#36359 CAROTID ENDARTERECTOMY IN A PATIENT WITH SEVERE AORTIC INSUFFICIENCY – A CASE REPORT

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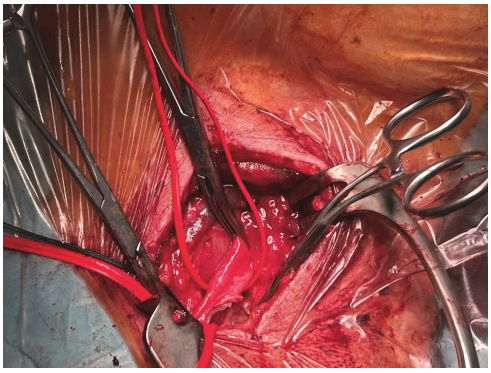
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Background and Aims Carotid endarterectomy is the mainstay of treatment for symptomatic carotid artery stenosis. Perioperative management of such patients is challenging(1). Anesthetic management involves decreasing diastolic time and thus regurgitant volume, as well as reducing afterload and aortic- ventricular gradient. We report a successful case of a patient with severe aortic insufficiency who underwent carotid endarterectomy under locoregional anesthesia.

Abstract #36359 Figure 1 Ultrasound guided intermediate cervical plexus nerve block



Abstract #36359 Figure 2 Carotid endarterectomy. The image shows open, cross-clamped carotid artery

Methods A 73-year-old man, ASA IV, with severe aortic insufficiency waiting for cardiac surgery, complained of episodic amaurosis fugax. Carotid doppler ultrasound demonstrated >90% stenosis of the right internal carotid artery. Carotid endarterectomy was proposed. On preoperative study, the echocardiogram showed severe aortic insufficiency with preserved global biventricular systolic function. After informed consent and anesthetic monitoring, 1 mg of midazolam and 50 micrograms of fentanyl were administered before the anesthetic blockade. An ultrasound-guided intermediate cervical plexus block with 15 ml of 0,75% ropivacaine was performed (figure 1). Another bolus of midazolam and fentanyl were readministered within 30 minutes of the first administration and again near the end of surgery. The patient remained hemodynamically stable and the procedure (figure 2) was uneventful. After surgery, the patient was transferred to a level 2 intensive care unit.

Conclusions For carotid endarterectomy some studies describe better intraoperative hemodynamic stability as well as enhanced control of postoperative pain using a locoregional technique (2). In our case, the execution of an intermediate cervical plexus block allowed for real-time intra-operative neurological monitoring in an awake patient and less cardiovascular impact on a high-risk cardiac patient while giving optimal anaesthetic effect for surgical purposes.

#36552 INTRAOPERATIVE AND POSTOPERATIVE EFFECTS OF ADJUVANT DEXMEDETOMIDINE AND TRAMADOL IN SUBKOSTAL TRANSVERSUS ABDOMINIS PLAN BLOCK

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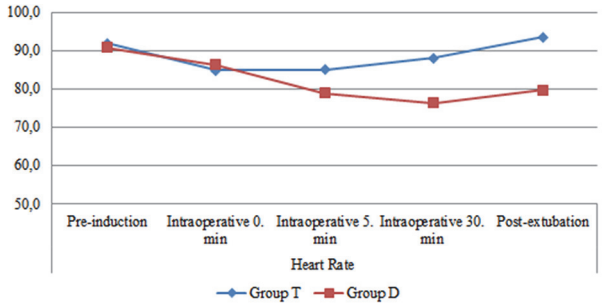
Background and Aims The dexmedetomidine and tramadol were added as adjuvant to bupivacaine in transversus abdominis plane block (TAP).

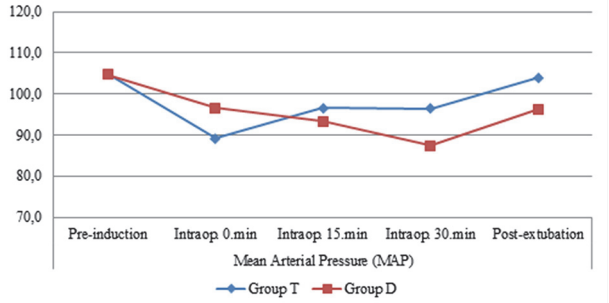
Methods The study was carried out with 60 ASA I-II class participants aged 20-60 years who underwent laparoscopic cholecystectomy at Van Yüzüncü Yıl University Faculty of Medicine. Participants were randomized into two groups. - Group T (Adjuvant Tramadol): 40 mL of 0.250% bupivacaine +

