

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

R Galea*, M Drake, N Schembri, G Buhagiar, GP Abela, PM Attard Cortis. *Mater Dei Hospital, Malta, L-Imnsida, 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

¹N Gautier, ²D Lejeune*, ³L Al Zein, ¹Y Ciccarella, ¹C Kesteloot, ⁴A Hadzic, ²J-F Brichant, ⁵L Bouvet, ¹P Gautier. ¹CHIREC Sainte-Anne Saint-Remi, Bruxelles, Belgium; ²CHU Liège, Liège, Belgium; ³Saint-Luc UCL, Bruxelles, Belgium; ⁴East Limburg Hospital, Limburg, Belgium; ⁵CHU Lyon, Lyon, France

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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).

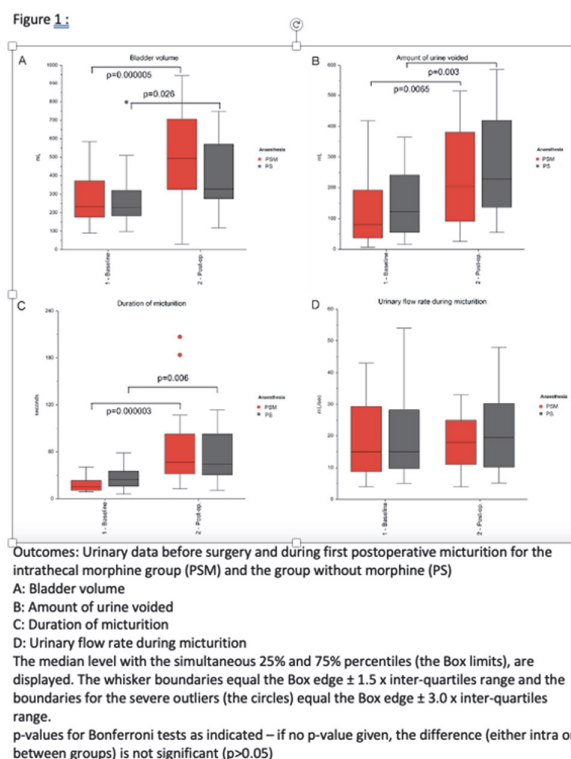
Methods The primary outcome variable was the effect of intrathecal opioids on urinary urodynamics; the secondary outcome was the need for urinary bladder re-catheterization.

56 patients undergoing elective CS under SA received a mixture of hyperbaric pilocarpine 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

Conclusions Our study is the first randomized double-blind trial to investigate the effects of IM on urodynamics after CS under SA. The addition of IM delayed voiding by 3 hours with no effect on urodynamics or PMRV. Future studies should investigate the risk-benefit ratio of adding IM in SA for elective CS.

B284 A STUDY TO ASSESS THE SAFETY, EFFICACY AND PATIENT SATISFACTION OF EPIDURAL ANALGESIA PROTOCOL IN LABORING PATIENTS

¹M Medina Torres*, ²S Martín Santiago, ¹MP Castillo Maffla. ¹Costa del Sol Hospital, Málaga, Spain; ²Virgen de la Victoria Hospital, Málaga, Spain

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Background and Aims To analyze the efficacy, patient satisfaction, and clinical side effects of the epidural analgesia protocol in laboring patients at the Costa del Sol Hospital.

Methods Observational study in 31 patients.

The medication was accorded by the current protocol:

-Initial epidural bolus with bupivacaine 0.125 - 0.25% 5 - 15 ml

-Continuous epidural infusion of bupivacaine 0.0625% 8 - 12 ml/h

-Rescue medication boluses with bupivacaine 0.125 - 0.25% 5 - 10 ml

Evaluated variables -Need for rescue boluses

-Pain before initial bolus

-Pain after initial bolus

-Time elapsed between initial bolus and analgesic rescues

-Side effects

-Patient satisfaction

Results -30 minutes after the first bolus, the EVA was 0–3 in 100% of the patients.

-54% of the patients analyzed required at least one rescue bolus due to pain during labor despite continuous epidural analgesic perfusion.

