

Midline and depth to posterior complex are seen as the primary landmarks to establish on ultrasound (Figure 2).

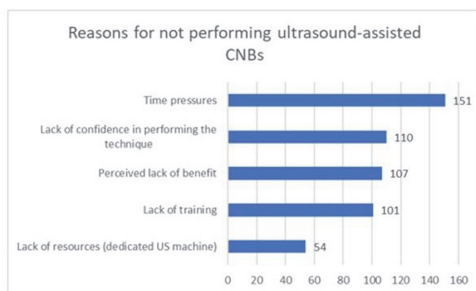
Figure 2
Reported benefits of using neuraxial ultrasound for CNB

Reasons for using ultrasound	Number of responses
Identify landmarks	
• Midline	121
• Level	76
• Depth	107
• Angulation	21
• Identify scoliosis	8
• Determine largest space	4
• Choose appropriate needle length	11
Improve performance of procedure	
• Reduce number of attempts / redirections	62
• Reduce failure rate	24
• Shorter procedure (in those where difficulty expected)	22
Reduce complications	
• Improve safety / less trauma	13
• Reduce risk of Accidental Dural Puncture	7
• Reduce incidence of paraesthesia	1
• Avoidance of GA	4
• Increased efficacy of epidural	5
Improved patient comfort / satisfaction	16
Teaching	12

Abstract B278 Figure 2

Perceived reasons why ultrasound might not be used are shown in Figure 3.

Figure 3
Reasons for not using neuraxial ultrasound for CNB



Abstract B278 Figure 3

Only 9% of departments have guidelines for ultrasound-assisted CNBs.

Conclusions Ultrasound-assisted CNBs in obstetric anaesthesia remains a divisive subject, despite evidence suggesting it is a low-skill technique with improved first-pass success, without adding excessive time.

40% of responders do not use ultrasound due to lack of training and confidence in the technique and fears that overreliance on ultrasound may lead to deskilling in landmark techniques.

Time pressures, lack of trainers and uncertainty of benefits are the main barriers to implementing training.

For ultrasound-assisted CNB to gain more acceptance, we suggest:

1. Recognising neuraxial ultrasound as a key skill
2. Further guidance and training from the OAA or other regional anaesthesia course providers

3. Teaching and competency achievements must be embedded into training

B280 UNILATERAL UPPER ARM SENSORY AND MOTOR BLOCKADE ASSOCIATED WITH IPSILATERAL HORNER'S SYNDROME AFTER EPIDURAL ANESTHESIA FOR URGENT CESAREAN-SECTION

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Background and Aims Subdural blockade is a rare complication after neuraxial anesthesia, which usually manifests as a patchy or disproportionate block.

We present a case of a primiparous that developed unilateral upper arm sensory and motor blockade associated with ipsilateral Horner's syndrome after epidural anesthesia for urgent cesarean-section.

Methods An obese primiparous, 23-years-old, 39 weeks and 4 days pregnant, ASA II, was admitted in latent phase of labour. After 12 hours, an epidural catheter was inserted (L3-L4 level) and 10 mL of ropivacaine 0.2% and 10mcg of sufentanil were injected with pain relief. Epidural analgesia was administered as requested with no complications during labour.

Results After 24h, an urgent cesarean-section was performed due to stationary labour. After injection of 12 mL of ropivacaine 0.75% through the epidural catheter, a fall superior to 20% of basal blood pressure was noted, with need for vasoactive drugs, associated with upper arm motor and sensitive blockade. After neurologic examination, ipsilateral Horner's syndrome was detected. High regional block was excluded. A newborn was delivered with APGAR score of 9–9–10. At the post anesthesia care unit, possible subdural drug spread was assumed, and the catheter removed. Two hours later, upper arm motor and sensitive blockade was reversed, with ptosis and miosis maintenance. The patient was discharged to the nursery.

After 12 hours, ptosis and miosis were solved. Discharge home occurred on the second postoperative day.

Conclusions New neurologic manifestations after epidural drug administration require brief evaluation to exclude complications as high regional block.

Effective communication with the patient is of utmost importance.

B281 NEAR MISS COAGULOPATHY! SHOULD PREECLAMPTIC PARTURIENTS WITH IV DRUG ABUSE GET SERIAL INVESTIGATION

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Background and Aims A 32-year-old G1P01 at 36-weeks-3-days with a history of alcohol and opioid abuse, asthma, gestational hypertension presented with severe pre-eclampsia(SP) by blood pressure criteria. The patient refused a trial of induction of labor and was scheduled for Cesarean section (CS) under neuraxial anesthesia. Her blood workup was normal 10 hours prior to her CS. A repeat workup showed

normal platelet count (314k/ul), elevated INR (2.8), PTT (45.4), lactate (3.5mmol/L), and low fibrinogen (215mg/dL) levels. Thrombo-elastography was also normal. The surgery was postponed and a diagnosis of acute fatty liver of pregnancy (AFLP) with superimposed pre-eclampsia was confirmed by clinical, laboratory, and imaging features.

Methods Hematological abnormalities such as thrombocytopenia and decrease in clotting factors may develop in pre-eclamptic women. The risk of abnormal hemostasis increases with the severity of pre-eclampsia.

