

59 CONTINUOUS SPINAL ANESTHESIA – A NEWBORN TECHNIQUE FOR TIMES OF NEED?

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Background and Aims Described during World War II, continuous spinal anesthesia (CSA) enables continuous administration of intrathecal drugs, offering several anesthetic options versus single shot technique, although underutilised.

Here we present 4 cases of CSA performed for patients undergoing urgent upper abdominal and lower extremity orthopedic surgery during the COVID-19 pandemic. Our patients were ranked between 90–100 years old with ASA score IV, in which we highlight the presence of ischemic heart disease and chronic obstructive pulmonary disease.

Methods Invasive hemodynamic measurement was performed before CSA technique. Given the lack of microcatheter-over-the-needle kits in our center, we performed the technique using Perifix® Complete Set – B Braun, with full aseptic technique. The 18G Tuohy needle was introduced via a midline approach until CSF was encountered. The 20G catheter was then introduced 3cm into the subarachnoid space. In all situations we opted for the administration of sufentanil 0.0025 mg plus subsequent aliquots of hyperbaric bupivacaine 0.125%, guided by sensory assessment of block level.

Results All surgeries were successfully concluded with minimal haemodynamic variation and avoidance of mechanical invasive ventilation. Patients were admitted in the PACU, where spinal catheters were removed, and continued their recovery at the speciality yard. No complications were observed, particularly post-dural puncture headache, neurologic or infectious events.

Conclusions CSA is a useful anesthetic technique with a low failure rate. Its best role is likely to be in high-risk surgical patients, as it can provide excellent blockade conditions, with small doses of LA and little haemodynamic variation frequently seen with single shot techniques.

60 PRILOCAINE AND CHLOROPROCAINE SPINAL ANAESTHESIA IN FRACTURED NECK OF FEMUR SURGERY

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Background and Aims Spinal anaesthesia using bupivacaine with opioids is commonly used in fractured neck of femur surgery(1,2). However this often results in a prolonged sympathetic block in the elderly causing significant hypotension which may require vasopressor support. Newer local anaesthetic agents such as prilocaine and chloroprocaine are already successfully used in elective orthopaedics and offer better cardiovascular stability with faster recovery(3,4). We decided to assess the suitability of these newer agents in neck of femur surgery and review its outcomes.

Methods 200 patients having fractured neck of femur surgery were given spinal anaesthesia using either 2% prilocaine or 1% 2-chloroprocaine for Hemiarthoplasty or Dynamic hip screw respectively. An additional femoral/lat. cutaneous nerve/fascial iliaca block was performed at the start to allow patient

positioning and provide an adjunct to increase the surgical operating time along with propofol sedation.

Results All patients had their surgery successfully without any conversions to general anaesthesia. We observed better cardiovascular stability intraoperatively and in recovery the blood pressure recording had returned to preoperative levels without any vasopressor support allowing faster recovery and discharge to the ward.

Conclusions We have shown that shorter acting spinal anaesthetics can be used in neck of femur surgery successfully when combined with nerve blocks. But more importantly these agents offer significant advantages over bupivacaine by providing better haemodynamic stability and faster recovery whilst also avoiding hypotension once the patient has left the recovery area. More research is desperately needed to identify if these agents could improve mortality and if they should be adopted into international guidelines.

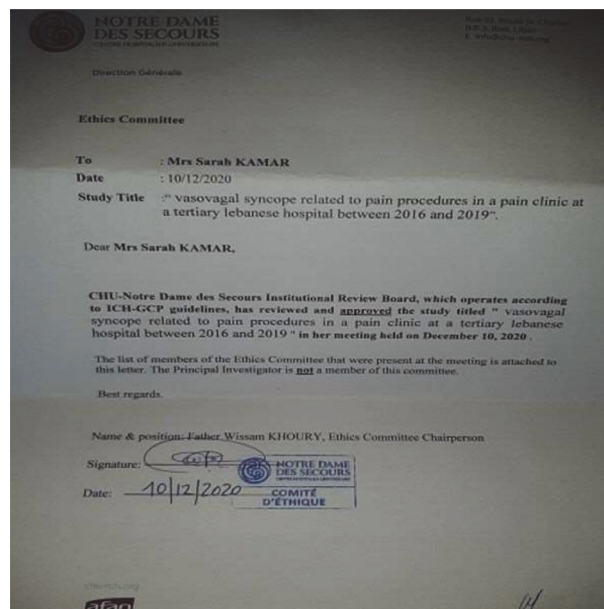
61 VASOVAGAL SYNCOPE RELATED TO PAIN PROCEDURES IN A PAIN CLINIC AT A TERTIARY LEBANESE HOSPITAL BETWEEN 2016 AND 2019

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Background and Aims A vasovagal reaction is a common cardiovascular complication that can occur during an interventional procedure. Our study focuses on evaluating the factors associated with vasovagal syncope (VVS) when having a pain procedure at the pain clinic as well as showing variation in vital signs associated with fainting across different periods of the procedure(before, during and after).

Methods A retrospective case control study was conducted in a university hospital in Lebanon (CHU-NDS) on adult Lebanese patients with data taken from the archives covering a 4 year period (2016–2019). It included 188 patients: 94 cases representing all the ones who had endured a VVS or



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presyncope related to a pain procedure during this timeframe and 94 controls with matching demographic features.

