Methods Following approval from our audit committee, we conducted a twelve-part telephone survey with thirty patients regarding their experience of RA.The survey explored the circumstances under which patients were consented, and their recall of the information provided.

Results Of the total number of patients interviewed (n=30), seventy percent (21) believed the NB was compulsory. Sixty percent (18) could not recall any of the possible advantages of receiving a NB and eighty percent (24) could not recall any risks. Sixty-six percent (20) of patients were consented for a NB in the holding bay. Sixteen percent (5) were consented in the induction room. Sixty percent (20) of patients said they would have valued written information regarding the NB. A majority (17) felt they did not have adequate time to consider the NB.Currently there is no formalized process that exists within our department for documentation of the risks and benefits discussed with patients. The practise of which can therefore vary greatly amongst practitioners.

Conclusions Our results demonstrate a paucity of information that is either delivered to, or retained by, our patients with regards to receiving RA. We aim to distribute a Patient information leaflet to better achieve informed consent from our patients.

#35958 NERVE BLOCK OR DOPPLER SIGNAL? WHICH ONE COMES FIRST?

[1]Vasyl Katerenchuk*, [2]Afonso Borges de Castro*, [3]Idalina Rodrigues. *[1]Anesthesiology, Centro Hospitalar de Setúbal, Setúbal, Portugal; [2]Anesthesiology, Hospital de Vila Franca de Xira, Lisboa, Portugal; [3]Anesthesiology, Centro Hospitalar de Lisboa Norte, Lisboa, Portugal*

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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 Proper pain management in patients undergoing Anterolateral Tigh (ALT) flap surgery is crucial to minimize early postoperative complications. We present a case of a 58-year-old male admitted for partial pelviglossectomy, mandibulectomy and ALT of the left limb, who received both limbs a femoral nerve block due to insufficient Doppler flowmetry on the limb first chosen by the surgeons. We aim to demonstrate that a pre-emptively femoral nerve block can be part of a multimodal analgesic strategy in these patients and that a second non-planned nerve block can be safely performed if the maximum dose of local anesthetic is taken into consideration.

Methods A total intravenous anesthesia with propofol and remifentanil was induced and a single-shot, ultrasound-guided, right and left femoral nerve blocks were performed using 15 ml of 0,75% ropivacaine on each side. A total of 30ml (225 mg) was administered – a safe dose of ropivacaine for an 80kg patient. The maintenance dose of remifentanil was low (up to less than 0,05-0,10 mcg/kg/min) and analgesia was complemented with ketorolac 30mg, paracetamol 1g and morphine 2mg.

Results There were no signs of local anesthetic systemic toxicity (LAST) and the patient was admitted to the post-anesthetic care unit after 10h of surgery without pain in the flap area, 0/10 (numerical rating scale pain) at rest and movement. Pain at rest was only reported more than 24h after the block.

Conclusions This case enhances the importance of performing vascular Doppler signals before anesthetic nerve blocks to avoid unnecessary blocks and risk for LAST.