MEDICALLY CHALLENGING CASES
REGIONAL ANESTHESIA AND ACUTE PAIN

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC56

Multiple Level Ultrasound Guided Intercostal Nerve Blocks for Thoracic Wall Surgery in a Patient With Duchenne Muscular Dystrophy: A Case Report

Emine A. Salviz, M.D., Catherine F. Vandepitte, M.D., Philippe Gautier, M.D., Pierre Bellen, M.D., Hiroaki Murata, M.D., Anesthesiology, Columbia University College of Physicians and Surgeons, St. Luke's Roosevelt Hospital Center, New NY, NY, Anesthesiology, Catholic University Leuven, Leuven, Belgium, Anesthesiology, Orthopedic Surgery, Clinique Ste Anne-St Remi, Brussels, Belgium, Anesthesiology, Nagasaki University School of Medicine, Nagasaki, Japan.

Patients with Duchenne muscular dystrophy(DMD) usually lose their ability to walk and develop respiratory insufficiency by age 9 and 15, respectively. Mortality is related to combined respiratory failure and dilated cardiomyear-old pathy. Surgery under GA or sedation presents an increased risk for pulmonary complications or ventilator dependency. We describe the utility of US guided intercostal nerve blocks for surgery on the chest wall in a patient with DMD and severe respiratory compromise. Injections of 4mL of ropivacaine0.75% at 5 consecutive intercostal spaces achieved expected dermatomal distribution of anesthesia. No sedation or additional analgesia was used and patient's respiratory function remained stable.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC57

Ultrasound-Guided Continuous Thoracic Paravertebral Block for Outpatient Acute Pain Management of Multi-level Unilateral Rib Fractures: A Case Report

Emine A. Salviz, M.D., Hiroaki Murata, M.D., Stephanie Chen, M.D., Catherine F. Vandepitte, M.D., Admir Hadzic, M.D., Ph.D., Anesthesiology, Columbia University College of Physicians & Surgeons St. Luke's Roosevelt Hospital, New NY, NY, Anesthesiology, Nagasaki University, Nagasaki, Japan, Anesthesiology, Catholic University of Leuven, Leuven, Belgium.

A 61 year-old male patient with multiple unilateral rib fractures (T3-T8) on the left was admitted. Due to opioid induced N/V, his acute pain management of IV morphine PCA was discontinued and CTPVB was performed. The fractured ribs were visualized under US and the needle was inserted towards PVS at T5. After 20 mL of 0.5% ropivacaine injection the catheter was advanced. He was able to breathe deeply and cough adequately. Then, the catheter was connected to a pump and the patient was discharged on the following day. After 3 days of continuous infusion of ropivacaine, the catheter was removed.

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Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC58

Intractable Hiccups Following Ultrasound-Guided Interscalene Brachial Plexus Catheter Placement

Megan J. Sharpe, M.D., Jamie L. Baratta, M.D., Kishor Gandhi, M.D., Wlodzimierz Grodecki, M.D., Anesthesiology, Thomas Jefferson University Hospital, Philadelphia, PA.

39 year-old male underwent a right total shoulder revision with ultrasound guided continuous interscalene brachial plexus catheter placed with out-of-plane technique. On POD#1 patient complained of hiccups after resolution of primary block. Patient was treated with thorazine with no improvement. The interscalene catheter was removed on the POD#2 and the patient's hiccups resolved on the evening of POD #2. Interscalene block has been used as treatment of hiccups however no case reports have described interscalene catheter as cause of intractable hiccups. We hypothesize the catheter was contacting the phrenic nerve causing irritation leading to hiccups.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC59

A Case of Right Sided Atelectesis After Ispilateral Continuous Inter Scalene Catheter Presenting With Syncope to the Emergency Department

Harpreet Singh, Loran Mounir Soliman, M.D., Ehab Farag, M.D., Wael Ali Sakr Esa, M.D., Anesthesiology Institute, Cleveland Clinic Foundation, Cleveland, OH.

We report a case of 56 year-old female presented to emergency department with syncope on post operative day 1 after having right sided rotator cuff repair surgery. On chest X-ray she was found to have right lower lobe atelectesis. She was treated with aggressive hyperinflation therapy and aerosolized bronchodilators, leading to re-expansion of her lungs, without the need of interruption or reduction in the concentration local anesthetic in the nerve block.
Routine lung hyperinflation therapy in patient receiving interscalene nerve block may reduce pulmonary complications in this group.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC60

US Guided Transversus Abdominis Plane (TAP) Catheter for Post Operative Pain Management of a Patient Undergoing Partial Hepatic Resection

Harpreet Singh, M.D., Hesham Elsharkawy, M.D., Tatyana Shuster, M.S.N., Wael Ali Sakr Esa, M.D., Anesthesiology Institute, Cleveland Clinic Foundation, Cleveland, OH.

56 year-old male patient with liver metastases from rectal cancer underwent partial liver resection with a right subcostal incision 3 cm below the costal margin. Patient was complaining of 10/10 pain, epidural was offered which he refused, his refusal for epidural made post operative analgesia challenging. He was offered a TAP catheter, which provided him excellent analgesia, his pain came down to 2/10 after the block. The catheter was kept for 3 days.TAP block may be a viable alternative method for post operative pain management in patient undergoing upper abdominal surgeries, in whom epidural is refused or contraindicated.

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Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC61

Continuous Superficial Peroneal Nerve Block for the Treatment of Complex Regional Pain Syndrome Type II: Case Report

George L. Smith, M.D., Douglas K. Jaffe, D.O., Daryl K. Henshaw, M.D., Pamela K. Nagle, M.D., Anesthesiology, Wake Forest University, Winston-Salem, NC.

Complex regional pain syndrome describes a constellation of symptoms including pain, trophic changes, hyperesthesia, allodynia, and dysregulation of local blood flow often following trauma, and is considered to be confined to the extremities. A case of CRPS Type II in a 19 year-old female with a history of foot trauma is reported in which a continuous infusion of local anesthetic at the superficial peroneal nerve (SPN) was utilized. While placement of peripheral nerve block catheters to augment chronic pain therapy and manage CRPS is not novel, the placement of a perineural catheter at the SPN has not been previously described.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC62

Dilemmas With Anaesthetic and Pain Management Strategies in a Congenital Arteriopath With Chronic Pan-Coronaritis Secondary to Factor V Leiden Mutation

Ioana Sintie, M.B.,Ch.B., Nazneen Sudhan, Preeti Mahadik, M.B.,B.S., Iffa Anjum, M.B.,B.S., Watson Gomez, M.D.,F.R.C.A., Anaesthetic and Intensive care, Norfolk and Norwich University Hospital, Norwich, United Kingdom, Anaesthesia, Bedford Hospital, Bedford, United Kingdom.

