



Abstract #36316 Figure 2 Abdomen CT scan

Methods Patient, 67 years-old, admitted to ICU for post-surgical management after a duodenocephalopancreatectomy 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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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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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.