Abstract #35949 Figure 1  Pulsated Doppler at the suprahepatic vein showing inversion of the S wave

Abstract #35949 Figure 2  Pulsated Doppler at the Porta vein showing increased pulsatility

Abstract #36421 Figure 3  Hepatic parenchyma is evident to the left, hypoechogenicity in the lower part of the picture corresponding to the Superior vena Cava. Gastric antrum appears to be hyperechogenic with heterogeneous solid content. Transectional area of gastric antrum was measured and that revealed an area of 16.12 cm². According to the equation proposed by Perlas et al (1.27.0 + 14.6 × ACSA*-1.28 × age), resulted in an approximation of 213 ml. This amount is higher than it is considered safe for general anesthesia induction. *Antrum Crossectional Area

Conclusions The use of gastric ultrasound to visualize the gastric antrum prior to surgical intervention is a quick technique that is safe for patients and can be useful to identify those who are at risk and consequently need adequate anesthetic management as a full stomach status.

Attachment: INFORMED CONSENT.pdf

HYPOTENSION AFTER CARDIAC SURGERY, USING POCUS TO KNOW WHICH WAY TO GO. A DOUBLE 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 The postoperative period is one of the most critical moments in a patient’s recovery process mortality is a lot higher than actual intraoperative. Hypotension is related to significant damage that could increase the risk of myocardial injury, mortality, and kidney injury. Therefore, controlling hypotension correctly in the postoperative period is essential.

Methods We present two patients; the first is a male 56 years old who underwent emergency cardiac surgery for an ascending aorta dissection, and the second, is a 65-year-old male who was operated on for a triple cardiac bypass. After surgery, they both get admitted into the critical care unit for postoperative care. Two hours after surgery the present persistent hypotension. To correctly treat the cause of the hypotension we decided to perform POCUS (point-of-care-ultrasound) following the algorithm proposed by Rodenas et al. Results are presented in Table 1.

Results Patient 2 develop correctly after the administration of continuous intravenous perfusion of norepinephrine. Patient 1 responded well to volume, but an hour after, hypotension started again, not responding to liquid administration, therefore we performed POCUS to orientate the origin. The echocardiographic evaluation showed us that the small pericardial effusion was now a pericardial tamponade (20mm). Immediate surgery was indicated.
Abstract #35949 Table 1  Integral velocity time index at the aorta exit (IVTI Ao), Left Ventricle (LV), Right Ventricle (RV), and Systolic Volume Variation (SVV)

<table>
<thead>
<tr>
<th></th>
<th>TSI cm</th>
<th>Global function</th>
<th>Pulmonary 8 lines</th>
<th>Abdominal echography</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>15</td>
<td>Adequate contraction but evidence of small pericardial effusion (5 mm)</td>
<td>No significant 8 lines</td>
<td>No venous congestion</td>
<td>-Volume charge administration.</td>
</tr>
<tr>
<td>Patient 2</td>
<td>11</td>
<td>Adequate contraction</td>
<td>&gt;3 8 lines per field</td>
<td>Moderate to severe congestion (Images 1 and 2)</td>
<td>-Liquid restriction. - Vasopressors</td>
</tr>
</tbody>
</table>

Conclusions In these two case reports, we can see the importance of using echography as a complementary tool to correctly orientate the cause of hypotension in the postoperative period, since it gives us valuable information in clinical practice. Using it in conjunction with regular monitoring will permit better care in this critical time.

AIRWAY ULTRASOUND FOR DIFFICULT AIRWAY MANAGEMENT; 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 Difficult airway intubation can be challenging for anesthesiologists, because of the unexpected situation. Using the ultrasonography can help mitigate any issues that may arise.

Methods A 57 year-old-woman was admitted to A&E, with stridor and dyspnea. A diagnosis of bilateral vocal cord paralysis was made, requiring an emergency tracheostomy. In the operating room, we assessed the upper airway using the ultrasound, which confirmed the vocal cord paralysis. The patient was prepared for an awake intubation. Nebulization with 5ml of

LUNG ULTRASOUND AFTER CENTRAL VENOUS CATHETER CANNULATION: WHEN THERE’S MORE THAN AIR – 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 Lung ultrasound has become standard practice following central venous catheter cannulation to detect pneumothorax. In addition to this complication, we present a case report of an iatrogenic subclavian artery hematoma visualized through thoracic ultrasound, which was not identified in the chest radiography.

Methods We present the case of a 58-year-old woman, ASA III, diagnosed with stage IV colon cancer resulting in intestinal occlusion and contained perforation. The patient was proposed for a right colectomy and a totally implantable central venous access device for chemotherapy. A balanced general anesthesia technique was employed, and an ultrasound-guided bilateral rectus sheath single-shot block was performed for analgesic purposes. The central venous implantable catheter placement needed several attempts, with iatrogenic subclavian artery puncture. After successful catheter placement, subsequent post-procedure lung ultrasound revealed the presence of lung sliding with hypoechoic displacement of the visceral and parietal pleura at the level of the first and second ribs on the same side as the procedure, compatible with an hematoma. A thoracic radiograph performed thereafter did not identify hemothorax; however, it did identify improper final positioning of the tip of the catheter, specifically at the contralateral subclavian vein.

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Conclusions This case report highlights the utility of lung ultrasound in identifying complications of central venous catheterization, such as hematoma following iatrogenic artery puncture. While thoracic radiography remains the standard for tip localization and exclusion of pneumothorax, lung ultrasound serves as an additional valuable tool in detecting other potential complications.