

**Conclusions** This case contributes to the experimental evidence that high dose ketamine can be used safely to achieve analgesia for refractory, phantom limb pain during the acute, postoperative period. High dose ketamine can be incredibly effective in achieving analgesia in refractory, acute, postoperative phantom limb pain.

### #35824 UNEXPECTED FOOT DROP AFTER PROXIMAL IPACK BLOCK

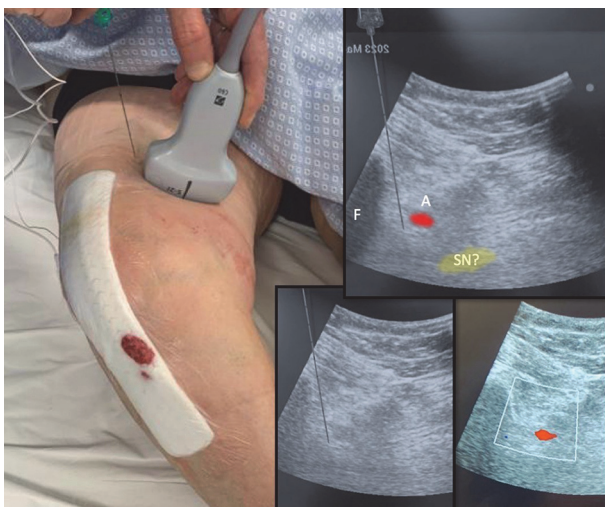
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**Please confirm that an ethics committee approval has been applied for or granted:** Not relevant (see information at the bottom of this page)

**Background and Aims** In our institution, a common practice for providing motor-sparing analgesia after total knee replacement (TKR) is by combining the distal IPACK with adductor canal block. These blocks are typically administered preoperatively after spinal anesthesia to enable pain-free early exercise or deambulation as the neuraxial block wears off. However, in this case report, we describe an inadvertent sciatic block following proximal IPACK block.

**Methods** Informed consent for publication was obtained. A 69-year-old woman scheduled for TKR, was admitted to the preoperative room with delay. Since the patient arrived late, we decided to proceed with spinal anesthesia and surgery, postponing the analgesic blocks to the recovery area. In order to avoid dressing manipulation and to maintain distance from the prosthesis, we performed the IPACK block postoperatively using the proximal technique, approximately two fingers above the patella in supine position. We injected 20 ml of 0.5% ropivacaine with dexamethasone 4 mg between the popliteal vessels and the femur.



**Abstract #35824 Figure 1** Proximal IPACK block simulation: F = femur shaft; A = popliteal artery; SN = possible location of sciatic nerve. The technique does not permit optimal visualization and require the needle to point an area at risk for nerve involvement. Nerve stimulation is recommended

**Results** The first evaluation was postponed to the following morning since it was late afternoon when the block was performed. The patient presented with complete sensory and motor block below the knee, which resolved completely about 18 hours after the block.

**Conclusions** Proximal approach to IPACK may increase the risk of local anesthetic spreading toward the sciatic nerve and subsequent motor block. Therefore, we recommend performing this block with nerve stimulator or to choose alternative analgesic techniques for the posterior capsule of the knee, unless a clear US real-time visualization of the nerve structures during injection is possible.

### #36316 TAP-BLOCK AS A DIAGNOSTIC AND MONITORING TOOL IN ACUTE SURGICAL ABDOMEN: A CASE REPORT

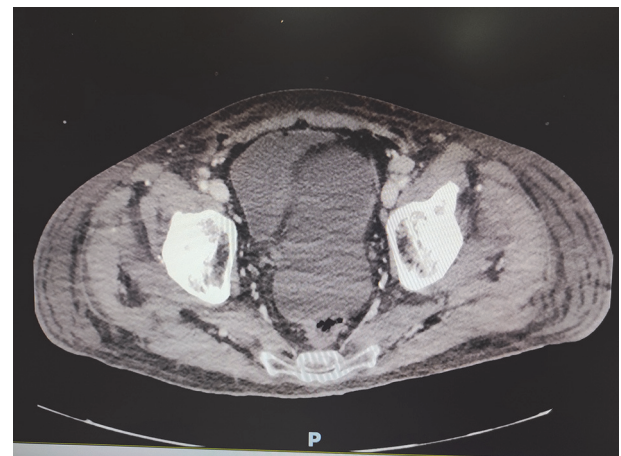
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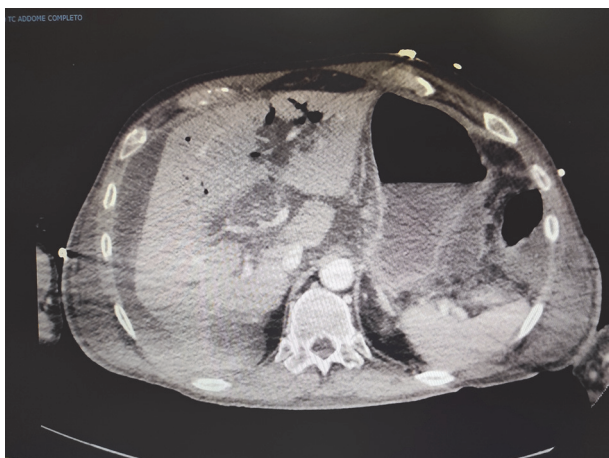
**Please confirm that an ethics committee approval has been applied for or granted:** Not relevant (see information at the bottom of this page)

