

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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10.1136/rapm-2022-ESRA.366

**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.<sup>1</sup>

**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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10.1136/rapm-2022-ESRA.367

**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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10.1136/rapm-2022-ESRA.368

**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.



Abstract B294 Figure 1



Abstract B294 Figure 2

**Results** The baseline parameters recorded were, HR68/min, NIBP-110/50, and SpO<sub>2</sub>-97%.

After 3 doses of epidural LEVOBUPIVAININE 0,2% 10 ML+ fentanyl 15 $\mu$ g and 4 hours later a live 3.5 kg baby was delivered. The procedure remained uneventful.

**Conclusions** We concluded that the proper preanesthetic evaluation including history, relevant investigations, proper patient positioning both before and after giving neuraxial anesthesia with proper explanation to the patient about the procedure played a key role in successful management of such case by an anesthesiologist.

#### B295 ANESTHESIA PRACTICE AND PREGNANCY IN COVID 19. A TWO YEARS' CLINICAL EXPERIENCE

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10.1136/rapm-2022-ESRA.369

**Background and Aims** The Coronavirus Disease 2019 (COVID-19) pandemic has had an unprecedented impact on pregnant women, maternity services and healthcare workers. We report data from our tertiary referral hospital and especially the anesthesia management and implication in two years' experience.

**Methods** Anesthetic information for all anesthetic interferences in covid 19 pregnant patients undertaken at our unit between April 1, 2020 and March 31, 2022 was reviewed from electronic records. No ethical approval was needed as the review was classed as an audit as per the Royal College of Anaesthetists (RCOA) standards. The deliveries were collected with the type of anesthesia, the patients were admitted to the Intensive Unit and to Department for surveillance and operations in pregnant covid patients.

**Results** From these data, the cesarean sections classified as category 2-3 and completed without general anesthesia. The mortality was 1 patient in 2022 and unfortunately >90% of pregnant covid were without vaccination. Use of spinal anesthesia should be the preferred method of anesthesia for all these patients with cesarean section. The only argument with the World Health Recommendations is the absence of epidural anesthesia in natural childbirth except for 1 case in March 2022

**Conclusions** Strategies to reduce the rate of general anesthesia for emergent cesarean delivery have included (1) heightened communication between obstetrical, nursing, and anesthesia teams and (2) early neuraxial labor analgesia with a well-functioning epidural catheter. It is important for the obstetric anesthesiologists when treating infected pregnant to follow national recommendations or guidelines and help anesthesia providers to prepare themselves to manage future pandemics.

#### B296 ANESTHETIC MANAGEMENT FOR EMERGENCY CESAREAN SECTION IN A PATIENT WITH THOMSEN ' S DISEASE

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10.1136/rapm-2022-ESRA.370