of maternal hypotension during elective cesarean section under combined spinal-epidural anaesthesia

Methods After Ethics Committee approval, one hundred parturients were randomized to receive either 6% hydroxyethyl starch 5 mL/kg before spinal anesthesia (colloid preload) or Ringer’s Lactate solution 10 mL/kg starting with intrathecal injection (crystalloid co-load). Both groups were also administered norepinephrine 4 µg/min, starting simultaneously with the administration of the subarachnoid solution. The primary outcome was the incidence of maternal hypotension (SBP<80% of baseline). The incidence of severe hypotension (SBP<80 mmHg), total dose of ephedrine administered as well as maternal side-effects and the neonatal outcome were also recorded

Results There were no significant differences in the incidence of hypotension (13.7% vs. 16.3%, p=0.933 or severe hypotension (0% vs. 4%, P=0.238) between colloid preload and crystalloid co-load groups, respectively. The median [range] ephedrine dose was also comparable between the two groups (P=0.807). There were no significant differences in maternal side-effects or neonatal outcomes between groups

Conclusions The incidence of hypotension during elective cesarean section is low and comparable when a norepinephrine infusion is used in combination with either colloid preload or crystalloid co-load, with perhaps a marginal superiority of colloid preload in the prevention of severe hypotension. It appears that the optimal regimen for prevention of maternal hypotension is a combination of fluids and a prophylactic vasoconstrictor like norepinephrine

**B278**

**COLLOID CO-HYDRATION IN MATERNAL HYPOTENSION: DOES THE ADDITION OF A VASOCONSTRICTOR MAKE A DIFFERENCE?**

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10.1136/rpm-2022-ESRA.352

Background and Aims This study aimed to investigate whether the addition of a fixed rate phenylephrine infusion or noradrenaline infusion to a colloid co-hydration regimen results in better maternal hemodynamic status as compared to the administration of colloids alone without any vasoconstrictor during elective cesarean section under combined spinal-epidural anaesthesia

Methods 120 parturients were randomized to either phenylephrine 50 µg/min (group P) or noradrenaline 4 µg/min (group N) or placebo (group C). As soon as the spinal injection started, all groups were administered 10 mL/kg of hydroxyethyl starch solution simultaneously with the onset of vasoconstrictor infusion. The primary end-point of the study was the incidence of maternal hypotension (SAP<80% of baseline)

Results The incidence of maternal hypotension was higher in group C than in both groups P and N (p=0.011 and p<0.001, respectively). The incidence of bradycardia was higher in group P than in group N (p=0.018). The incidence of reactive hypertension was higher in group P than in both groups N and C (p=0.029 and 0.005, respectively). The need of modification of the infusion rate was higher in group P than in both groups N and C (p<0.001 and p=0.002, respectively). Post-delivery Apgar scores were similar in all groups

Conclusions The combination of a fixed-rate infusion of noradrenaline with the co-administration of colloid seems to be the most effective in the management of the parturient during cesarean section, being superior to either a combination of colloid co-administration with a fixed rate of phenylephrine or to the administration of colloid alone without any vasoconstrictor agent

**B279**

**AN OBSTETRIC ANAESTHETISTS’ ASSOCIATION (OAA) SURVEY OF THE USE OF ULTRASOUND SCANNING TO ASSIST WITH CENTRAL NEURAXIAL BLOCKS IN OBSTETRIC ANAESTHESIA**

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10.1136/rpm-2022-ESRA.353

Background and Aims Central Neuraxial Blocks (CNBs) are key to obstetric anaesthetic practice. They are performed by landmark technique, however, there is increasing evidence supporting the use of ultrasound-assisted CNBs.

This survey aims to explore:
- Current use of ultrasound-assisted CNBs
- Current training being delivered
- Barriers to training

Methods We conducted an OAA-approved national survey of UK obstetric anaesthetists in 2021, with 394 completed responses.

Results 86% of responders were consultant obstetric anaesthetists. 69% said they perform ultrasound-assisted CNBs, but some only in specific circumstances (Figure 1). 40% do not use ultrasound at all due to lack of training or lack of confidence in the technique.

Abstract B278 Figure 1