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

**Background and Aims** The transversus abdominis plane (TAP) block is a regional technique for anterolateral abdominal wall analgesia. It is widely used for postsurgical acute pain management, in the context of a multimodal opioid-sparing analgesia. The cornerstone of major abdominal surgery pain management is continuous epidural analgesia. However, especially in the ICU environment, the insertion of an epidural catheter, in addition to being affected by the coagulative arrangement, could be contraindicated by antiaggregation or anticoagulation therapy. It also required advanced technical skills. Moreover, TAP block presented fewer contraindication and it is a rather simple procedure with a shallow learning curve and it provides long-lasting analgesia.



**Abstract #36316 Figure 1** Pelvic CT scan



Abstract #36316 Figure 2 Abdomen CT scan

**Methods** Patient, 67 years-old, admitted to ICU for post-surgical management after a duodenocephalopancreatotomy for cholangiocarcinoma. In 12th day he developed an acute abdominal pain, prevalent in the upper quadrants, radiating to the back, with a progressive anemization. The clinical pain manifestation, described by patient, seemed suggestive for acute post-surgical pancreatitis. We decided to make a TAP block for pain relief and to discriminate between visceral or somatic pain. Within few minutes, the patient was free of pain. So, in the suspicion of hemorrhagic complication, as the pain trigger, we performed a FAST-US which revealed free fluid around liver and in the Douglas cavity. The patient was subjected to a CT confirming the US finding and he underwent an abdominal surgical procedure.

**Conclusions** We described a case report in which TAP block was successfully used in the differential diagnosis of an acute abdomen in critical care setting.

#35637 **SERRATUS PLANE BLOCK FOR POSTOPERATIVE PAIN MANAGEMENT AFTER MINIMALLY INVASIVE HEART VALVE SURGERY: CASE SERIES**

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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 widespread use of ultrasonography in regional anesthesia in recent years; resulted in identification of new blocks such as serratus plane block (SPB). SPB is a regional analgesic technique that blocks T2-T9 which has an excellent role in postoperative pain management for cardiothoracic surgeries. We performed SPB for postoperative analgesia in 5 patients undergoing minimally invasive heart valve surgery (MIHVS).

**Methods** After obtaining informed consents, SPB block was performed after induction of general anesthesia and before the surgical incision, using 1,5mg/kg 0.25% bupivacaine. Pain was

measured using a visual analogue score (VAS) (0, no pain; 10, worst pain imaginable) in recovery and at 6th, 12th, 18th, and 24th hours. VAS was less than 3 for the 24th hour and patients had no need for additional analgesics for a post-block period of 12 hours.

**Results** SPB provides prolonged postoperative analgesia in patients undergoing MIHVS. Further randomized controlled trials are needed to enhance the efficacy of the SPB.

**Conclusions** Thoracic pain is thought to be transmitted via nerves originating from T2 to T9. Blockade of unilateral intercostal nerves can provide sufficient analgesia after MIHVS. Combination of opioids, non-steroidal antiinflammatory agents and regional methods; with different mechanisms of action in postoperative pain management is considered to be more effective for post operative analgesia and minimizes side effects as well as reduces incidence of chronic pain.

#36365 **MIRACULOUS TREATMENT OF EXCESSIVE SWEATING ASSOCIATED WITH INTRATHECAL MORPHINE: 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)

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

**Background and Aims** This case report highlights the successful treatment of excessive sweating related to Intrathecal (IT) morphine with atropine.

**Methods** A 23-year-old male patient, weighing 70 kg and measuring 172 cm, referral to our clinic for segmentectomy. Preoperative vital signs were normal. After obtaining consent from the patient, spinal analgesia was performed 350 mcg of IT morphine. Anesthesia induction was achieved with propofol, rocuronium bromide, and remifentanyl. A double-lumen endotracheal tube was placed in the left main bronchus. Forced-air warming was used to prevent hypothermia. Video-assisted thoracoscopic surgery was performed on the left hemithorax, and the mass was excised. Sweating was observed on the patient's head and upper body starting from the second hour of the operation. No other intraoperative complications occurred. Three hours later, extubation was performed with sugammadex. Upon arrival in the recovery room, the body temperature was 33.2°C. The patient continued to experience excessive sweating. 0.5 mg of atropine was administered and miraculously, the sweating stopped within 1-2 minutes. With the normalization of vital signs and body temperature, the patient was transferred to the ward. As the patient remained asymptomatic during follow-ups, he was discharged on the second postoperative day.

**Conclusions** Rarely, excessive sweating accompanied by hypothermia can be observed after IT opioid injection. Among the active treatment options, naloxone and lorazepam are included. Atropine is suggested as an option. Acetylcholine is the main pre- and postganglionic neurotransmitter of the sympathetic nervous system that innervates sweat glands, thus the use of anticholinergic medication like atropine significantly reduces or eliminates sweating.