While on all known anticoagulants in the pharmacopoeia and various narcotic analgesics and tranquilizers, this year-old ung Factor V Leiden mutation sufferer presented for an AKA secondary to acute on chronic limb ischaemia. This diffuse pro-thrombotic state left him with an extensive past history of having suffered from myear-old cardial infarctions secondary to a completely occluded coronary circulation, pulmonary embolisms, cerebrovascular accidents and limb ischaemic events.A desflurane-remifentanil anaesthesia with invasive blood pressure monitoring was supplemented by a single shot femoral nerve block. A sciatic nerve catheter was placed and a continuous infusion of levobupivacaine using the Painbuster system[*Bath asu UK*]was instituted for a successful outcome.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC63

Lower Extremity Motor Blockade After Paravertebral Nerve Blocks in Urological Surgery

Shruthima Thangada, M.D., Jacques E. Chelly, M.D., Department of Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

A pre-operative bilateral T10 paravertebral nerve block catheters was performed for postoperative pain management in a 57 year-old man undergoing a cystoprostatectomy under general anesthesia. Postoperatively an infusion of 0.25% lidocaine was initiated at 7ml/hr. On postoperative day 1 the patient was found to have bilateral lower extremity motor blockade and decreased sensation. Nerve blocks turned off, but motor block still persisted. Upon discharge and a month later, since the patient was still complaining of significant lower extremity weakness, a neurologist was consulted.

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Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC64

Regional Anesthesia in Medical Mission Trips

Shruthima Thangada, M.D., Sharad Khetarpal, M.D., Department of Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

Peripheral nerve block techniques are widely accepted throughout the United States as being advantageous. The importance of utilizing these skills in developing countries where one is faced with the challenge of an unfamiliar environment, minimal monitoring capacity, and lack of readily available narcotics is beneficial. A medical mission trip to Deschapelle, Haiti took place. Several PNB were performed with some being used for surgical anesthesia in the adult and pediatric population. Most PNB employed the use of a nerve stimulator and landmark based anatomy knowledge. We found this technique to be safe and successful demonstrating superior patient satisfaction.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC65

The Safety of Paravertebral Nerve Blocks: Landmark Based Versus Ultrasound Guidance

Shruthima Thangada, M.D., Kevin King, D.O., Department of Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

77 year-old female with lung cancer, CAD, HTN, and SLE presented for left sided VATS with upper lobe segmentectomy. Using a classical landmark approach technique for insertion a left sided T4 paravertebral catheter was placed. Intra-operatively PVB found to be intra-pleural with VATS camera and catheter was withdrawn into the paravertebral space under direct visualization and secured. Also noted at that time was bruising of either the sub-parietal pleura or serosal aorta likely caused by catheter tip or from tip of Tuohy needle upon insertion of PVB. Despite complications patient was found to have adequate pain relief with PVB.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC66

Treatment of Phantom Limb Pain With Regional Nerve Block

Antony Tharian, M.D., Farzad Ebrahimi, M.D., Yashar Illkchoui, M.D., N. Nick Knezevic, Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.

A healthy 68 year-old female developed progressive left shoulder pain for 2 years. Arthroscopy showed mass lesion and biopsy specimen reported myear-old epithelioma of the bone affecting the shoulder joint. A left forequarter amputation was done under GA and an interscalene nerve block for post operative analgesia was performed. She developed persistent excruciating pain of left arm and forearm, 8-10hours after worn off anesthesia. Analgesic medications failed to control pain. Supra-clavicular nerve block was done under ultrasound with 20ml of 0.2%Ropivacaine which resulted in pain relief. Regional nerve blocks could be considered for phantom pain relief as one of the intervention therapies.

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Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC67

Ultrasound-Guided Bilateral Supraclavicular Nerve Block for the Treatment of Excruciating Pain Secondary to Reynaud's Phenomenon

Antony Tharian, M.D., Airiauna Reid, D.O., N. Nick Knezevic, Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.

A 63-year-old man presented with bilateral hand pain, blistering, bruising, discoloration, and swelling after cleaning a roof in a cold weather. PE showed right 2,3and 4 digits and left 2 and 3 of distal pharyngeal were swelling; cyanosis nail beds, and dorsal ecchymotic with multiple blisters.
Severe vasospasm from Reynaud's phenomenon secondary to cold weather or chemical exposure was suspected. Instead of stellate ganglion block, bilateral supraclavicular nerve block under ultrasonographic guidance with 15ml of 0.2%ropivacaine was performed for pain relief in order to minimize the possibility of profound bradycardia and heart block. The patient had excellent results for pain relief.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC68

Persistent Cerebrospinal Fluid-Cutaneous Fistula After Epidural Analgesia: A Case Report and Review of Literature

Andrea L. Tsai, Pascal H. Scemama de Gialluly, M.D.,M.B.A., Jingping Wang, M.D., Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Boston, MA.

Presented is a case of persistent high-output cerebrospinal fluid (CSF) leak following epidural catheter removal on postoperative day 5 for a 64 year-old patient after exploratory laparotomy. Epidural catheter placement required multiple attempts preoperatively and was complicated by "wet tap". Diagnosis of CSF leak was made with glucose, protein and beta-2 transferrin testing. The patient remained without signs or symptoms of intracranial hypotension or infection and was managed conservatively with prophylactic antibiotics and a sterile stitch sealing the cutaneous fistula site. With literature review, we propose an algorithm to help early detection and management of CSF-cutaneous fistula.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC69

Novel Use of an Infraclavicular Catheter for Brachytherapy Treatment

Benjamin Vaghari, M.D., Jaime Baratta, M.D., Bernadette Grady, R.N., Kishor Gandhi, M.D.,M.P.H., Anesthesiology, Thomas Jefferson University Hospital, Philadelphia, PA.

We present a case of a 57 year-old female with history of soft tissue sarcoma who was admitted for insertion of brachytherapy catheters and subsequent radiation therapy. Brachytherapy is often painful due to local tissue inflammation/destruction and catheter manipulation. Effective analgesia was maintained throughout this period via an infraclavicular catheter placed with ultrasound guidance. We administered a local anesthetic infusion for a total of 11 days with no evidence of local irritation, infection, or neurologic sequelae.

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Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC70

Regional Anesthesia in a Coagulopathic Patient

Dusty R. Watson, Anesthesia, Vanderbilt, Nashville, TN.

