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POTENTIAL PITFALLS OF PERIPHERAL NERVE BLOCKS IN PATIENTS WITH MUSCULAR DYSTROPHY: A REPORT OF TWO CLINICAL CASES

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Background and Aims Muscular dystrophies are genetic disorders characterized by progressive muscular degeneration. Recommendations for the anesthetic management of these patients frequently include a preference for regional anesthesia and analgesia. Although case reports exist of peripheral nerve blocks in patients with muscular dystrophy, exceptionally few mention important difficulties that may be encountered. We aim to highlight these potential pitfalls.

Methods A thirteen-year-old boy with a diagnosis of Duchenne muscular dystrophy presented for equinovarus foot correction. He had tetraparesis and mild nocturnal hypoventilation. Intravenous anesthesia with target-controlled propofol and remifentanyl infusions was combined with ultrasound guided popliteal sciatic and femoral nerve blocks.

A thirty-year-old man with a diagnosis of myotonic muscular dystrophy presented for patellar fracture and ligament reconstruction. He had an intellectual disability, stable hypoventilation syndrome and dysphagia. Ketamine sedation and a subarachnoid block were followed by ultrasound guided popliteal sciatic and femoral nerve blocks, and intraoperative soothing music.

Results Adequate analgesia was obtained without the use of long-acting or postoperative opioids. In the first case, altered muscular echostructure hampered identification of the adductor canal and femoral nerve. Patellar response to nerve stimulation was tenuous even when discomfort was elicited on injection. In the second case, sonographic visualization was unimpeded and nerve stimulation was not used to avoid triggering myotonia. Only light sedation was necessary.

Conclusions Although regional anesthesia is of benefit for patients with muscular dystrophy, potential pitfalls include

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altered muscular echostructure, a decreased response to or the need to avoid nerve stimulation, and intellectual disability. Expert help should be considered if difficulties are encountered.

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PECTORAL NERVE AND PARASTERNAL BLOCK COMBINATION IN BREAST CANCER SURGERY: SUBCUTANEOUS MASTECTOMY WITH RECONSTRUCTION UNDER REGIONAL ANESTHESIA AND SEDATION. A CASE STUDY

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Background and Aims US-guided pectoral nerve block may provide anaesthesia of lateral area of thorax, dermatomes T2-T6. US-guided parasternal block may provide anaesthesia of medial area of breast. A combination of these blocks and sedation may be used in mastectomy especially in high risk patients.

Methods Patient aged-70, BMI 20; breast cancer (5cm triple-negative Ki50%). Primary chemotherapy. Internal jugular vein thrombosis. Hypertension. Smoking. Anemia. ASA3. Subcutaneous mastectomy, sentinel lymph-node biopsy, reconstruction. After valid informed consent, anatomy and needle's tip correctly viewed, aseptically, US-PECS2 block was performed, 80-mm echogenic needle; 0.5% ropivacaine 20 ml were injected. US-PsB, second-fourth intercostal spaces, was performed; 50-mm needle; 0.375% ropivacaine 4 ml injected for each block. No complications. Pneumothorax excluded by LUS. Patient received IV midazolam 2 mg + fentanyl 50mcg; ketamine initial bolus 30 mg (0,5 mg/kg) then boluses, 90 mg in 2 hours, to induce and maintain light sleep with arousability. IV lidocaine 40 mg, clonidine 75mcg, dexamethasone 8 mg at beginning of surgery. IV lidocaine 2% 1 ml h⁻¹ was provided for 2 hours after initial bolus. Acetaminophen 1g before awake. Spontaneous breathing and supplemental oxygen 40%.

Results Monitored Anesthesia Care (MAC) was provided. Surgery began 15 minutes after MAC, 30 minutes after blockades placement. Surgery lasted 145 minutes, patient vital signs stable. No supplemental opioids or additional local

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