

B289 INTRATHECAL MIGRATION OF AN EPIDURAL CATHETER DURING LABOR: A CASE REPORT

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Background and Aims Epidural catheter migration is a known complication, but migration to subarachnoid space is extremely rare, with only a few case reports in the literature.

Methods This case describes the intrathecal migration of a previously functioning epidural catheter.

Results 28 years old, G1P0 without relevant medical history, was admitted to the labor ward. After an unsuccessful attempt, the epidural catheter was placed at L3-L4 intervertebral space, using an 18G Tuohy needle with loss-of-resistance to saline technique. The aspiration test was negative. 8 ml ropivacaine 0.1% and 10µg sufentanil were given, with satisfactory pain relief. The epidural pump was programmed to administer a PIEB of 8 mL of 0.1% ropivacaine every hour with PCEA boluses of 5 mL. She was hemodynamically stable and without motor block.

Five hours later, she complained about motor block of lower extremities. The sensory level to cold was T4-T5. The epidural pump was stopped. A colorless liquid was aspirated through the catheter and the glucose test was compatible with liquor.

After reversal of motor block, the intrathecal catheter was successfully used to provide labor analgesia. The delivery was uneventful. She had no post-dural puncture headache or other postpartum complications.

Conclusions Since the epidural catheter is hardly able to penetrate an intact dura, in our patient there was probably an inadvertent dural puncture on the first attempt, with subsequent migration through the dura hole. Another possibility is the initial placement in subdural space, with pain relief for the first PIEB doses, and then migrated through the arachnoid mater into the intrathecal space.

B290 SPINAL ANAESTHESIA IN CATEGORY 1 VS CATEGORY 2 CAESAREAN SECTIONS: PATIENT SATISFACTION AND COMPLICATION RATES

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Background and Aims Category 1 caesarian section (Cat-1 section) is usually performed under general anaesthesia (GA), but recently this has been replaced with the rapid sequence spinal (RSSp) technique [1]. This audit assessed the anaesthetic complication rates and patient satisfaction, and foetal outcomes by comparing Cat-1 (Immediate threat to the life of woman or foetus) and Cat-2 (Maternal or foetal compromise not immediately life-threatening) sections done under spinal anaesthesia.

Methods Forty-three patients underwent Cat-1 sections between 1/3/2020 and 1/3/2022. Of these patients, twenty-three had RSSp anaesthetic. For these patients, the following data were collected from the local electronic maternity archive: (1) Grade of anaesthetist performing the RSSp, (2) Intraoperative complications, including conversion to GA and the use of IV or inhalational analgesia, (3) postoperative

patient satisfaction with spinal anaesthesia (either positive = satisfied or negative=not satisfied) and the likelihood of having spinal anaesthesia if offered in the future (yes or no) and (4) Foetal outcome (either positive = alive or, negative=dead).

Then, the same data were collected for twenty-three patients who underwent Cat-2 sections under spinal anaesthesia during the same period.

Results

	Cat-1 section RSSp (n=23)	Cat-2 section spinal (n=23)
Grade of anaesthetist	Consultant 61% Trainee 39%	Consultant 62% Trainee 38%
Intraoperative analgesia	Yes 8.7% No 91.3	Yes 4.3% No 95.7%
Conversion to GA	Yes 4.3% No 95.7	Yes 8.7% No 91.3%
Patient satisfaction with intraoperative spinal anaesthesia	Negative 4.3% Positive 95.7%	Negative 4.3% Positive 95.7%
Would you have a spinal again?	Yes 95.7% No 4.3%	Yes 95.7% No 4.3%
Foetal outcome	Positive 100%	Positive 100%

Abstract B290 Figure 1

Conclusions These results show no significant differences between Cat-1 section RSSp and Cat-2 section spinal anaesthesia outcomes, and this could help support the use of RSSp for Cat-1 sections.

B291 LOW DOSE OF SPINAL ADMINISTRATION OF LEVOBUPIVACAINE IN COMBINED SPINAL EPIDURAL ANESTHESIA WITH EPIDURAL VOLUME EXTENTION FOR CESAREAN SECTION IN TWO PREGNANTS WITH MULTIPLE SCLEROSIS

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Background and Aims Multiple sclerosis (MS) is a relapsing and remitting disease that may include symptoms of sensory or motor deficits, optic neuritis, bowel or bladder dysfunction, ataxia. Epidural administration of LA for cesarean delivery has historically been thought to be less risky for patients with MS than a spinal technique.

This report related to the use of low dose combined spinal epidural anesthesia and epidural volume extension for cesarean section in two pregnant with multiple sclerosis

Methods Two pregnant, 34 and 38 years old, are scheduled for an elective cesarean section for obstetric reasons. After informal consent and the same characteristics of gestation without complication, asymptomatic disease of MS for years and standard monitoring, combined spinal epidural technique was performed with the women in sitting position, level L3-L4, with intrathecal administration of 1,6 ml Levobupivacaine 0,5% + fentanyl 20γ and placed epidural catheter.

