Abstracts

Continuous Spinal Anesthesia for Open Cholecystectomy: Customized Anaesthetic Management in a Challenging Patient

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Background and Aims Continuous spinal anesthesia (CSA) provides fast onset titratable neuroaxial block. In the context of upper abdominal surgery on patients with acute respiratory distress, it offers minimization of respiratory complications and ensures adequate anaesthetic conditions.

We aim to present a CSA for open cholecystectomy in a patient with multiple neurological deficits and acute pneumonia.

Methods A 60-year-old woman, 40 kg, 152 cm. Past history of rickets having severe skeletal deformity; hypertension; status post cerebellar tumor resection with multiple sequelae: loss of visual and auditory acuity, dysphagia, dysphonia, respiratory insufficiency and ventriculoperitoneal shunt. Admitted for urgent open cholecystectomy having alongside acute pneumonia with pleural effusion. Laboratory tests and current medication posed no contraindication to spinal anesthesia.

Spinal catheter 20G was introduced through 18G tuohy needle at L3-L4 level. On supine position the adequate block level was achieved using bed tilting and sequential doses of hyperbaric bupivacaine (total of 10 mg) and sufentanil (total of 10 mcg). During the 1h procedure there was no need for sedation. The spinal catheter was removed on the operating room (OR) after a morphine 100 mcg administration. Neither respiratory nor regional anesthesia complications were reported on the postoperative period.

Results Although a CSA in this patient was a challenge we considered that the benefits exceeded the risks and surpassed limitations of other techniques. The anaesthetic plan was sustained by careful communication with the patient and strict collaboration of the surgical team.

Conclusions CSA allowed a safe and effective management during the intraoperative period and optimized the postoperative recovery.

Temporary Meningeal Symptoms After Epidural Blood Patch

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Background and Aims Post-puncture headache – an unpleasant rare event. Associated with epidural and spinal anesthesia. With epidural anesthesia, its cause is an unintentional puncture of the inner leaf of the dura mater. With spinal, intrathecal puncture itself.

Methods 20 years of experience in post-puncture headache in a maternity hospital (~ 200 observations), associated with epidural analgesia in childbirth.

Results Almost 100% of observations – unintentional puncture of the inner leaf of the dura mater with an epidural needle. Manifests 6–18 hours after removal of the epidural catheter. In less than 50% of cases amenable to conservative treatment. Classical triad (bedrest, hydration, tylenol) – temporary unstable relief. Most have an epidural blood patch. In case of refusal, contraindications for filling, strict adherence to bed rest for 10–14 days. A single epidural blood patch with autologous blood, with a volume of 10–20 ml in almost 100% permanently relieves a headache. Repeated epidural autologous blood filling is required only in 1–2% of cases. In 1–2% of our cases of epidural blood patch, we observed short-term, up to 3–5 days, development of meningeal symptoms, in particular, pronounced occipital rigidity against the background of complete disappearance of positional headache. This occipital stiffness looks quite frightening, but usually practically does not bother patients and regresses spontaneously by 5 days after a blood patch.

Conclusions A possible explanation for the development of meningeal symptoms immediately after an epidural patch is the ingestion of a small amount of autologous blood into the subarachnoid space, followed by irritation of the dura mater.
surgical procedure with minimal hemodynamic impact, ensuring a reliable block with quick onset and low risk of local anesthetic toxicity. In the case allowed adequate hemodynamic management to avoid mitral regurgitation deterioration and optimize graft perfusion. Continuous spinal anesthesia was suitable for the surgical procedure and contributed to an individualized management essential to the outcome of the patient.

**AGAINST ALL ODDS: EPIDURAL HAEMATOMA IN A MINOR HEPATIC METASTASECTOMY**

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**Background and Aims** Epidural analgesia (EA) in patients undergoing liver resection remains controversial because of the increased risk of epidural haematoma (EH), although extremely rare [1]. We report a case of EH in a patient submitted to a hepatic metastectomy, after EA.

**Methods** A 71-year-old, diagnosed with metastatic cholangiocarcinoma and previously submitted to cephalic pancreatodudenectomy, was admitted for elective metastasectomy (2×3 centimeters). Her history included hypertension on bisoprolol and chemotherapy two years previously. Preoperative assessment revealed minor changes, as described in table 1. The patient consented a combination of EA with general anaesthesia and a lower thoracic epidural catheter (T9-T10) was uneventfully placed.

**Results** A two-hour surgery was performed successfully, with insignificant blood loss. On postoperative day 2, the patient underwent emergent reintervention due to severe hemoperitoneum but no vascular bleeding point was detected and therefore, coagulopathy was assumed. After transfusion of 3 units of fresh frozen plasma (FFP) and 1 platelet concentrate (PC), haemorrhage resolved and the epidural catheter was removed the next day, considering a 12 hour interval since the last administration of prophylactic enoxaparin. 18 hours later, the patient presented with severe lumbar and inferior limb pain and paraparesis. A CT scan revealed an EH from T8-T10, and emergent laminectomy was performed. 1 PC, 4 FFP and 1000U of prothrombin complex concentrate were administered, ROTEM guided. After several months of rehabilitation, the patient managed to walk unassisted.

**Conclusions** Despite following every recommendation for epidural catheter handling, masked coagulopathy can prevail and thus a high level of EH suspicion should always subsist.