Results Platelet count is routinely used as a primary test to evaluate the coagulation status in parturients with SP 1. It has been shown that when the platelet count < 100,000/mm³, other hemostatic abnormalities, such as prolonged prothrombin time (PT) and partial thromboplastin time (PTT), and reduced fibrinogen concentration, may also be presented 2. About 50% of patients with AFLP have preeclampsia, and there is some overlap with the HELLP syndrome 3.

Conclusions This case highlights that in parturients with SP, the platelet count should not be used as the sole mean to evaluate the coagulation status, as there are conditions such as acute fatty liver of pregnancy and viral-hepatitis that can mimic or overlap pre-eclampsia in the absence of thrombocytopenia.

B282 AUDIT OF THE EPIDURAL ANALGESIA SERVICE AT THE CENTRAL DELIVERY SUITE, MATER DEI HOSPITAL, MALTA

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Background and Aims Mater Dei Hospital in Malta provides a 24-hour neuraxial analgesia service in its delivery suite. The Royal College of Anaesthetists (RCoA) recommends that in such set-ups, an anaesthetist should attend to labouring women within 30 minutes of request, and in exceptional cases, within one hour^[1]. Other standards of care include a re-siting rate of <15% and an accidental dural puncture (ADP) rate of <1%^[1]. The aim of this audit was to examine these standards in our unit.

Methods After ethical approval, data was collected retrospectively over four weeks from September to October 2021, looking at time of call to the anaesthetist, time of test dose administration, re-siting rates, and number of ADPs. The time interval from the call to time of test dose administration served as a surrogate to the actual waiting time. Data was inputted and analysed using MS Excel spreadsheet.

Results A total of 86 parturients requested epidural analgesia out of a total 345 deliveries (25%). The average time from request to administration of test dose was 34 minutes. Average maternal age was 30.5 years, 3.5% required re-siting of their epidural catheter and there were no ADPs.

Conclusions Using the surrogate marker, the average epidural waiting time was surmised to be within the recommended RCoA standard as were the epidural re-siting and ADP rate. This may be limited by the relatively short period of time the study was carried out over. Epidural analgesia remains the gold standard to manage labour pain and so our results are both satisfactory and encouraging.

B283 EFFECTS OF INTRATHECAL MORPHINE ON URINARY BLADDER FUNCTION AND RECOVERY IN PATIENTS HAVING CESAREAN SECTION

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Background and Aims The effects of intrathecal morphine (IM) are well studied on analgesia, nausea and vomiting but not on bladder function. We aimed to determine the effects of IM on urodynamics in women having spinal anesthesia (SA) for Cesarean section (CS).

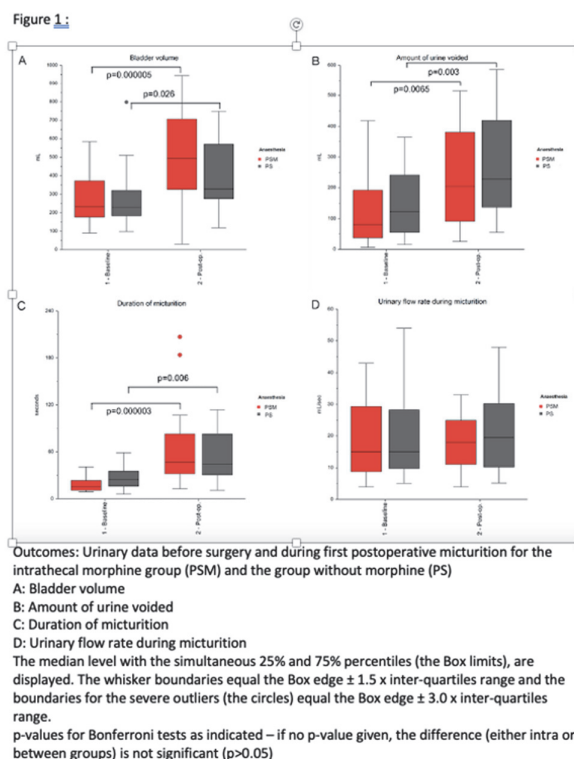
Methods The primary outcome variable was the effect of intrathecal opioids on urinary urodynamics; the secondary outcome was the need for urinary bladder re-catheterization.

56 patients undergoing elective CS under SA received a mixture of hyperbaric pilocaine and sufentanil with the addition of 100mcg morphine or NaCl.

We evaluated bladder volume, micturition volume, peak flow, duration of miction and postmicturition residual volume (PMRV) before and after CS.

Independent continuous variables were compared by X2 test or Mann-Whitney test. Repeated bladder functions data were compared by the analysis of variance for repeated measures with mixed models and a Bonferroni test.

Results The addition of IM prolonged the time to recovery of bladder awareness (8.1 hours ± 3.6 - 8[6–10] v.s. 5.3 hours ± 1.3 - 6[4–6], p<0.001), and time to micturition by 25% (10.4 hours ± 3.3 - 10[8–12] and 6.8 hours ± 1.6 - 6[6–8], p<0.001). Two patients who received IM required a single bladder catheterization (Figure 1).



Abstract B283 Figure 1