

ejection fraction of 30%. Chest X-ray findings: multiple small consolidatory radiodense lesions noted in bilateral lung fields. In view of his compromised cardiopulmonary reserve we chose continuous fractional spinal Anesthesia over general Anesthesia. Patient was preloaded with 200 ml RL over 15 min and Graded continuous fractional spinal anesthesia was performed with 18G Tuohy needle and intentional dural puncture was done at the level of L1-L2 and 20G catheter was introduced and 2cm catheter placed in subarachnoid space. 0.5% Hyperbaric bupivacaine was given in graded manner through the catheter (0.6+0.6+0.6+0.6+0.6+0.6+0.6+0.6+1+0.6+0.6+0.5). T4 level of sensory blockade was achieved and intraoperative haemodynamics were stable.



Abstract B265 Figure 1

Results Continuous fractional spinal anesthesia offers the advantage of fractionating the doses of local anesthetic in the subarachnoid space and has lesser effect on respiratory and cardiac physiology

Conclusions Continuous spinal anesthesia (CSA) is a safer alternative technique to general anesthesia in patients with severe cardio - respiratory disease in whom general anesthesia could result in prolonged ICU stay.

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NEURAXIAL ANAESTHESIA FOR ACUTE ABDOMEN SURGERY IN A MEDICAL-HUMANITARIAN MISSION IN SUB-SAHARAN AFRICA

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Background and Aims Acute abdomen is an emergency requiring immediate surgical intervention, for which midline exploratory laparotomy is the most commonly performed procedure. Although traditionally performed under general anaesthesia in

the developed world, general anaesthesia can be challenging in Sub-Saharan Africa due to resource gaps. Therefore, in under-developed countries the anaesthetic approach must be frequently adjusted, with regional anaesthesia growing in relevance.

Methods The authors describe the successful use of neuraxial anaesthesia in a 38-year-old female patient with acute abdomen proposed for emergent midline exploratory laparotomy during a medical-humanitarian mission at the Simão Mendes National Hospital in Guinea-Bissau. Considering the scarcity of resources, namely lack of access to functioning anaesthetic machines, basic airway equipment, capnography, and even oxygen cylinders, regional anaesthesia was preferred rather than general anaesthesia. After informed consent, a combined spinal-epidural anaesthesia was performed using a separate needle technique with an initial subarachnoid injection of 2.5 ml of 0.5% bupivacaine and 2.5 µg of sufentanil (L1-L2 level) followed by placement of an epidural catheter (T8-T9 level) for potentially prolonged surgery and postoperative multimodal analgesia. Despite airway security and pulmonary aspiration concerns, the patient remained conscious, on spontaneous ventilation.

Results General anaesthesia was successfully avoided and there was no need for supplemental oxygen therapy or vasopressors, although episodes of vomiting did occur. Intestinal perforation was diagnosed intraoperatively and small bowel resection and anastomosis were performed uneventfully. Postoperative recovery was unremarkable.

Conclusions Neuraxial anaesthesia may be a safe, effective, and less expensive approach for acute abdomen surgery in Sub-Saharan Africa patients under similar circumstances.

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OLD WINE IN A NEW BOTTLE- US GUIDED CONTINUOUS CAUDAL ANESTHESIA FOR CESAREAN SECTION IN A PARTURIENT WITH THORACIC GIBBUS & DIFFICULT AIRWAY: A CASE REPORT

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Background and Aims Internationally obstetric anesthesia guidelines recommend regional over GA for most cesarean deliveries. continuous caudal anesthesia in obstetric anesthesia was first reported in 1943, after which lumbar access to the peridural space became widely used. we report the anesthetic management of a parturient with difficult spine in whom we were able to place a us guided continuous caudal catheter and provide adequate anesthesia for the surgery.

Methods 25 yr old primigravida with 38 weeks gestation, short stature (121.8 cms) with a thoracic gibbus and difficult airway was posted for cesarean section. Mri of the spine could not be done due to financial constraints. Preprocedural scanning of the neuraxis done in view of altered spine anatomy. Spinal anesthesia could not be achieved despite multiple attempts due, since neuraxial scan revealed good view of caudal space, a continuous caudal catheter was placed under ultrasound guidance using 18 G Tuohy needle.