the groups between transverse and sagittal use in terms of procedure time, distance measured by USG and applied needle. It was found that the distance measured by USG was approximately 1 cm lower than the needle measurement applied.

Conclusions We think that in the determination of the intervertebral space before subarachnoid block, in geriatric patients with concomitant disease, ultrasound localization is easy and reliable and will increase patient comfort.

68 1% CHLOROPROCAINE SPINAL ANESTHESIA FOR SHORT DURATION SURGICAL PROCEDURES

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Background and Aims While permitting complete surgical anesthesia, subarachnoid blocks for ambulatory surgery are underused because of risk for urinary retention and delayed recovery of motor functions [1]. 1% Chloroprocaine is a fast onset and offset drug, which allows rapid recovery [2].

We report our experience with different short-duration surgical procedures.

Methods With the patients' consent, 60 short procedures were carried out under spinal anesthesia with 1% chloroprocaine, with a 27 pencil-point needle; different injection levels and dosages were used achieving different results.

Data regarded: type of procedures and duration; heart rate, blood pressure; pain; block level and Bromage score trends; complications.

Results Procedures: urologic n. 15; hysteroscopy n. 8; foot n. 11; hernia n. 12; knee arthroscopy and stem cell treatment n.7; pilonidal cyst n. 2; liposuction n.5.

Durations ranged between 15 and 80 minutes. Higher dosages (40–50 mg) lead to a decrease in blood pressure and heart rate when the injection level was L1-L2 or higher. IV Atropine avoids or restores physiologic heart rate. With lithotomy position, hypotension occurred less frequently. No patient experienced pain, with one exception of a hysteroscopy which received 30 mg at L2-L3 interspace. No complications were recorded. Levels and Bromage trends are displayed in table 1.

Conclusions Spinal anesthesia with 1% chloroprocaine is a valid technique for short surgeries. From our experience, we may assume that 35–40 mg administered between T12 and L2 provide a reliable block up to T9-T10 lasting 40 minutes and regressing within 90 minutes, without significant hemodynamic changes. Research trials are needed to confirm our data.

69 AORTIC STENOSIS: IS REGIONAL ANAESTHESIA A STILL CONTROVERSIAL OPTION?

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Background and Aims Aortic stenosis (AS) requires tight haemodynamic control during surgery. Sudden decreased in systemic vascular resistances could be fatal, therefore, neuraxial anaesthesia (NA) is traditionally contraindicated. However, evidence about this subject is sparse and the alternative of general anaesthesia (GA) may pose some troubles, especially in elderly patients with comorbidities.

Methods Female, 89-years, ASA IV, with hypertension, atrial fibrillation, severe AS and COPD, was admitted for hip fracture repair. We decided to perform a continuous spinal anaesthesia (CSA). Under standard ASA and invasive blood pressure monitoring, a 18G Tuohy needle was inserted, at L3-L4, into subarachnoid space and through it a 20G catheter was introduced 3cm into the space. After aspiration of cerebrospinal fluid, 5 mg of bupivacaine was administered in two divided doses with a 10-minute interval.

Results An adequate anaesthesia level at T10 was guaranteed throughout intraoperative. Hemodynamic parameters remained stable, with median arterial pressure superior to 80% of baseline, without vasopressor use. No additional bupivacaine was needed. Spinal catheter was removed before discharge of recovery and no post-dural puncture headache was detected.

Conclusions NA in severe AS is traditionally contraindicated due to sympatholytic effect that potentially lead to a diminished cardiac output. In our case, GA poses a great risk of morbimortality, due to patient age and comorbidities. By incremental minimal doses, CSA achieves a meticulous level and duration of block without excessive sympathectomy, while avoiding adverse effects of GA.

NA is no longer contraindicated in patients with AS, and CSA may even become the gold- standard for patients with multiple comorbidities.

70 ABDOMINAL SURGERY IN HIGH-RISK CARDIOVASCULAR PATIENT – ANESTHETIC OPTION

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Background and Aims Continuous spinal (CSA) comparing to spinal anesthesia offers advantages in patients with multiple comorbilities. Fractionation of doses allows to obtain a satisfactory sensory and motor block with lower total doses of local anesthetic and less hemodynamic collapse.

Methods 89-year-old female, ASA IV admitted for emergency hernioplasty due to strangulated umbilical hernia. She had Hypertension, Diabetes Mellitus, obesity, OSAS, stage IV CKD and heart failure.

She was polypneic, tachycardic and hypotensive. The airway assessment was poorly done due to the patient's lack of collaboration.

Given the severity of the patient's clinical situation, the surgical proposal, as well as the absence of criteria for admission to the ICU, we opted for CSA.

Caregiver's consent to anesthesia was obtained.

A Tuhoy 18G needle was used in the L3-L4 space and the catheter was inserted 4cm into the subarachnoid space. 2.5 mg of 0.5% hyperbaric bupivacaine were administered through catheter, followed by 1 mL of saline. 5' and 10' after the first administration, 1.25 mg + 1.25 mg bupivacaine were administered, respectively. A satisfactory block at T7-T8 level was obtained. The surgery lasted 2.5 hours. At the end of the first and second hour after surgical incision, reinforcement was needed with 2.5 mg of 0.5% bupivacaine.