Results After 10 minutes the sensitive block was achieved at T8 level. 5 ml of epidural saline was administrated and 5 minutes later the sensitive block was at T6. The women remained with stable blood pressure and cardiac rhythm with low dose of neosynephrine. The cesarean sections developed without complications. Into the Recovery Room the patients had Grade II motor blockade (Bromage scale) without complications.

Conclusions A small dose of spinal Levobupivacaine can induce adequate analgesic levels with lower incidence of

hypotension and motor block (in relation to sensitive) and the epidural injection of saline afterwards stabilize the safety and duration of analgesia to these patients, offers advantages over alternative techniques.

B292 CONTINUOUS SPINAL FOR LABOR ANALGESIA IN A PATIENT WITH HYPERTROPHIC CARDIOMYOPATHY WITH HIGH OUTFLOW GRADIENT

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Background and Aims Pregnant women with hypertrophic cardiomyopathy (HCM) have an increased risk of cardiovascular complications during labor. Particularly when a high outflow gradient is present, tachycardia and systemic vasodilatation are not well tolerated and may lead to cardiac arrest.¹

Methods A 39-years-old, ASA III, 39-week pregnant woman with HCM was admitted in a tertiary obstetric center for labor induction. HCM was diagnosed two years before following routine electrocardiogram (EKG). At time of delivery patient presented with dyspnea for medium efforts and was taking bisoprolol 2.5mg id. Holter identified occasional polymorphic ventricular extrasystoles. Transthoracic echocardiography revealed asymmetric hypertrophy of ventricular walls with anterior-inferior septal predominance producing high outflow gradient. Global systolic function was preserved.

Results After hemodynamic monitoring including continuous EKG and invasive blood pressure, labor was induced with vaginal misoprostol and continuous spinal analgesia was early performed. A total of Sufentanil 2.5mcg and Ropivacaine 0.2% 5mg were titrated without hemodynamic repercussion and good pain relieve. Vacuum delivery was uneventful. The new born had an Apgar score of 9/10.

Mother surveillance and hemodynamic monitoring was maintained during the first 12h of puerperium in an intermediate care unit.

Conclusions To address this case, a multidisciplinary team composed by cardiologists, obstetricians and anesthesiologists was assembled. It was decided to perform a vaginal delivery induction with misoprostol avoiding oxytocin. Vacuum delivery was a strategy to shorten expulsive period. Early and effective labor analgesia with minimal hemodynamic repercussion was key to maintain cardiovascular homeostasis during labor in a patient with symptomatic HCM. Continuous spinal technique was definitely the best option.

B293 NEURAXIAL ANAESTHESIA IN SPINA BIFIDA OCCULTA: IS IT WORKS?

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Background and Aims Women with spina bifida present both obstetrical and anaesthesia challenges. They are more likely to require a caesarian delivery and traditionally neuraxial

anesthesia has been avoided due to concerns of worsening neurologic disability.

Methods A 35-year-old G1P0, at 37 weeks' gestation, was proposed to an elective caesarean section because of her spinal bifida occulta medical history. An MRI scan could not be performed before hospital admission. She reported no motor or sensory deficits. At physical exam, we could see a skin dimpling, 3,5 cm away from the anal margin. Despite we don't have a spinal image, we decided to perform a combined spinal and epidural anaesthesia. With the patient in sitting position, the puncture in L3-L4 epidural level was performed with a Tuohy 18 G needle. The epidural space was located 5 cm deep from the skin. The spinal block was performed with the "needle-through-needle" technique. After clear cerebrospinal fluid flowed, it was administered 8,5 mg of 0,5% hyperbaric bupivacaine and 2,5 µg of sufentanyl in the subarachnoid space. After the injection, an epidural catheter was introduced 9 cm cephalic.

Results The block reached approximately T4 level in about ten minutes after injection, at which point surgery was begun. The surgery lasted about 60 minutes and there was no need to epidural top-up.

Conclusions Administration of epidural or combined spinal and epidural anaesthesia may be considered in women with various forms of spinal dysraphism and stable neurologic function. The complications encountered are related to the altered anatomy.

B294 SUCCESSFUL EPIDURAL ANESTHESIA FOR NATURAL CHILDBIRTH IN A MULTIGRAVIDA PATIENT WITH MORBID OBESITY

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Background and Aims Morbid obesity is associated with a significantly higher risk of pre-existing medical conditions, developing antenatal complications, induction of labour, caesarean section. We report the anesthetic management of a multigravida woman with morbid obesity.

Methods A 36 years old, multigravida with 41 weeks' gestation, 198 kg, BMI 67, with massive swelling of lower limbs and body presented for the procedure of delivery. There was no history of any significant co-morbidity. The surgical history included appendectomy, tonsillectomy and inguinal hernia repair. She was a medium smoker and she was 110 kg in her first gestation. The baseline vital parameters including heart rate (HR), non-invasive blood pressure (NIBP), electrocardiogram (ECG) and oxygen saturation (SpO2) were attached and noted. The patient was planned to give epidural anesthesia for vaginal delivery in sitting position. An informed consent was obtained from the patient for publication of the report without disclosing his/her identity. The lumbar puncture was done at L2-L3 interspace. The epidural space was found in 7 cm and the catheter was inserted plus 7 cm.