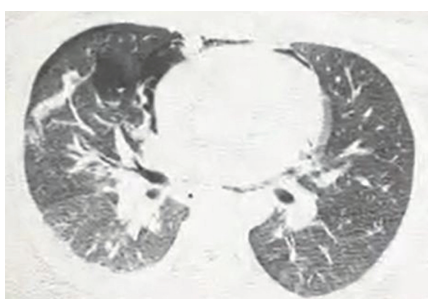


Abstract #35938 Figure 2 AHL2



Abstract #35938 Figure 3 T1

Results Support for NFA is not commonly performed with ECMO. The finding of AHL is not a common complication seen in these cases nor a favorable outcomes.

Conclusions VV-ECMO should be considered to be part of support in NFA but thus should be addressed in future trials.

#35945 CERVICAL SUBCUTANEOUS EMPHYSEMA AND PNEUMOMEDIASTINUM SECONDARY TO PENETRATING TRAUMA

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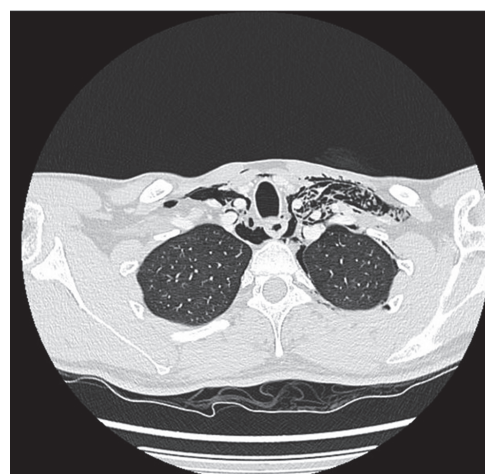
Application for ESRA Abstract Prizes: I don't wish to apply for the ESRA Prizes

Background and Aims Subcutaneous emphysema (SE) is a finding of gas within the subcutaneous soft tissues, usually in the chest or neck. There are numerous causes for this phenomenon, including blunt and penetrating trauma, soft tissue infection, and surgical instrumentation.

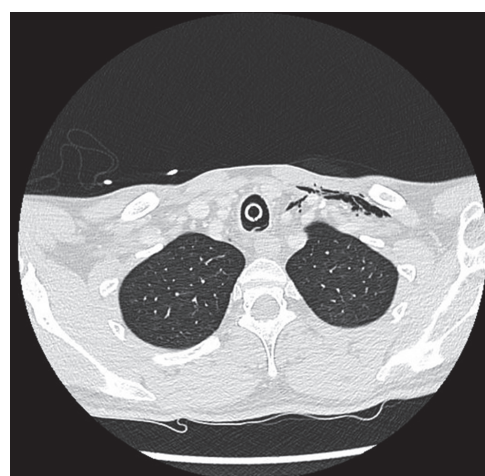
Methods We present the case of a 39-year-old man with cervical SE and pneumomediastinum after penetrating cervical

trauma due to attempted suicide. A cervical-thoracic CT showed the presence of pneumomediastinum and significant cervical subcutaneous emphysema. As a preventive measure, the patient was admitted to the Resuscitation Unit to ensure the airway through orotracheal intubation. He was kept under sedation for 48 hours and broad-spectrum empirical antibiotic therapy was prescribed. After this time, the CT was repeated and, given the marked decrease in emphysema, the patient was extubated without incident.

Results SE occurs when air becomes trapped under the skin. Air forced into the interstitial tissues around the pulmonary vasculature travels back toward the hilum, leading to pneumomediastinum, and this eventually spreads to the soft tissues of the neck, face, and chest wall. In our patient, penetrating trauma was the event that caused the entry of air into the tissues. In most cases, it does not involve airway compromise as subcutaneous air easily accommodates the distensible subcutaneous tissues and conservative treatment is adequate. Subcutaneous drainage or supraclavicular incisions are safe techniques with no reported complications (2).



Abstract #35945 Figure 1 Cervical thoracic CT: significant subcutaneous emphysema extending from the prevertebral space at the level of the oropharynx to the mediastinum (anterior and posterior)



Abstract #35945 Figure 2 Cervical-thoracic CT (after 48h): Marked decrease in subcutaneous emphysema compared to previous study, predominantly in the left supraclavicular fossa

Conclusions SE is usually not necessarily dangerous, and conservative treatment is usually sufficient. However, on occasions like the case presented here, it can compromise the airway and require invasive therapeutic measures.