57 year-old male with severe portopulmonary hypertension, liver cirrhosis and multiple MIs with ICD placement presented for fasciotomy of his hand due to an Edwardsiella tarda infection. Upon admission patient had new onset renal failure, INR of 2.2 and platelets of 29k. A infraclavicular single shot was done with 1% lidocaine and no sedation was given intraoperatively as to not exacerbate the patient's severe pulmonary hypertension leading to RV failure.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC71

Multimodal Analgesia for Open Liver Resection in an Anti-Coagulated Patient

Ammar N. Yamani, M.D., Stanlies D'Souza, M.D., Anesthesiology, Tufts Baystate Medical Center, Springfield, MA.

A 55 year-old male with a history of alcoholism, smoking, mitral valve replacement on chronic anti-coagulation and thrombocytopenia underwent laparoscopic left hepatectomy converted to laparotomy for carcinoid tumor. He received 500 micrograms of fentanyl at the beginning of the case, and near the conclusion of a four hour case received clonidine 40 micrograms, ketamine 40 milligrams, and bilateral transversus abdominis plane block with bupivicaine. He was extubated in the OR. His PACU course required only 0.4 mg of hydromorphone, and the remainder of his hospital course required very minimal intravenous narcotics via PCA.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC72

Sinus Arrest Immediately Following Right Interscalene Brachial Plexus Block: Is Unintentional Stellate Ganglion Block The Culprit?

Shiraz Yazdani, M.D., Gregory Vanginault, C.R.N.A., Ashraf Farag, M.D., Anesthesiology, Texas Tech University, Lubbock, TX.

A 59 year-old female presented for right shoulder arthroplasty. After uneventful induction of general anesthesia, a right interscalene brachial plexus block was performed under ultrasound guidance. Following injection of local anesthetic, the patient went into asystole. Atropine was administered with subsequent return of sinus rhythm within 3 minutes. She was immediately extubated and transferred to the ICU. She was discharged three days later. We theorize that an unintentional stellate ganglion block led to unopposed parasympathetic tone to the SA node, with other considerations being the Bezold-Jarisch reflex, reverse Bainbridge reflex, and carotid sinus hypersensitivity.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC293

Case of the Unstable Cervical Spine

Titilopemi Aina, M.D., Allen Coleman, M.D., Anesthesiology, University of Florida, Gainesville, FL.

15 year-old female status-post motor vehicle rollover with type II fracture of dens, left occipital condyle fracture, anterior cervical (C7) fracture, C6-7 anterolisthesis, left distal radius fracture, right wrist (triquetral) fracture, and bilateral upper extremity soft tissue loss with retained foreign body. She was admitted to the pediatric intensive care unit and maintained in cervical traction while awaiting definitive surgical management of cervical fractures. Patient presented urgently to the operating room for right arm and left hand wound debridements. The surgery was performed under regional anesthesia (right infraclavicular and left axillary blocks) and minimal sedation.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC294

Use of Namenda (Memantine) as Part of a Multimodal Approach to Treat Phantom Limb Pain in a Patient With Traumatic Limb Amputation

Nawraz Alan, M.D., Paul Dangerfield, M.D., Catherine Cleland, M.D., Jeffery Berger, M.D.,M.B.A., Department of Anesthesiology and Critical Care Medicine, George Washington University, Washington, DC.

A 54 year-old male involved in a motorcycle accident experienced severe left lower extremity injury. Despite undergoing an operation to save the limb, his left leg was later amputated below the knee. Aside from the acute surgical pain, he experienced phantom limb pain, which was treated with IV/oral narcotics, ketamine infusion, peripheral nerve blocks, and other agents. Despite these efforts, the patient still complained of phantom limb pain. He was started on Namenda (memantine) 5mg PO BID, titrated to 15mg PO BID. Within a few days, memantine allowed for discontinuation of his IV narcotics and significantly reduced his phantom limb pain.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC295

Identification of the Location of Anterior Sciatic Nerve Catheter Using Pumping Technique

Lovkesh Arora, M.D., Hesham Elsharkawy, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.

59 year-old female with h/o recurrent left knee prosthetic joint infection underwent patellectomy and then wound closure with staged gastrocnemius / microcutaneous flaps. Considering patient's longstanding surgical history, inadequate pain control with iv/po/pca opioids in the past, got USG guided Lt side Femoral nerve catheter along with Lt side Anterior approach Sciatic nerve catheter preoperatively, using the pumping technique to identify the location of the tip of the sciatic catheter using colour doppler. Postoperatively patient’s pain was well controlled using continuous infusions with minimum requirement for opioids. USG images will be attached with detailed description of the Pumping mechanism.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC296

Unconsciousness After Retrobulbar Block

Emily Ashford, M.D., Yi Hua, M.D., Anesthesiology and Perioperative Medicine, Georgia Health Science University, Augusta, GA.

60 year-old male presented in outpatient clinic for vitrectomy Pre-operative vital signs were BP 179/99, HR 58. After conscious sedation with fentanyl and midazolam,retrobulbar block was performed by surgeon. 5 minutes after block, patient's BP was significantly higher than baseline (210/120) with HR of 90, not responding to labetalol and esmolol. 10 minutes after block, patient noticed to be unconscious while maintain spontaneous breathing. Procedure aborted. Flumazenil 0.2mg iv was given. Patient was transferred to the hospital's ER. After 2 hours stay at the ER without further intervention. patient became conscious and BP return to baseline without any complications.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC297

An Unexpected Wake Up

Ashot Aslanyan, M.D., Miguel Cruz, M.D., Anesthesiology, CCF, Cleveland, OH.

The patient is a 56 year-old male with hx of DM, ESRD, HTN, PVD, pancreas-kidney transplant and multiple amputations scheduled for finger amputation under U/S guided right supraclavicular and axillary block. A propofol infusion provided an uneventful sedation until the end of surgery, when the propofol was discontinued and the patient had tonic-clonic movements of all extremities except RUE with altered consciousness. He remained hemodynamically stable. 4mg of Midazolam controlled the abnormal movements. The mental status returned to baseline shortly under continuous monitoring.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC298

Supine Ultrasound Guided Sciatic Popliteal Approach on a Septic Obese Patient

Alisha Bhatia, M.D., Carlo D. Franco, M.D., Anesthesiology, John H. Stroger Hospital, Chicago, IL.

A 55 year-old female with hypertension and uncontrolled diabetes presented to the operating room for a right midfoot amputation. During preoperative evaluation, she was found to be septic and obtunded. She was also noted to have a difficult airway so we decided to perform regional anesthesia in the supine position, in the operating room so that we would be prepared to resuscitate if necessary. We performed a sciatic nerve block in the popliteal fossa using an out of plane approach to limit the amount of local anesthetic given.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC299

Paravertebral Nerve Block Facilitates Extubation in a 5 Week Infant With Rib Fractures

Karen R. Boretsky, M.D., Sarah Cunningham, B.S., Katherine Boretsky, B.S., Aviva Katz, M.D., Anesthesiology, Surgery, University of Pittsburgh Medical Center, Pittsburgh, PA.

