Regional anesthesia technique for carotid surgery

T. Gramosli; N Hristov; D. Vuckova; M. Gjorgon; D. Popevski; E. Stoicovski; Z. Mitrev
Zan Mitrev Clinic, Skopje, Republic of North Macedonia

Background: The decision for general anesthesia (GA) vs regional anesthesia (RA) for staged carotid endarterectomy (CEA) is an ongoing debate [1,2]. Should be done on an individual basis [3].

We present a case of a highly-comorbid patient with dilated cardiomyopathy (DCM) undergoing staged CEA using RA.

Case report: A 72-year-old patient with previous stroke and soft carotid bifurcation plaque was admitted for right CEA. He experienced an infarction 4 years ago, left untreated, thus developing dilated cardiomyopathy, diabetic with an GFR of 43.7 mL/min/1.73 m². Preoperative evaluation showed dyspnea at rest NYHA IV; and intermittent chest pain CCS IV. We opted for staged CEA shortly followed by coronary revascularization. Due to minimal invasiveness, RA was chosen because of the high-risk of myo-

cardial infarction, intraoperative stroke and renal insufficiency. Deep cervical plexus block was performed, from C2 to C4 using 10 ml 0,5% bupivacaine and 10 ml 1% lidocaine [4]. Surgery was uneventful, pain free, with stable hemodynamics, using eversion endarterectomy and no shunt.

Postoperative recovery was uneventful, patient was discharged on the 2nd day following surgery.

Conclusion: Staged CEA in high risk coronary patients can be safely performed using minimal invasive RA. Our ongoing study for RA vs GA in this patient will give definitive answer.

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Corresponding author:

Tanja Gramosli, Zan Mitrev Clinic, Skopje. e-mail: tanja.gramosli@zmc.mk