#35920

THE ASSOCIATION BETWEEN PREOPERATIVE FRAILTY AND HYPOTENSION DURING THE BEACH-CHAIR POSITION IN PATIENTS UNDERGOING TOTAL SHOULDER ARTHROPLASTY UNDER GENERAL ANESTHESIA WITH INTERSCALENE BRACHIAL PLEXUS BLOCK

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10.1136/rapm-2023-ESRA.441

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

Application for ESRA Abstract Prizes: I apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims The beach-chair position (BCP) is commonly used for shoulder surgery but is known to increase hypotension incidence. Older age and interscalene brachial plexus block (ISB) have also been identified as risk factors for hypotension during BCP. As altered blood pressure control mechanisms and autonomic dysfunction, which cause hypotension, are more likely to occur in frail older patients, we investigated the association between preoperative frailty and hypotension during BCP in older patients.

Methods Patients aged ≥ 65 years who underwent elective total shoulder arthroplasty in BCP under general anesthesia with preoperative ISB were included. The frailty of participants was assessed before surgery using the Reported Edmonton Frail Scale. Quadriceps depth was measured by ultrasound preoperatively, and values < 2.3 cm were considered significant. Hypotension was defined as a mean blood pressure < 65 mmHg or a decrease of $\geq 20\%$ from baseline.

Abstract #35920 Table 1 Demographic and intraoperative variables

Variable	n = 46
Gender, M/F (n)	18/28
Age (yr)	72.8 \pm 6.3
BMI (kg/m ²)	25.8 \pm 2.7
ASA classification (I/II/III)	5/37/4
Non-frail/ Pre frail/ Frail (n)	37/5/4
Hypertension (n)	32
Diabetes (n)	10
Duration of anesthesia (min)	154.4 \pm 42.5
Duration of surgery (min)	102.8 \pm 32.4
Duration of beach chair position (min)	132.3 \pm 38.2
Angle of operation table (°)	42.4 \pm 2.7
Fluid administration (ml)	1120 (820, 1820)
Blood loss (ml)	80 (30, 400)

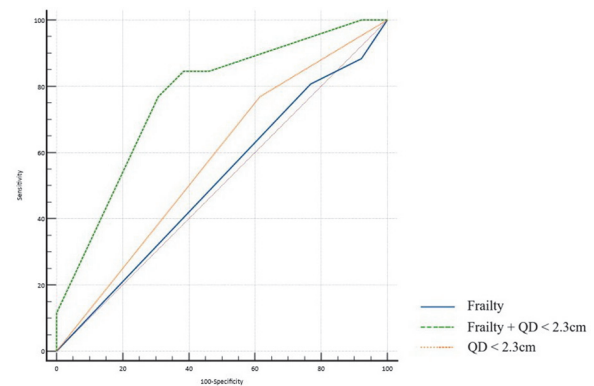
Data are presented as number, mean \pm SD or median (interquartile range)

BMI: body mass index, ASA: American Society of Anesthesiologists

Abstract #35920 Table 2 Variables associates with hypotension during beach-chair position

	Hypotension	
	Odds ratio (95% CI)	Adjusted odds ratio (95% CI)
Age, year	1.055 (0.947 - 1.175)	0.973 (0.832 - 1.139)
Sex (reference: male)	2.333 (0.630 - 8.637)	1.705 (0.250 - 11.654)
BMI (kg/m ²)	0.882 (0.693 - 1.123)	
ASA classification		
I	Reference	
II	0.591 (0.059 - 5.905)	
III	0.750 (0.032 - 17.506)	
Diabetes	0.897 (0.193 - 4.172)	
Hypertension	1.667 (0.430 - 6.460)	
Frailty group(score)		
Non-frail group (0-5)	Reference	Reference
Pre frail group (6-7)	1.692 (0.169 - 16.912)	0.337 (0.010 - 11.097)
Frail group (8-18)	1.269 (0.119 - 13.583)	1.157 (0.001 - 19.943)
Frail score	1.067 (0.828 - 1.375)	1.310 (0.766 - 2.240)
Quadriceps depth (cm)	0.123 (0.029 - 0.518)	
Quadriceps depth < 2.3 cm	6.720 (1.502 - 30.071)	8.491 (1.389 - 51.897)

BMI: body mass index, ASA: American Society of Anesthesiologists, CI: confidence interval



QD: Quadriceps depth

Abstract #35920 Figure 1 The receiver operating characteristic (ROC) curves comparing the predictive power of hypotension during beach-chair position

Results Data were analyzed from 46 patients (mean age: 72.8 yrs). The incidence of hypotension during BCP was 71.7% (non-frail/pre frail/frail; 70.3%, 80% and 100%). A decreased quadriceps depth < 2.3 cm was an independent risk factor for hypotension during BCP (odds ratio, 8.49, 95% confidence interval [CI], 1.38 – 51.90). The predictive power of hypotension during BCP was higher when both frailty and quadriceps depth were considered together, compared to considering frailty alone (AUC [95% CI], 0.766 [0.60-0.89] vs 0.51 [0.35-0.68], $p=0.01$).

Conclusions A reduced quadriceps depth is associated with hypotension during BCP. Assessing both frailty and quadriceps depth may enhance the screening tool for identifying older patients at risk of developing hypotension during BCP.

Attachment CRIS.pdf