A 5-week-old, 5kg infant suffered rib fractures and a pulmonary contusion secondary to penetrating trauma to the chest. The infant remained intubated for pain control with narcotics. A T7 paravertebral nerve block catheter was subsequently inserted under ultrasound guidance, bolused with ropivicaine and an infusion started. Narcotics were weaned and the infant met extubation criteria within 24 hours. To our knowledge, this is the first reported case of the use of a paravertebral block in an infant for pain relief following rib fractures and the first reported case of the use of ultrasound guidance in an infant less than 10kg.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC300

An Approach to Neuraxial Anesthesia for the Severely Scoliotic Spine

Clifford Bowens, Jr., M.D., Katherine Dobie, M.D., John Corey, M.D., Anesthesiology, Vanderbilt University School of Medicine, Nashville, TN.

We report on a case in which computer tomography was used to guide placement of an epidural catheter in a patient with severe scoliosis and congenital dwarfism. In addition, the computer tomograms were correlated with ultrasound and fluoroscopic images in the patient. Three years later, the patient had a spinal anesthetic performed with only the use of ultrasound-guidance. Ease of placement of the epidural and spinal was greatly enhanced by imaging. With an emphasis on utilizing imaging modalities, we present a systematic approach to performing neuraxial anesthesia in the patient with severe scoliosis to ensure safety, efficiency, and success.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC301

Delayed Onset of Motor Blockade After Sciatic Nerve Block

Michael J. Bowling, D.O., Daniel C. Sizemore, M.D., WVU, Morgantown, WV.

Prior to revision of an ankle arthroplasty, a sciatic nerve block utilizing 20mL of 0.5% ropivacaine and subsequent catheter placement was performed on a 56 year-old male. Immediate postoperative evaluation failed to demonstrate satisfactory blockade. The catheter was removed after the patient noted a metallic taste in his mouth with a 5mL bolus of 1.5% mepivaciane. Approximately five hours later the patient developed sciatic nerve palsy. CT of the thigh failed to demonstrate hematoma secondary to placement of nerve block. Approximately twenty hours after initial placement the blockade resolved without permanent sequelae.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC302

Occipital Neuralgia Induced Headache Presenting in the PACU and a Novel Treatment

Kenneth Burckardt, M.D., Cornelia Atherton, M.D., Marina Varbanova, M.D., Laura Clark, M.D., University of Louisville, Louisville, KY.

Patient positioning during anesthesia is an important consideration for anesthesiologists. Even with vigilant attention, complications likely related to intraoperative positioning can occur. We report a case of a pharmacologically resistant intractable post-operative headache after a case involving neck manipulation and successful treatment with a novel approach; bilateral occipital nerve blocks. This therapy provided adequate analgesia and avoided potential side effects associated with further pharmacologic treatment. We also offer a discussion of post-operative headache, occipital neuralgia and its treatment.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC303

Delayed Onset of Symptomatic Phrenic Nerve Blockade After Interscalene Brachial Plexus Block in a Middle-Aged Patient

Kenneth D. Candido, M.D., Jonathan Kamerlink, M.D., Jose Rivera-Melendez, M.D., N. Nick Knezevic, Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.

A 42 year-old male presented for a right shoulder arthroscopy and open acromioplasty. An interscalene block (ISB) for postoperative analgesia was performed with 30mL of 0.5%ropivacanine under ultrasound guidance at 1.5cm depth. Surgery was done within 2hours without complications. Five-hours after the ISB, he developed dyspnea and chest discomfort without vital sign instability. A chest-X-ray showed right diaphragmatic hemiparesis consistent with the right phrenic nerve blockade. The patient was kept on supplemental oxygen. The next morning the nerve block had resolved, and his dyspnea disappeared. This report should raise awareness of the possibility of delayed respiratory symptoms in any patient following ISB.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC304

The Safety of Peripheral Nerve Blocks in Patients With Hemophilia A

Jeffrey Derham, Toni Torrillo, M.D., Anesthesiology, Mount Sinai Hospital, New NY, NY.

A 58 year-old male with a past medical history of HIV and hemophilia A presented for right knee replacement secondary to hemophiliac arthropathy. Preoperative labs included INR=1.1, aPTT=28.4, HCT=30, and Factor VIII level of 190%. After a discussion with the patient, a regional technique consisting of a femoral nerve catheter and a sciatic nerve block was planned. Twenty minutes before surgery antihemophilic factor 6000 units was given. The surgeons requested general anesthesia because of concerns of masking compartment syndrome. One unit of RBC's was given intraoperatively. In the postoperative period, the patient was febrile with decreasing hemoglobin despite transfusions.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC305

Unpredictable Circumstances Call for Heroic Measures: Bilateral Femoral and Sciatic Catheters Prevent Phantom Pain After a Devastating Tornado Amputates Lower Extremities

Jenna L. Dismore, M.D., Laura Clark, M.D., Anesthesiology, University of Louisville, Louisville, KY.

A 37 year-old female sustained bilateral crush injuries while lying on her children to protect them as a tornado destroyed their home. Due to her injuries, a left AKA and right BKA were necessary. Bilateral femoral and sciatic peripheral nerve catheters were placed for pain control and to prevent pain memory in attempt to eliminate phantom limb pain. The catheters were maintained for fourteen days and three additional surgeries. Her pain was well controlled. No interfering phantom pain was experienced. She continues to progress in rehabilitation without interference from phantom limb pain and does not require any oral pain medications.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC306

Subcostal TAP Block Supplemented by Intercostal Block for Post-Operative Pain Control in an Opioid Tolerant Patient Undergoing Major Upper Abdominal Surgery

Anis Dizdarevic, M.D., Anesthesiology, Columbia University, New Nork, NY.

40 year-old man with chronic abdominal pain requiring escalating doses of opioids presented for a reversal of gastric bypass. Preoperatively, patient refused recommended thoracic epidural. Intraoperatively he received significant doses of opioids, remifentanil and ketamine infusions. In the PACU, patient appeared in visible discomfort, and additional doses of opioids provided minimal relief. He received bilateral subcostal TAP blocks, and shortly after reported significant pain relief in the mid-lower part of the incision. Next, bilateral T7 intercostal nerve blocks were performed and this provided substantial pain relief across the entire surgical incision which lasted approximately 12 hours.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC307

A Case of an Epidural Abscess: Don't Always Blame the Epidural Catheter

Grant Doornbos, M.D., Laura Clark, M.D., Daisy Sangroula, M.D., Anesthesiology, University of Louisville, Louisville, KY.