Results The multivariable analysis showed that a higher systolic blood pressure per-procedure was significantly associated with lower odds of having vasovagal syncope.

An adequate dose of a vasopressor like ephedrine can be used to prevent a vasovagal event from happening.

In our study the blood pressure component was more significant than the heart rate component which stayed in the normal range limit in the three different periods of the procedure.

Cases having a pain procedure for the first time represent 59.6% of the occurrence of VVS.

Conclusions Enduring an interventional procedure combines both physiological and psychological challenges. Our study suggests taking preventive measures for patients with first time infiltration status especially if appearing in an anxious state.

62 POSTOPERATIVE NEUROLOGIC LESIONS: WHO'S THE ONE TO BLAME?

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Background and Aims Etiologic evaluation of postoperative neurologic lesions after regional techniques can be challenging. We present a case of a neurologic lesion after a gynecologic procedure under combined epidural and general anesthesia.

Methods Forty-one-year-old female, ASA I, scheduled for abdominal hysterectomy. Epidural catheter was placed before surgery at L3-L4: linear and atraumatic technique, without pain/paresthesia and a negative 0.375% ropivacaine test dose. The surgery lasted 2h in supine position. Gosset retractors were used.

In postoperative care unit, a 0.2% ropivacaine bolus (10 ml) was performed and 0.16% ropivacaine epidural perfusion (5.2 ml/h) was connected. Motor block at discharge: Bromage II.

Results Twenty-four-hours after surgery epidural perfusion was stopped due to proximal right inferior limb paresthesia and hemiparesis. These complaints persisted and a formal neurological evaluation was performed, documenting decrease segmental strength and allodynia at L3-L4 distribution and hypoesthesia at L5 dermatome.

Radiologic evaluation (head/lumbar spine CT and MRI) excluded acute complications. Electromyography revealed decreased motor response on right femoral nerve territory: absent motor activity on vastus-medialis and rectus-femoris muscles; mild signs of active denervation.

Physical rehabilitation resulted in progressive improvement of motor deficit. Two months after, hypoesthesia of L2-L4 territory persisted.

Conclusions Radiculopathy is a complication of 2.19/10000 epidurals. It can be a consequence of mechanical lesions or neurotoxicity. With a linear epidural technique and normal imaging, the first seems unlikely, but neurotoxicity cannot be excluded. On the other hand, the use of static retractors can cause mechanical or ischemic femoral nerve lesions. Regardless of the etiology, early recognition and implementation of motor rehabilitation programs are crucial.

63 COMBINED THORACIC SPINAL EPIDURAL ANESTHESIA FOR LAPAROSCOPIC SLEEVE GASTRECTOMY; ONE HUNDRED CASES EXPERIENCE

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Background and Aims Obesity is a growingly impacting human health. Laparoscopic sleeve gastrectomy is one of successful management procedures for morbid obesity. However, general anesthesia (GA) used in this major surgery has its documented drawbacks in such patients with high risk. Combined thoracic spinal epidural anesthesia (CTSEA), a modern regional anesthesia procedure, has the advantages of both spinal and epidural anesthesia, with the avoidance of their shortcomings. Aim of the study: This study is a case experience to assess the feasibility of CTSEA as an anesthesia option for LSG.

Methods 100 patients recruited for LSG as a management procedure of morbid obesity were performed under CTSEA. Peri-operative events, functional parameters and patients satisfaction scores were recorded

Results Our study showed successful use of CTSEA in 91% of the patients, one patient (1%) was converted to GA due to severe pain and anxiety. Few adverse events occurred, and they were managed accordingly. Satisfaction score revealed that 94% of the patients were satisfied.

Conclusions CTSEA was successful anesthetic alternative procedure for LSG surgery.

64 PNEUMOCEPHALUS A RARE COMPLICATION AFTER COMBINED SPINAL EPIDURAL ANAESTHESIA

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Background and Aims Aim – Discuss a case report of pneumocephalus which is a rare complication after combined spinal epidural anaesthesia (CSE). Background – A 21 years old female P2L2 presented with complaint of abdominal pain. NCCT Abdomen suggested that intrauterine copper containing device (CuT) is in pelvic cavity not in uterine cavity. She was diagnosed with misplaced CuT and planned for laparotomy under CSE anaesthesia.

Methods We retrospectively reviewed a case of a 21 years old female P2L2 with misplaced CuT and planned for laparotomy under CSE anaesthesia. Intraoperatively she was prepared for CSE in sitting position in L3-L4 space. Epidural space was identified with loss of resistance to air in syringe method. On puncture of dura with spinal needle patient started complaining of a sudden severe headache and vomiting. Procedure was abandoned and deferred for post evaluation.

Results Post operatively in CT head subdural air collection was seen in bilateral frontal right more than left with extension into falx, multiple air pockets in left side of cerebellar left temporal and bilateral occipital and parietal region suggestive of pneumocephalus.

Conclusions Pneumocephalus is a rare complication after CSE. The possible entry of air in subarachnoid space by displacement of epidural needle from epidural space to subarachnoid space could be while checking loss of resistance through air in syringe method or when spinal needle was inserted through epidural needle or when the stylet had been withdrawn from