

technique. Ten minutes later, the patient became agitated, referring general discomfort, blurred vision, perioral numbness and metallic flavour. She became progressively more lethargic and less responsive to stimulus. She became bradycardic and with high blood pressure. LAST treatment was immediately started according to our hospital's protocol. After stabilization, she was admitted to anaesthetic post-care unit for surveillance and treatment of eventual complications. The symptoms progressively disappeared and she was discharged on the day after.

**Conclusions** Despite ultrasound technique may increase safety compared with landmark block technique, the risk of vascular injection is not completely abolished.<sup>3</sup> The anatomical inter-individual differences of brachial plexus vascularization could be the major factor for reported LAST cases after this approach.

### 29 POSTOPERATIVE DELIRIUM: A SURGEON'S DILEMMA

R Khandelwal\*. *AHPGIC, Cuttack, India*

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**Background and Aims** Iatrogenic meningitis following spinal anesthesia is rare but serious complication which can perplex the surgeon. The diagnosis of iatrogenic meningitis is difficult in the usual setting. As, all post-operative complications are directly targeted at the surgeon, this one too puts the surgeon in a challenging situation. It at times becomes difficult to explain to the relatives the cause of the patient's condition.

**Methods** A 49 year female attended the OPD for complain of post menopausal bleeding since 3 months. Her ultrasound report showed an endometrial thickness of 11 mm with slightly enlarged uterus. An office endometrial biopsy (EB) was done. The EB report was suggestive of simple hyperplasia without any atypia. So, considering her symptoms she was planned for vaginal hysterectomy and, pre-anaesthetic clearance was obtained. Eight hours following the surgery, the patient was found to be somnolent and confused.

**Results** Post-spinal meningitis should be considered in differential diagnosis of patients having post-spinal headache, convulsions and changes in mental status. Its etiology includes failure of aseptic techniques, presence of asymptomatic bacteremia, contamination during puncture through microscopic bleeding and possibility of aseptic chemical meningitis.

**Conclusions** The diagnosis of post-spinal aseptic meningitis caused probably by the hyperbaric bupivacaine injected in the subarachnoid space was made and this should alert surgeon and anesthesiologist about the possible but rare consequences of spinal anesthesia. We believe that the rarity of this complication necessitates health care providers all over the world to share such cases for early diagnosis and for instituting proper care to such patients.

### 30 CASE REPORT: IMPORTANT CONSIDERATIONS FOR NEURAXIAL ANAESTHESIA IN THE MULTIDISCIPLINARY MANAGEMENT OF THE PATIENT WITH PLACENTA ACCRETA

S Chan\*, R James. *Royal Victoria Hospital, Belfast, UK*

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**Background and Aims** Placenta accreta is a spectrum disorder ranging from abnormally adherent to deeply invasive placental tissue. It is frequently associated with major obstetric haemorrhage. Multidisciplinary planning is vital in optimising maternal and fetal outcomes. In this case report, we describe some important considerations for the anaesthetist planning the use of neuraxial techniques for prophylactic procedures prior to caesarean section. Awareness of the limitations of patient positioning for these procedures is required in order to avoid difficulties in administering neuraxial blockade. In particular, the need to avoid hip flexion following iliac artery balloon insertion can hinder subsequent patient positioning for spinal or epidural anaesthesia.

**Methods** Case report and review of the literature.

**Results** A 47 year old parturient with placenta accreta, possibly invading the cervix and bladder serosa, presented for elective caesarean section. Prophylactic measures to reduce the risk of major haemorrhage began with radiological iliac artery occlusion balloon insertion under local anaesthetic. Thereafter, she underwent spinal anaesthesia to facilitate cystoscopy and prophylactic bilateral ureteric stent insertion. However, due to the need to avoid hip flexion and the risk of dislodging the balloon catheters, these procedures had to be carried out with the patient in a suboptimal position. The intrathecal block was administered with the patient in the left lateral position, without any hip or knee flexion, increasing technical difficulty. We discuss the implications of this and possible solutions.