A 63 year-old hispanic female presented for an elective Hysterectomy. She received a pre-operative low thoracic epidural for post-operative pain management. The catheter was removed and patient discharged on POD #3. This patient returned on POD #16 with left leg pain and fever. She was found to have an epidural abscess at this time. Initially, the catheter placed by the anesthesia team was believed to be the offending agent. Further work-up including repeat MRI's and cultures identified the source to be a perineal abscess that tracked to the anterior, lumbar epidural space.

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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC308

Seizure in Surgical Patient 23 Hours After Regional Anesthesia and Perineural Catheters Insertion: Polypharmacy and Local Anesthetic Systemic Toxicity - The Last Straw

Elizabeth Dwyer, M.D., Kurt Grathwohl, M.D., Brooke Army Medical Center, San Antonio, TX.

24 year-old male trauma patient receiving antimicrobials and multimodal pain medications developed seizure 23 hours after regional analgesia and perineural catheters insertion. After fixation of a tibial fracture the patient required rescue femoral and sciatic nerve blocks with 0.5% ropivacaine totaling 300 mg. Perineural catheters infused 0.2% ropivacaine totaling 40 mg/h. 23 hrs later the patient seized. Serum ropivacaine level was 3.3 mg/L (severe neurotoxicity >3mg/L). Clinically acceptable doses of local anesthetic may produce toxic levels when combined with multiple medications that effect CYP1A2 metabolism. Attention to metabolism interactions should be considered with local anesthetic injection.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC741

Epidural Blood Patch for Acute Intracranial Pneumocephalus

Peter A. Norstedt, M.D., Dalia H. ElMofty, M.D., Anesthesia & Critical Care, University of Chicago, Chicago, IL.

A 56 year-old male underwent resection of an ethmoid sinus carcinoma extending into the frontal lobe. A CT scan on POD#0 revealed expected mild intracranial blood in the resection cavity, and evidence of pneumocephalus. Due to concern for meningeal detachment and brain sag from pneumocephalus, an autologous epidural blood patch (EBP) was requested by the neurosurgery service on POD#4. 20 ml autologous blood was injected into the L5-S1 epidural space after removal of his lumbar drain. A repeat CT scan of the head showed significant reduction in size of the pneumocephalus post-EBP.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC742

Neuraxial Blockade in a Patient With Antiphospholipid Syndrome

Kelly Elterman, M.D., Richard Urman, M.D.,M.B.A., Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, Boston, MA.

74 year-old woman with large pelvic mass, elevated PTT, and positive lupus anticoagulant presented for exploratory laparotomy. Given history of miscarriage, albeit no thromboembolic events, ntiphospholipid syndrome (APS) was presumed. While elevated PTT due to anticoagulation frequently contraindicates neuraxial blockade, APS does not preclude regional anesthesia. Several studies have demonstrated, although not proven, safe regional anesthesia in such patients. Considering risk-benefit balance, thoracic epidural placement was undertaken in this patient. Placement and remainder of the perioperative course were uneventful. Despite elevated PTT, regional anesthesia may be beneficial, can be safe, and should be considered for patients with APS.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC743

Five Day Continuous Spinal Analgesia for Postthoracothomy Pain

Ramsis F. Ghaly, M.D., Yuriy Slota, M.D., Sergio Gonzalez, M.D., N. Nick Knezevic, Kenneth D. Candido, M.D., Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.

A 65 year-old female was admitted for a thoracotomy and removal of the right lower lobe mass. Epidural 19G catheter was placed intrathecally and continuing spinal anesthesia(CSA) with fentanyl 12mcg/ml and ropivacaine 1.5mg/ml(0.15%) at rate 1.5ml/hr were administered for postoperative pain as. CSA was discontinued on POD4 with good satisfactory(VAS0-2/10). CSA is an established technique with several clinical advantages such as ability to specify dermatomal level control, less systemic sedation, required a fraction of the epidural local anesthetic dose (1/10 of the epidural dose)with faster onset, denser block and providing better outcomes. Disadvantages of CSA are cauda equina syndrome, or post-dural puncture headache.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC744

Bilateral Transversus Abdominis Plane Catheters for Pain Control in a Complex Patient Receiving an Exploratory Laparotomy

Diane Gordon, Cincinnati Children's Hospital, Cincinnati, OH.

A 22 year-old male with recurrent renal cell cancer complicated by abdominal metastases presented for exploratory laparotomy and bowel resection for palliative purposes. His severe chronic pain was managed with large doses of IV narcotics as well as an intrathecal morphine pump. As epidural analgesia was contraindicated, bilateral transversus abdominis plane (TAP) nerve block catheters were placed to provide extended analgesia. Post-operatively the patient’s abdomen was soft and palpable. A dexmedetomidine infusion was started to treat severe agitation, and the patient went to the intensive care unit sedated but breathing with his natural airway.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC745

Suboxone Therapy Should be Continued for Patients on Maintenance Therapy for Chronic Pain

Shaun E. Gruenbaum, M.D., Keun Sam Chung, M.D., Department of Anesthesiology, Yale University School of Medicine, New Haven, CT.

A 38 year-old man with a history of seizure disorder, chronic neck and back pain on suboxone 8mg/2mg presented for anterior cervical discectomy and fusion under general anesthesia. Intraoperatively, a ketamine and propofol infusion was initiated at 100 mcg/kg/hr and 125 mcg/kg/min, respectively, and ketorolac 30 mg was administered intravenously. Postoperatively, the ketamine infusion was continued, and he was treated with ketorolac 15mg IV q6h and suboxone 8mg/2mg sublingual q6h. The patient experienced excellent pain control, with a pain score of 2/10 on the day of surgery and 1/10 by postoperative day 2, when he was discharged to home.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC746

Treatment of Acute Postoperative Pain in an Adult With Severe Opioid Dependence Secondary to Epidermolysis Bullosa

Shaun E. Gruenbaum, Benjamin F. Gruenbaum, B.Sc., Raymond S. Sinatra, M.D., Ph.D., Department of Anesthesiology, Yale University School of Medicine, New Haven, CT, Department of Anesthesiology and Critical Care, Ben-Gurion University of the Negev, Beer Sheva, Israel.

A 53 year-old lady with severe opioid dependence and possible opioid-induced hyperalgesia secondary to epidermolysis bullosa (EB) presented for a right below the knee amputation. Her home medications included 420 mg of oxycodone q2h and Ativan 0.5 mg q4h prn. After an intraoperative spinal, she reported 10/10 somatic and neuropathic pain postoperatively. Hydromorphone PCA, methadone, and gabapentin therapy were initiated, and by post-op day 4, she was weaned down to opioid doses lower than her pre-operative requirements. She was referred to a pain specialist prior to her discharge for long-term management of her pain.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC747

Delayed Spinal Epidural Hematoma Following Epidural Catheter Removal With Re-Initiation of Warfarin: A Case Study

Padma Gulur, M.D., Jordan L. Newmark, M.D., Jing Ping Wang, M.D., Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Boston, MA.

