

previous history of difficult airway management with postponement of this procedure 3 days before. After patient's consent, we successfully managed the case with an ultrasound-guided IPB and a PIFB (figure 2), total local anaesthetic solution – 20 mL of mepivacaine 1,5% & ropivacaine 0,375% under light sedation. The procedure was uneventful, for patient and surgical team.

**Conclusions** IPB and PIFB successfully managed anaesthesia & analgesia of this case under light sedation, avoiding GA and management of a documented difficult airway patient. Latest evidence supports IPB as a good technique for BCS(2) and PIFB is a relatively novel block suited for inner quadrant breast surgery approach(3). RA has been a good alternative avoiding airway management on this documented difficult airway, provided excellent surgery conditions, pain relief and a high level of patient satisfaction.

Approval has been granted by the ethics committee

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**PTERYGOPALATINE BLOCKADE IN THE ALGORITHM OF TREATMENT OF OPHTHALMIC COMPLICATIONS OF HERPES ZOSTER**

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**Background and Aims** Ophthalmoplegia in herpes Zoster is quite rare. At the same time, we observed a case of relapse of herpes Zoster with the clinic of ptosis of the upper eyelid on the background of a pronounced pain syndrome without vesicular rashes as the primary clinical signs. Relief of pain syndrome against the background of antiviral therapy is one of the primary tasks. To evaluate the effectiveness of pterygopalatine blockade (PPB) in the algorithm of treatment of atypical ophthalmic herpes Zoster with severe pain syndrome and ophthalmoplegia.

**Methods** Patient 60 years old. Complaints about OS blepharoptosis, pain (VAS = 4). The edge of the OS eyelid is lowered to the upper edge of the pupil, the cornea is transparent, there are no signs of uveitis. The condition is regarded as ganglionitis n.opthalmicus of unknown etiology. The patient underwent PPB (4 mL ropivacaine 0.5%) for pain relief in herpetic ophthalmic neuralgia

**Results** 40 minutes after PPB, the pain was relieved, VAS = 0. 2 hours after PPB, the ptosis decreased. After 72 hours the patient had a draining herpetic rash on the skin in the projection of the III branch of the trigeminal nerve on the left. Further treatment of the patient was continued by an infectious disease specialist.

**Conclusions** The experience gained in the use of the PPB in the algorithm for the treatment of ophthalmic complications of herpes Zoster allowed us to achieve not only the relief of pain, but also to reduce the severity of the inflammatory reaction of extraocular muscles, ptosis.

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**ULTRASOUND GUIDED COMBINED SCIATIC PLUS FEMORAL NERVE BLOCK IN HIGH RISK PATIENTS POSTED FOR LOWER LIMB SURGERIES**

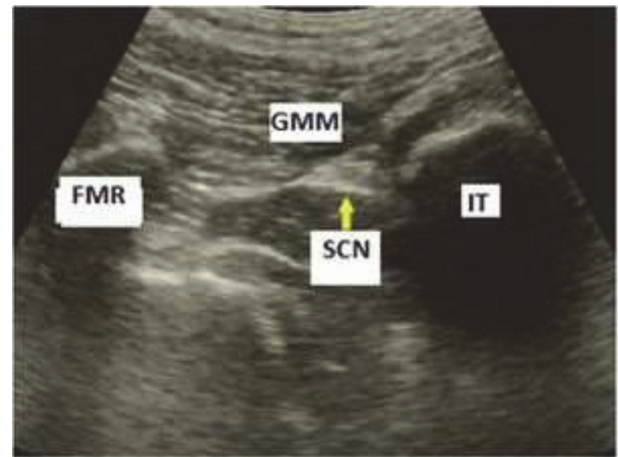
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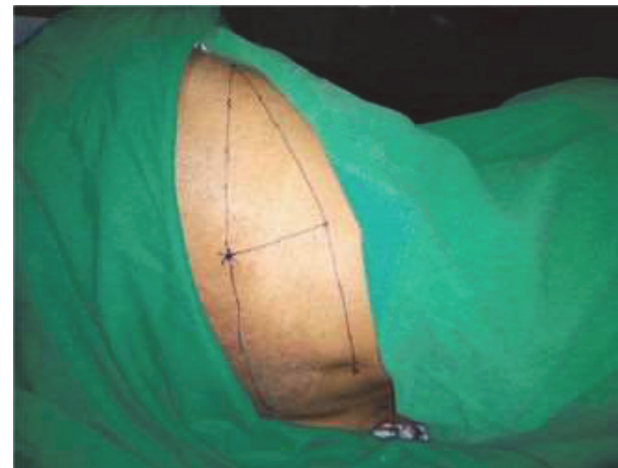
**Background and Aims** Regional Nerve Blocks are now the mainstay for high risk patients undergoing surgery where General, Spinal or Epidural Anaesthesia have poor outcome. Combined Sciatic and Femoral Nerve block given for lower limb surgeries like amputation, arthroplasty, ORIF in patients having multiple co-morbidities like Ishaemic Heart Disease (IHD), COPD, Uncontrolled DM and HTN. Ultrasound guided nerve blocks are effective, safe and have reduced incidence of neurological damage and Local Anaesthetic Systemic Toxicity (LAST).

**Methods** 5 patients undergoing lower limb surgery, in KLE's Dr. Prabhakar Kore Charitable Hospital and MRC were considered. Three of the patients had IHD with EF 40%. One had RV Dysfunction with IVC collapsibility <50%. Another had COPD and was in sepsis. A complete pre-anaesthetic evaluation was done after selecting appropriate patients. Under ultrasound guidance, with patient in sciatic and femoral nerve blocks were given with equal mixtures of 0.5% Bupivacaine + 2% Lignocaine + 2 ml of Soda Bicarbonate. Intra-operatively hemodynamics was maintained. Case 1 required rescue Epidural Anaesthesia. For case 3 i.v paracetamol was given for additional analgesia. In rest of the cases no additional analgesia/anaesthesia was needed.

**Results**



Abstract 172 Figure 1



Abstract 172 Figure 2