**Conclusions** Multidisciplinary planning can help avoid potential pitfalls in administering neuraxial techniques to patients with placenta accreta undergoing multiple prophylactic procedures.

### 31 REGIONAL ANAESTHESIA MANAGEMENT OF A TRAUMA PATIENT WITH UPPER AND LOWER EXTREMITY INJURIES

<sup>1</sup>M Georgiou\*, <sup>1</sup>E Xynis, <sup>2</sup>S Coppens. <sup>1</sup>Nicosia General Hospital, Nicosia, Cyprus; <sup>2</sup>University Hospitals, Leuven, Belgium

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**Background and Aims** Regional anaesthesia remains an essential part of perioperative care. Along with excellent pain control it reduces opioid need while diminishing stress response. Despite these obvious advantages, regional anaesthesia is often underutilized in trauma patients. This is due to time management issues as well as fear of complications like masking of compartment syndrome and nerve damage. We present a case of multiple trauma patient with upper and lower extremity injuries managed solely with regional anaesthesia and sedation.

**Methods** 47-year-old male 75 kg presented to the emergency department after a motorcycle accident with fractures of the left femur, pelvis, right tibia and left wrist. Further radiological results were negative. The patient showed signs of upper respiratory tract infection. The perioperative plan incorporating regional anaesthesia was consented.

**Results** Combined spinal epidural anaesthesia was initiated for surgery of lower extremity injuries. Additionally, an infraclavicular block was performed for anaesthesia of wrist fracture. Sedation with propofol and ketamine aided with protracted operative time. The procedure was further uneventful.

**Conclusions** Trauma patients are more prone to long term opioid dependence. Therefore sparing opioid use and

combining multiple regional techniques is a safe alternative, using low dose local anesthetics to reduce chances of LAST. Follow up, monitoring and a multimodal analgesia plan is imperative. More evidence is needed on the effect of inflammation, wound healing, length of stay and chronic pain.

### 32 SUCCESSFUL SELECTIVE SENSORY NERVE BLOCKS FOR AWAKE HAND SURGERY USING NERVE STIMULATOR

A Oiwa\*. *Toho University School of Medicine, Oomori-Nishi, Ota-ku, Tokyo, Japan*

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**Background and Aims** The selective sensory nerve blocks in awake tendon reconstruction have been started since 2020 in our institute. We managed these surgeries under general anesthesia combined with blocking only sensory nerves under echo guidance.

**Methods** In this presentation, we would like to present 11 cases and extract our problems. The surgeries were finger tendon repairs and finger/hand joint functional reconstructions. The tourniquet was used during surgery in all cases. General anesthesia was performed by the 'asleep-awake' technique, and the patient was awakened when the tourniquet was released after the tendon repairment.

**Results** The sites of regional anesthesia were the lateral forearm cutaneous nerve, the medial upperarm/forearm cutaneous nerve, the posterior cutaneous nerve, the distal radial nerve, the forearm interosseous nerve, and the distal ulnar nerve.

2.5–4 ml of 0.1 to 0.125% levobupivacaine was used for cutaneous nerves and 1–3 ml of 0.5% levobupivacaine was used for other nerves. In all 8 cases, it was possible to move their digits during surgery. The most important is, even though we tried to reduce the injection amount and tried more regionally, but in the first 2 cases, the maintenance of finger muscles strength was slightly insufficient. After using the nerve stimulator, this problem was resolved.

**Conclusions** There was one patient who complained of pain, but it was possible to deal with adding local anesthesia. No vomiting, toxicity or respiratory problems were observed, and no cases abandoned awakening. Hand surgery with selective sensory nerve blocks was a good method with high treatment accuracy.