We report two cases of spinal epidural hematoma and lower extremity paraesthesia in patients who presented for endovascular repair of an abdominal aortic aneurysm. Following standard guidelines, Warfarin therapy was ceased several days prior to surgery and heparin infusion was stopped six hours prior. Upon re-initiation of anticoagulants following epidural removal, both patients reported lower extremity weakness and MRIs revealed a lesion in the lower thoracic and/or lumbar area (T9-L1; L2-L3). Treatment was unique in each case - one patient's symptoms resolved within 24 hours while the other underwent a thoracic/lumbar fusion and an anterior/posterior decompression.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC748

Spinal Cord Stimulation for Intercostal Neuralgia in a Patient With Implantable Cardiac Defibrillator and Biventricular Pacing

Padma Gulur, M.D., Stanley Kang, M.D., Marcos F. Vidal Melo, M.D., Anesthesia, Critical Care & Pain Medicine, Massachusetts General Hospital, Boston, MA.

39 year-old patient reported sharp pain radiating from a thoracoscopic incision for a prophylactic implantable defibrillator. The patient was prescribed EMLA cream and underwent two injections into his left chest, both of which provided minimal pain relief. After careful consideration, a SCS trial was performed. A Medtronic octrode lead was introduced into the epidural space and the tip was advanced to the T6 vertebra. Monitoring of the patient's AICD showed no interference when the SCS was activated and used at different frequencies. The patient returned to report excellent coverage of his pain and he underwent permanent implantation of the SCS.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC749

Continuous Adductor Canal Block, Selective Posterior Tibial Block, and Weak Femoral Block for Total Knee Arthroplasty

Mike Guzman, Community East Hospital, Indianapolis, IN.

Internet blogs have reported unreliable adductor canal block(ACB) outcomes for TKA. We have overcome reported deficiencies by combining an ACB,with a selective posterior tibial block, and a weak femoral block for 75 patients postoperative analgesia for TKA. Pain scores were 0-3/10, length of stay was reduced by .5 day. No single block technique has been shown to be ideal for TKA. The results for our TKA have exceeded our expectations. Same day ambulation is now a reality. Addition of a weak femoral, and a selective posterior tibial to a continuous ACB, significantly reduces immediate postoperative pain and allows early ambulation.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC750

Pneumoencephalus After Epidural Labor Analgesia

Anthony T. Han, Joshua Gaines, Quynh Nguyen, Cosmin Guta, M.D., Department of Anesthesiology, Texas Tech University Health Sciences Center, Paul L. Foster School of Medicine, El Paso, TX.

Pneumoencephalus accompanied by headache is a relatively rare, but well-described complication of unintentional dural puncture. We describe a patient who developed unrelenting headache and pneumoencephalus, unresponsive to known therapeutic modalities of postdural puncture headache, which spontaneously resolved.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC751

Fascia Iliaca Block for Acute Pain Control in a Trauma Patient on Maintenance Buprenorphine/Naloxone Therapy

Norman R. Harvey, M.D., Thomas I. Epperson, M.D., John J. Freely, M.D., Anesthesia and Perioperative Medicine, Medical University of South Carolina, Charleston, SC.

Background: With rising prescription drug abuse comes more patients on opioid blockers, posing difficult analgesia in acute surgery. We report nerve blockade with adjuncts in such a case. Methods: A 21 year-old MVC trauma on Suboxone arrived with femur fracture. FI block with ropivacaine was performed with ultrasound and midazolam/ketamine sedation. Results: Traction pins were placed under sedation and nerve block. Later the patient had femoral IM nailing, receiving dexmedetomidine, ketamine, and ketoralac. Conclusions: FI block with non-opioid adjuncts worked effectively in a patient with mu receptor blockade, suggesting regional blocks and adjuncts be considered for analgesia in this group.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC752

Use of Continuous Sciatic Nerve Block Catheter for Treatment of Complex Pain in Traumatic Neurovascular Extremity Injury

Ranu R. Jain, Maria Matuszczak, M.D., Anesthesia, University of Texas Health Science Center at Houston, Houston, TX.

13 year-old involved in ATV accident was transferred to our hospital from outside facility. He presented with nonfunctional lower leg, uncontrolled pain depression, somnolence, anorexia, nausea, weight loss on multiple pain medication. Initial injuries were mid femur fracture, transection of superficial femoral artery repaired with saphenous graft which later thrombosed requiring thrombectomy, ,fasciotomy X4 .We started multimodal treatment including a continuous sciatic nerve block after discussing the advantage of the block in the presence of nerve injury. The block was continued for 23 days allowing the medications to be weaned to paracetamol and gabapentin and initiation of physical therapy.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC753

Acute Onset of Superior Vena Cava Syndrome in a Patient Undergoing Dialysis Graft Revision

Vineet K. Jassal, M.D., Paul Bigeleisen,, M.D., Department of Anesthesiology, University of Maryland Medical Center, Baltimore, MD.

22 year-old male with ESRD secondary to focal segmental glomerulosclerosis and history of venous thrombosis needed a dialysis fistula in left upper arm. Anesthetic plan was ultrasound guided supraclavicular block and sedation. Patient had difficultly ventilating and developed significant neck swelling and chemosis intraoperatively. Differential diagnosis included anaphylaxis and superior vena cava syndrome; given dexamethasone, diphenhydramine and intubated awake fiber-optic. Vitals signs maintained stable. Interventional radiology study showed stenosis in the left brachiocephalic vein and patient had successfully venoplasty and extubation. SVC syndrome developed from new venous thrombosis; surgery and regional anesthesia were contributing factors.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC754

Acute Onset Dyspnea After Placement of Thoracic Paravertebral Nerve Block Catheter

Daniel S. Cormican, M.D., James A. Jernigan, M.D., Arie Kandel, M.D., Jacques A. Chelly, M.D., Ph.D., Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

A T4 continuous paravertebral block was performed on a 67 year-old gentleman presented for right sided thoracotomy. The paravertebral space was identified using a blind approach, without complication. Because of difficulty threading the perineural catheter, the needle bevel was rotated 90 medially to facilitate catheter placement. Shortly after dosing the catheter with 0.5% ropivacaine, the patient reported bilateral upper extremity paresthesia and breathing difficulty. The patient was transferred to the operating room for immediate general anesthesia induction and intubation. The patient was extubated upon emergence without respiratory compromise or pain.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC755

Inadvertent Intrathecal Catheterization With Persistent Motor Blockade in PACU in a Patient With Co-Existing Spinal Stensosis

Greesh John, M.D., Neelam Malhotra, M.D., Ramsis Ghaly, M.D., John H. Stroger Hospital of Cook County, Chicago, IL.