1.5mg/kg and a maximum of 100 mg tramadol adjuvant - Group D (Adjuvant Dexmedetomidine): 40 mL of 0.250% bupivacaine + 0.5 mcg/kg and a maximum of 50 mcg dexmedetomidine adjuvant Standard general anesthesia was applied. After intubation, bilateral subcostal TAP block was performed by the same anesthesiologist, demographic data were recorded. Intraoperative vital signs of the participants (pulse, non-invasive blood pressure and peripheral oxygen saturation measurement), additional opioid and muscle relaxant needs, and complications were recorded. Extubation was performed after standard decurarization with atropine and neostigmine. Postoperative side effects (nausea, vomiting, pruritus, shivering), postoperative additional analgesic need, and 0 hour (Modified aldrete score ≥9 time was accepted as 0 hour), 3rd hour and 6th hour Visual Analogue Scale (VAS) scores were evaluated and recorded.

Results There was no statistically significant difference between the groups in terms of demographic data, intraoperative opioid consumption, muscle relaxant use, postoperative analgesic effects, side effects and postoperative mobilization time. (figures 1, 2).



Abstract #36552 Figure 1 Heart rates



Abstract #36552 Figure 2 Mean arterial pressure changes

Conclusions The dexmedetomidine as an adjuvant to bupivacaine in the bilateral subcostal TAP block will provide stable hemodynamics. It should be supported by studies with large participation.
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#36485 ARE WE ALL READY TO PERFORM & TEACH THE PLAN-A BLOCKS?

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

Background and Aims The 2021 curriculum for anaesthetists in training in the United Kingdom recognises the importance of regional anaesthesia. All anaesthetists in training are now expected to be able to perform regional anaesthesia to the abdominal wall, chest wall, lower limb and upper limb independently by the end of their training . The Regional Anaesthesia UK (RA-UK) Plan A blocks documents provide a framework for regional anaesthetic techniques covering each region of the body. We wanted to assess the readiness of our department to be able to perform and/or teach these skills.

Methods We designed an anonymous questionnaire to assess the readiness of permanent staff members within our department to perform and teach each technique listed in the RA-UK plan A blocks, including catheter techniques.

Results 62 responses were received. Of these, 47 were from consultants or locally employed doctors who would be expected to supervise trainees during their daily work. Table 1 demonstrates that, In our institution we identified a high proportion of permanent staff members able to teach the upper and lower limb plan A blocks, but a much lower confidence level with trunk blocks.

Conclusions This survey demonstrates the need to focus on training of the permanent staff body in plan A trunk blocks in particular before we can reliably teach anaesthetists in training. 92% respondents felt future departmental teaching/sessions on scanning and teaching on Plan A blocks would be helpful for their development, including the use of perineural/fascial plane catheter techniques.

Attachment Plan A blocks abstract.pdf

#35963 WALANT TECHNIQUE FOR HAND SURGERY: WHAT'S THE ADVANTAGE? – CASE REPORT

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Background and Aims Regional anesthesia has been used for hand surgeries for many years, but a recent technique has been becoming increasingly popular: the 'wide- awake local anesthesia no tourniquet' (WALANT). This allows the combination of sensitive block and a bloodless field, with preservation of motor function.

Methods We selected a 63-year-old male patient with an old traumatic tendon section in the first finger of his hand that resulted in loss of mobility. One year later, he was proposed for tendon transposition from the second to the first finger to reestablish total abduction ability. The patient only had grade 1 obesity. We performed ultrasound guided peripheral nerve blocks of the radial, ulnar and median nerves at the forearm level, which preserved motor function during the surgery and guaranteed loss of pain sensation. To obtain a bloodless field without a tourniquet, we performed ultrasound assisted subcutaneous infiltration of lignocaine and epinephrine on the dorsal surface of the hand.

Results The surgery lasted two hours, and the size of the transposed tendon was deemed appropriate through intraoperative observation of ideal hand mobility (see QR code). The orthopedics team confirmed optimal surgical field conditions with this technique. The patient was evaluated at 1 month and, with physical therapy, regained almost all mobility of the hand and showed immense satisfaction.