### 33 TEAMWORK AND COMMUNICATION IN THE OPERATING ROOM (OR) – A LOCAL ANESTHESIA (LA) SYSTEMIC TOXICITY CASE REPORT

<sup>1</sup>J Castro Nunes, <sup>2</sup>G Cruz\*, <sup>2</sup>A Claudia. <sup>1</sup>*Instituto Português de Oncologia, Lisboa, Portugal;* <sup>2</sup>*Centro Hospitalar Universitário Lisboa Norte, Lisboa, Portugal*

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**Background and Aims** Local anesthetic systemic toxicity (LAST) is a rare but potentially life-threatening adverse event that occurs after local anesthetic administration through different routes<sup>1</sup>. This case intends to highlight the importance of bidirectional communication in the operating room (OR) and identification of warning signs and symptoms of LAST.

**Methods** A healthy 22-year-old female (weight 56 Kg, height 159cm), with a type III odontoid fracture due to a vehicle roll over was brought to the OR for a halo-vest placement. The procedure was executed under monitored anesthesia care,

with the use of local anesthetic (LA) alone, as requested by the surgical team, allowing neurological examination throughout its execution. 2% lidocaine without adrenaline was administered subcutaneously in the frontotemporal region for pin insertion.

**Results** After 40 minutes, the patient became agitated, complained of blurred vision, metallic taste, and developed supra-ventricular tachycardia. When questioned, the surgical team revealed that 30 mL of lidocaine had been administered. The anesthesia team presumed the complaints were due to LAST and Institutional protocol was implemented. It includes anti-epileptic therapy, hemodynamic and ventilatory support and lipid emulsion therapy. Upon termination, the patient was transferred to a post-anesthetic-care-unit and was discharged 24h later without any further complications.

**Conclusions** Systemic toxicity can be life threatening and rapid identification is key to prevent mortality. Although subcutaneous administration is less prone to toxicity, multiple injections in the scalp, which is a highly vascularized area, cause a rapid absorption<sup>2</sup>. Bidirectional team communication in the OR is essential for complication prevention, intraoperative differential diagnosis and systematic approach in such critical events.

### 34 SUBARACHNOID HEMATOMA AFTER ATTEMPTED SPINAL BLOCK

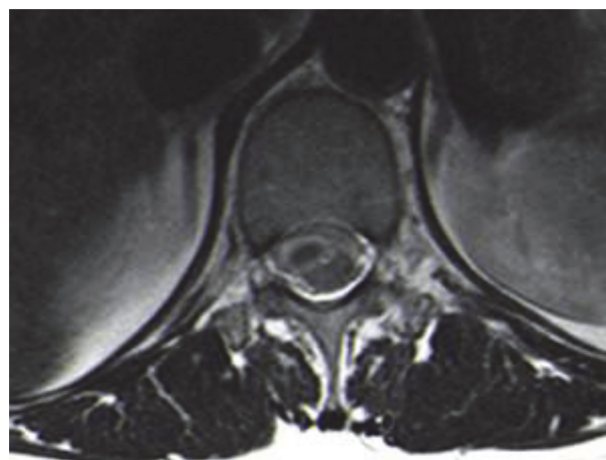
RF Santos, RL Silva\*, A Gomes, N Ribeiro, F Moura. *Centro Hospitalar Tâmega e Sousa, Guilhufe, Penafiel, Portugal*

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**Background and Aims** Subarachnoid hematoma is a rare but potentially serious complication of a subarachnoid block. Its occurrence is associated with several risk factors such as multiple spinal attempts, traumatic puncture and concurrent therapy with anticoagulants and/or antiplatelet agents.<sup>1</sup>

**Methods** Description of a case report in the section below.

**Results** Case Report: A healthy pregnant woman was admitted for an elective c-section under subarachnoid spinal block. After two hematic punctures at different lumbar levels, it was decided to proceed with a general anaesthesia instead. Surgery was performed with no reports of complications. About 7 days later, the patient reported neurologic symptoms and a spinal hematoma was diagnosed (figure 1 and 2). After



**Abstract 34 Figure 1** Dorsolumbar MRI, T2 axial section image of dorsolumbar subarachnoid hematoma with a maximum width of 9 mm