Poorly developed spinal muscles and small epidural space secondary to ligament and facet hypertrophy predisposes to accidental dural puncture. We present a difficult epidural placement for a total gastrectomy with dense motor weakness, hypotension and significant pain in the recovery room. Clear, warm fluid with glucose of 120 gm/dl was aspirated from the catheter. CT lumbar spine to rule out epidural hematoma showed the catheter traversing the midline on axial images with the tip located ventrally in the anterior epidural space 1-2 levels cephalad after acute angulation. The epidural catheter was removed with no residual deficit.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC756

Unusual Ultrasound Finding Complicating Placement of a Femoral Nerve Stimulating Catheter for Analgesia After Knee Surgery

H. David Hardman, M.D.,M.B.A., Andrew Lobonc, M.D., Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.

A 57-year-old female was scheduled for surgical removal of an infected total knee prosthesis. Her past medical history was complicated by asthma, diabetes, hypertension, chronic renal insufficiency, morbid obesity and peripheral vascular insufficiency.
In order to provide post-operative analgesia in this complicated patient, an ultrasound-guided continuous femoral nerve catheter placement was planned. However, we were initially unable to visualize the femoral nerve lateral to the patent vascular structures identified via color Doppler flow. Further examination revealed a femoral artery occluded by thrombus, with an unusual sonographic circumferential appearance, that was later determined to be an unknown previously placed metallic stent.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC757

Interscalene Peripheral Nerve Stimulating Catheter Resulting in a Cervical Epidural

David Lowery, M.D., Brian Fitzgerald, M.D., Anesthesiology, San Antonio Military Medical Center, San Antonio, TX.

In an ambulatory surgery setting, the placement if an interscalene peripheral nerve block with a stimulating catheter for an elective shoulder surgery resulted in a cervical epidural. Despite consistent stimulation of the catheter during placement and its final position, a bolus dose of local anesthetic was delivered to the patient's cervical epidural space. This resulted in a bilateral C4 to T3 block, as well as hypotension and bradycardia, which were carefully managed in the post anesthesia care unit until the block resolved and the patient met discharge criteria.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC758

Thoracic Paravetebral Anesthesia for Breast Surgery in a Difficult Airway

Nina K. Marok, D.O., Ehab Farag, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.

Thoracic paravertebral block has been used as an alternative to epidural placement for the management of pain postoperatively. Its use for surgical anesthesia has been described for breast, thoracic, and abdominal surgery. The authors present a case of breast surgery which was successfully performed on a woman with a difficult airway, requiring a partial mastectomy by thoracic paravertebral block without complications.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC759

Unusual Clinical Presentation of Large Epidural Hematoma After Blodless Wet Tap During Attempted Thoracic Epidural Placement

Merrick Miles, M.D., Dominika James, M.D., Kari Lange, B.S.N., H. David Hardman, Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.

A 58 year-old female with rectal cancer was scheduled to receive epidural analgesia prior to surgery. During a routineT10 paramedian approach, she complained of sudden leg heaviness. The procedure was immediately abandoned and a large epidural hematoma was diagnosed on MRI. We will discuss this unusual presentation and her treatment.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC760

Ropivacaine-Induced Atrial Fibrillation Following Supraclavicular Block

Rahul Mishra, D.O., Shiraz Yazdani, M.D., Ashraf Farag, M.D., Department of Anesthesiology, Texas Tech University Health Sciences Center, Lubbock, TX.

An 84 year-old female received a supraclavicular block following a bony resection for a previous left olecranon fracture. Within minutes after a successful ultrasound guided supraclavicular block, the patient developed atrial fibrillation (AF) with subsequent supraventricular tachycardia and premature atrial contractions. Her condition was self-limiting and a sinus rhythm was appreciated. This paroxysmal AF may result from sympathovagal discharges caused by ropivacaine-induced autonomic electrical imbalances of the atria. There have been reports of ropivacaine-induced cardiac dysrhythmias and even cardiac arrest but to our knowledge this is the first report of new onset atrial fibrillation following a supraclavicular block.

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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC761

Dyspnea With a Home-Going Supraclavicular Catheter

Sharif Mohamed, M.D., Gamal Eid, M.D., Ehab Farag, M.D., Wael Ali Sakr Eissa, M.D., Cleveland Clinic Foundation, Cleveland, OH.

A 61 year-old 107 kg Female presenting with Colle's fracture for ORIF. She got a Supraclavicular block and catheter for postoperative pain management, after surgery she was discharged home with a home pump delivering ropivacaine 0.2% 8ml/h and a demand dose of 12ml/1h. On POD 3 the patient c/o acute onset Dyspnea, sweating and dizziness, she was asked to stop pump and call 911, in the ED work up for differential diagnosis included CAD, PE, pneumothorax, phrenic nerve paralysis from the block and she was found to have acute extensive pulmonary embolism, heparin was started and fortunately she was stable.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC913

Bone Cement Implantation Syndrome During Total Elbow Arthroplasty With a Patent Foramen Ovale

Rana Movahedi, M.D., Shalini Sharma, M.D., Anesthesia, Keck School of Medicine of USC, Los Angeles, CA.

A female with undiagnosed PFO presented for left total elbow arthroplasty. She received a supraclavicular block, was taken to the OR and underwent GA . During cementing, patient suddenly developedbradycardia and a precipitous drop in end tidal CO2. Patient underwent ACLS , a TEE was performed, an intra-aortic balloon pump was placed, and the patient was taken to the cardiac catheterization lab. She was noted to have multiple peripheral pulmonary emboli. It has been documented that methyl methacrylate can cause microemboli resulting in fatal myear-old cardial depression. In a patient with a PFO, the results can be devastating.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC914

Paravertebral Nerve Block as an Adjunct for Anterior Approach for Complex Spine Surgery

Eman M.s. Nada, M.D., Sree Kolli, M.D., Wael Ali Sakr, M.D., Loran Mounir Soliman, M.D., Ehab Farag, M.D., Anesthesiology Institute, Cleveland Clinic Foundation, Cleveland, OH.

A 62 year-old female with history of chronic pain, had a complex spine surgery through a thoracotomy incision.A continuous infusion of ropivacaine through an intrapleural catheter was started on discharge from OR, a high Hydromorphone IV PCA bolus with a basal, and oral home pain medications failed to bring her pain any less than 10/10. A left paravertebral block dropped her pain to 2/10, then a continuous infusion of Ropivacaine was started and the intrapleural catheter was discontinued. We were able to reduce the IV PCA bolus dose and stop the basal when the pain was at acceptable levels.

