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.

Results The patient remained hemodynamically stable and conscious. She was discharged from the hospital with no record of complications.

Conclusions The number of high-risk frail patients is increasing. CSA allows the anesthetist to better manage these patients due to the fractionation of doses and greater control over the hemodynamic repercussions.

Chronic pain management

71 REPETITIVE SHPENOPALATINE GANGLION BLOCK USING THE TX360 NASAL APPLICATOR FOR THE TREATMENT OF TRIGEMINAL NEURALGIA: A PILOT STUDY

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Background and Aims Sphenopalatine ganglion (SPG) is situated in the posterior nasal cavity and belongs to the cranial part of the autonomic nervous system. Trigeminal neuralgia (TGN) is currently considered as an indication for SPG block, especially in medication-resistant cases. The aim of this study was to assess the effectiveness of the SPG block for the treatment of trigeminal neuralgia, using a noninvasive transnasal approach, by delivering local anesthetic with the alternative device Tx360 nasal applicator.

Methods Four patients (three women, aged 67, 56 and 75 and a man, aged 58) presented with either classical or atypical, V2 (maxillary branch) or V3 (mandibular branch) TGN, partly or completely drug-resistant. Pain severity during paroxysmal attacks was recorded using the visual analogue scale and it scored between 8 and 9 for all patients. The SPG block was achieved using the Tx360 nasal applicator in order to deliver 0.3 ml of xylocaine 2%, once a week, for 6 to 8 weeks. Participants in this study received up to 8 SPG blocks.

Results All patients reported significant pain relief and were completely symptom-free after the 2nd or 3rd application. This favorable outcome lasted for up to 3 months for each case. No significant adverse events were noted.

Conclusions Data extracted from this pilot study suggest that repetitive SPG block with the Tx360 nasal applicator may constitute an easy, rapid, safe and efficient treatment of trigeminal neuralgia. Further relative double-blind, randomized studies are required in order to draw solid conclusions.

72 IMPROVEMENT OF HEALTH-RELATED QUALITY OF LIFE AND FUNCTIONAL DISABILITY IN PATIENTS WITH FBSS PAIN AND IMPLANTED WITH A RECHARGEABLE SPINAL CORD STIMULATION SYSTEM

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Background and Aims The Product Surveillance Registry (PSR, Medtronic) is a prospective, long-term, multicentre registry to monitor the performance and safety of Medtronic Spinal Cord Stimulation (SCS) systems. We present an exploration of the effect of SCS with 2 rechargeable systems (RestoreSensor and Intellis) in patients with Back Pain of Failed Back Surgery Syndrome (BP-FBSS) on Health-Related Quality of Life (HR-QoL), and functional disability (Oswestry Disability Index, ODI).

Methods Patients with a diagnosis of BP-FBSS, a general pain score ≥ 5, and an initial implant were included. EQ-5D and ODI scores were summarized at baseline, 6-months, and for the change from baseline to 6-months (paired t-tests evaluated within-group change).

Results EQ-5D UK scores showed statistically significant and clinically relevant improvements for both RestoreSensor and Intellis from baseline to 6 months; 0.47 ± 0.21 to 0.57 ± 0.28 ($n=78$; $P=0.001$), and 0.45 ± 0.25 to 0.60 ± 0.26 ($n=82$; $P<0.0001$), respectively.

ODI scores reduced from 51.1 ± 13.3 to 45.1 ± 16.4 ($n=76$; $P=0.001$) and 50.9 ± 12.6 to 39.3 ± 16.6 ($n=85$; $P<0.0001$), for RestoreSensor and Intellis, respectively.

Conclusions To assess clinical relevance, research suggest a minimum clinically important difference (MCID) of 0.081 in EQ-5D in a subgroup of patients with back pain and 9.2 in ODI in patients with FBSS. Our analysis shows statistically significant and clinically relevant improvements in health-related quality of life, and functional disability from baseline to 6-months in patients diagnosed with BP-FBSS and implanted with a rechargeable SCS-system.

73 THE ROLE OF ULTRASOUND GUIDED PULSED RADIOFREQUENCY (PRF) FOR THE TREATMENT OF RHIZARTHROSIS: A CASE REPORT

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Background and Aims Rhizarthrosis is a disabling condition of the hand that affects 30% of postmenopausal women[1]. It commonly treated with physiokinesitherapy, non-steroidal anti-inflammatory drugs, intra-articular corticosteroid injections[2] and trapeziectomy.

Intra-articular PRF produces an electric field that disrupts smaller pain-carrying fibers of the synovial lining and reduces the levels of cytokines in the joint microenvironment[3].

Methods This report describes one case in which the ultrasound guided pulsed radiofrequency of the radial nerve offered a safe treatment for the management of chronic rhizarthrosis pain. The case was a 74-years-old man with a 12 month history of severe pain at the thumb basal joint. At his first visit, the VAS measured 8/10. The patient was sitting on the operating table with the trapezium metacarpal joint up. After preparation of the radial region, the sterile linear high frequency probe was longitudinally placed on the joint

(figure 1). Then, a 22 G 50 mm radiofrequency needle was introduced near the superficial radial. nerve (figure 2). Subsequently a thermocouple connected to a radiofrequency generator was inserted to reproduce the patient's paresthesia