



Abstract 34 Figure 2 Dorsolumbar MRI, sagittal section image

consultation with a neurosurgical team, a conservative approach was decided upon. The patient was admitted to the hospital for close monitoring of neurological signs and throughout the 12 days of in-hospital stay, there was a spontaneous remission of symptoms as well as a significant reduction in the size of the hematoma, confirmed by magnetic resonance imaging. The patient was discharged home asymptomatic.

Conclusions Although the recommended treatment for a subarachnoid hematoma is an emergent surgical decompression, there have been reports of small subarachnoid hematomas associated with mild pain complaints that are conservatively managed with satisfactory results.²

35 EPIDURAL ANESTHESIA: WHEN THE BENEFITS OUTWEIGH ITS RISKS IN CARDIOVASCULAR PATIENTS

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Background and Aims The patient with cardiac pathology is one of the greatest challenges in anesthesiology since they are often medicated with anticoagulants and anti-aggregants which leads to a higher risk of perioperative cardiovascular complications. In this case, we show the use of an epidural technique in order to maintain hemodynamic stability despite the patient's coagulation changes (INR>1.5).

Methods Data were collected from the patient's process.

Results A 59 years old man, diagnosed with a strangulated inguinal hernia, proposed for an emergent inguinal

hernioplasty. He had arterial hypertension, ischemic dilated cardiomyopathy, heart failure treated with levosimendan, implantable defibrillator (ICD), severe pulmonary hypertension, history of stroke without sequelae and chronic kidney disease. Medicated with anti-aggregants and anticoagulants. Laboratory values: Hb 10,6g/dL; platelets $149 \times 10^9/L$ and INR 1,54. The echocardiogram showed a 20% left ventricular ejection fraction, severe mitral regurgitation, and moderate tricuspid regurgitation. An epidural block with slow induction was performed (0,75% ropivacaine fractional bolus), under standard monitoring and invasive blood pressure. A magnet was used to protect the ICD and the immediate availability of vasopressor drugs was ensured. The procedure took place without major complications with hemodynamic stability until recovery. Analgesia was guaranteed with epidural morphine.

Conclusions This case shows the importance of neuraxial anesthesia in patients with cardiovascular comorbidities. The use of an epidural technique allows maintenance of hemodynamic stability in a patient that does not have a good physiologic condition despite coagulation changes. For this reason, in this case, the benefits of a neuraxial technique outweigh its risks compared with a general anesthesia technique.

36 ULTRASSOUND-GUIDED COSTOCLAVICULAR BLOCK: AN ALTERNATIVE APPROACH TO SHOULDER SURGERY – A CASE REPORT

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Background and Aims Analgesia after shoulder surgery remains a major challenge. Alternative phrenic sparing techniques for post-operative shoulder analgesia like the shoulder block (suprascapular and axillary nerve blocks) have been advocated. Nevertheless, as shoulder innervation is complex, shoulder block may provide an incomplete blockade and two punctures are needed, so other options are still being searched. Costoclavicular brachial plexus block (CCBPB) was presented as a valid option carrying only 2.5% of phrenic paralysis, against 39.8% with interscalene approach¹.

We intend to increase awareness to CCBPB as a safe and effective phrenic sparing technique for shoulder surgery.

Methods Case report and literature review.

Results A 64-years-old patient, ASA III due Diabetes Mellitus, peripheral venous insufficiency, dyslipidemia, obesity and history of snoring, was admitted for shoulder surgery. An ultrasound guided CCBPB was performed instead of an interscalene or supraclavicular approach to minimize the risk of phrenic nerve hemiparesis. Ropivacaine 0.375% was administered. The patient reported generalized upper limb sensitive block, while maintaining motor capacity after 5 minutes. Then, general anesthesia was induced. Surgery was uneventful. Despite no conventional analgesia has been given before emergence, 0.4 mg of naloxone was needed to recover spontaneous ventilation. After emergence she denied pain, only referring sensitive and motor block of upper limb. Rescue analgesia was not needed.

Conclusions CCBPB mode of action relies on the local anesthetic (LA) retrograde dispersion within the costoclavicular