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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC915

Supraclavicular Catheter Placement in a Patient Epidermyear-old lysis Bullosa

Harika Nagavelli, M.D., Anesthesiology, Yale University School of Medicine, New Haven, CT.

32 year-old Female with esophageal strictures, ESRD secondary to Goodpasture's with peritoneal dialysis had epidermolysis bullosa with multiple skin lesions, scarring, easy bruising and webbing of extremities. This patient developed multiple squamous cell carcinoma (SCC) with fungating wounds requiring a left above-elbow amputation. On exam, the patient had poor oral hygiene with suspicion of airway scarring and an unknown Mallampati classification due to an oral aperture less than 2 cm. Concern for this patient's probable difficult and potentially traumatic airway manipulation led to the use of a left supraclavicular catheter placed prior to surgery for anesthesia and post-operative analgesia.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC916

Bilateral Transversus Abdominis Plane (TAP) Block for Open Colostomy Revision and Debridement in a Patient Pending for Coronary Artery Bypass Surgery

Huiling Pang, M.D., Ph.D., Anesthesiology, University of Nebraska Medical Center, Omaha, NE.

An 84 year-old patient was scheduled for an urgent open colostomy revision and debridement of the infected abdominal wall before a coronary artery bypass surgery. He had a history of significant left main coronary artery disease, cardiomyear-old pathy, chronic obstructive lung disease, and was oxygen dependent. Ultrasound guided bilateral transverses abdominis plane (TAP) block was successfully performed for surgical anesthesia and post-operative pain control. The bilateral TAP block avoided the potential cardiac and respiratory risks of general anesthesia and reduced systemic opioid requirement. This technique is effective as part of a multimodal anesthesia management for high risk patients.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC917

Interescalene Block on a Patient With an Ulnar Nerve and Spinal Cord Stimulator in the Way

Ivan Parra-Sanchez, M.D., Hesham Elsharkawy, M.D., Anesthesiology, Cleveland Clinic, Cleveland, OH.

58 year-old male for right shoulder arthroscopy. History of chronic pain, right ulnar nerve and spinal cord stimulator. Pre-operative x-rays showed stimulator leads in the shoulder area. Stimulator turned off preoperatively. Scars over the shoulder area. Ultrasound-guided interscalene block performed, stimulator leads seen and avoided (images will be provided). Nerve catheter placed with good spread of anesthetic. Postoperatively, stimulator was turned back on. Interscalene catheter started at continuous and demand doses with good pain control. Patient discharged on day of surgery. Pain continued being under control and nerve catheter discontinued on POD 4. Only complication, mild SOB postoperatively.

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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC918

Acute Obstructing Uvular Edema in the PACU After Spinal Anesthesia

Neil Patel, M.D., James Heitz, M.D., Anesthesiology, Thomas Jefferson University, Philadelphia, PA.

A case of a 56 year-old AAM who received spinal anesthesia with MAC for bilateral total knee replacements and subsequently developed acute and isolated uvular edema with complete oral cavity obstruction in the PACU setting. No airway manipulation or excessive upper airway obstruction was noted. The patient did report a history of marijuana use and recent (3 days prior) exposure. The patient was treated with intravenous steroids and close monitoring without intubation and showed marked improvement over 24 hours. Case studies show uvular edema as a rare but serious complication which merits preoperative risk assessment.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC919

Transversus Abdominis Plane (TAP) Block as Perioperative Analgesia for a Case of Complicated Cholecystectomy

Murali S. Patri, M.D.,F.R.C.A, William Alarcon, Anesthesia, Henry Ford Health System, Detroit, MI.

We would like to present a case of laparoscopic cholecystectomy, which was complicated by requiring conversion to open procedure. The patient received ultrasound guided bilateral Transversus Abdominis Plane (TAP) block preoperatively and required only small quantities of opoids following surgery. He was comfortable and was completely satisfied with the conduct of anesthesia.TAP block is an abdominal field block, that can provide analgesia by blocking multiple abdominal wall nerves, with a single point of injection. It has the potential for providing analgesia for various intra abdominal procedures, reducing opoid usage and related side effects, resulting in improved patient satisfaction.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC920

Skin Is in: Using Regional Anesthesia in Epidermolysis Bullosa Patients

Tara L. Paulose, M.D., William Rosenblatt, M.D., Yale University School of Medicine, New Haven, CT.

Recessive Dystrophic Epidermolysis Bullosa (RDEB) is an autoimmune disorder resulting in severe blistering of the skin and mucosa with minor mechanical friction and increased risk of Squamous Cell Carcinoma. This case examines use of a single-shot spinal anesthetic technique for resection of a lower extremity lesion in a 53 year-old female with RDEB. Surgical anesthesia was achieved, while avoiding instrumentation of fragile airway mucosa and adhesives. The patient experienced no further desquamation in the perioperative period. Spinal anesthesia, therefore, represents a novel anesthetic technique to safeguard RDEB patients and optimize surgical conditions.

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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC921

Successful Treatment of Ulnar Artery Thrombosis via Supraclavicular Brachial Plexus Block After Failed Stellate Ganglion Block

Joseph S. Pierson, M.D., Magdalena Anitescu, M.D., Department of Anesthesia and Critical Care, The University of Chicago, Chicago, IL.

A 33 year-old male presents with persistent fifth digit and hand pain due to ulnar artery thrombosis secondary to homocysteinemia. Revascularization attempt and stellate ganglion block (SGB) were both unsuccessful in increasing regional blood flow or alleviation of pain. Therefore we performed a supraclavicular brachial plexus block with excellent pain relief. Patient did not require further intervention for his condition and was managed medically with anticoagulants. He remained pain free without signs of ischemia 2 months post intervention. Our case showed that a supraclavicular block may be superior to SGB in selective cases.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC922

Bradycardia and Hypotension in the Sitting Position After Supraclavicular Block

Gabriella J. Reubins, M.D., Anesthesiology, NYU Langone Medical Center, New NY, NY.

44 year-old male for shoulder arthroscopy. Pre-op vital signs were within normal limits. A right supraclavicular block was done. Pt was put in the beach chair position, no response to surgical stimuli. About 30 minutes into the case HR dropped until the monitor read asystole, cuff BP at that time read 67/39. The surgeons were alerted to stop. Atropine and ephedrine were given; pt was put in the supine position. Soon after, HR returned to normal, repeat BP returned to baseline. Pt was put back into the beach chair position and the operation resumed. No further complications during the procedure.

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