-70% of the patients requiring a rescue bolus reported obtaining good pain control until the end of labor.

-Low rate of adverse effects.

Conclusions The current epidural analgesia protocol at the Costa del Sol Hospital with continuous epidural perfusion of bupivacaine 0.0625% seems insufficient for pain control, especially in the first 4 hours needing rescue boluses.

Given the findings, it is possible to suggest changing the protocol to other methods with better pain control that do not depend on demand rescue boluses.

B285 PSEUDOXANTHOMA ELASTICUM AND LABOUR ANALGESIA: AN ANAESTHETIC CHALLENGE

C Salgueirinho, S Lopes*, AL Diass, H Meleiro. Centro Hospitalar e Universitário São João, EPE, Porto, Portugal

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Background and Aims Pseudoxanthoma elasticum (PXE) is a rare heritable disorder of connective tissue calcification that mainly affects skin, eyes and cardiovascular system. There are several disease features that may influence the anaesthetic management such as the development of arrhythmias, premature ischaemic heart disease, difficult airway management,

haemorrhagic complications including the theoretical risk of epidural hematoma. Since there's only a few cases described in the literature, we aim to report a case of neuro-axial labour analgesia in a parturient with PXE.

Methods This case reports a 39-year-old nulliparous woman with PXE diagnosed at the age of 29 with the typical skin and ophthalmological features. Cardiac evaluation ruled out any abnormalities. She had no previous history of anaesthetic procedures and she was diagnosed with gestational diabetes controlled with diet. At 38-week gestation the labour was induced due to premature rupture of membranes and an epidural catheter was inserted at L3-L4 for labour analgesia under ASA standard monitoring. After an initial bolus of 0.2% ropivacaine together with sufentanil the analgesia was maintained with 0.2% ropivacaine boluses hourly.

Results During labour she remained hemodynamically stable with a good analgesic control. Four hours later a female newborn was born via eutocic uneventful delivery. Neurologic evaluation was performed in the postpartum period excluding any complications from epidural catheter placement.

Conclusions A good analgesic control is essential for preventing hemodynamic changes that might be harmful for these patients overcoming the risk of epidural hematoma. The rare cases of this disease make it essential to report the anaesthetic management especially during pregnancy.

B286 COMBINED NEURAXIAL TECHNIQUE IN A TWIN PREGNANCY COMPLICATED WITH VASA PREVIA

C Salgueirinho, S Lopes*, M Passos. Centro Hospitalar e Universitário São João, EPE, Porto, Portugal

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Background and Aims Vasa previa is a rare condition where umbilical blood vessels cross the cervical os with abnormal membranous insertion into the placenta. It's a cause of peripartum haemorrhage and the foetus can exsanguinate within minutes during membrane rupture. When diagnosed antenatal caesarean delivery is scheduled and a catastrophic foetal haemorrhage can be prevented. For non-urgent delivery, neuro-axial techniques are preferable since the second foetus in gemelar gestations is at greater risk of exposure to anaesthetic agents.

Methods This case reports a 32-year-old nulliparous woman with a twin pregnancy complicated with an ultrasound diagnosis of vasa previa at 22 weeks of gestation. She was admitted to the obstetric unit at 30 weeks for surveillance and foetal lung maturation. A caesarean delivery was scheduled at 32 weeks and foetal matching blood units were available, if required. Under ASA standards monitoring, a combined spinal-epidural technique was performed at L3-L4 with intrathecal administration of 0.5% levobupivacaine and sufentanil. Epidural morphine and 0.2% ropivacaine were administered for postoperative analgesia.

Results Both twins were born healthy with an Apgar score of 9, 9 and 10 at 1, 5 and 10 minutes respectively and were transferred to the neonate unit. The procedure occurred without any significant maternal and foetal bleeding.

Conclusions Membrane rupture in vasa previa requires an emergent caesarean with general anaesthesia due to acute foetal distress. This case highlights the huge impact of the antenatal diagnosis with consequent elective caesarean on