



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 15γ 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

<sup>1</sup>S Tsakiliotis, <sup>1</sup>O Papagiannopoulou\*, <sup>1</sup>D Gogali, <sup>1</sup>M Doumparatz, <sup>2</sup>A Chatziaggelou, <sup>2</sup>T Mikos. <sup>1</sup>General Hospital Papageorgiou, Thessaloniki, Greece; <sup>2</sup>University Obstetric and Gynaecology Clinic/General Hospital Papageorgiou, Thessaloniki, Greece

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**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

A Fucak\*, M Zupčić, V Sotosek. University Hospital Rijeka, Rijeka, Croatia

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**Background and Aims** A 30-year old patient at 39 week gestation, was scheduled for an emergency cesarean section. She had Thomsen myotonia- an autosomal dominant genetic disorder which affects skeletal muscles leading to delayed relaxation after voluntary contraction because it affects the CLCN gene located on the 7th chromosome which encodes skeletal muscle chloride channels. Patients with this disease are sensitive to anesthesia, especially depolarizing muscle relaxants and pregnancy deteriorates patient's symptoms so our preferred anesthesia method was neuraxial anesthesia-spinal block.

**Methods** The patient received the spinal block with 0,5%Bupivacaine combined with 2,5 mcg of Sufentanyl, but the block was inadequate, so we converted to general anesthesia without using any muscle relaxants, just propofol and sevoflurane for maintenance and for airway management a LMA. After the delivery of the baby, we administered 25 mcg sufentanyl intravenously for the rest of the operation.

**Results** The c section was performed successfully resulting with a healthy baby, and the mother emerged without complications. For postoperative pain we gave an ultrasound guided Transversus abdominis plane Block using 0,25%Levobupivacaine 20 ml on each side.

**Conclusions** Thomsen myotonia is an anesthetic management challenge. Complications are common in these patients especially using depolarizing muscle relaxants. Regional anesthesia is the preferred method for cesarean section. In this case general anesthesia was used without relaxants and the procedure finished without complications.

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#### A CLINICAL AUDIT OF POST-OPERATIVE ANALGESIA IN ELECTIVE CAESAREAN SECTION FOLLOWING NEURAXIAL ANAESTHESIA

S Rooney\*, A Bell, D Cosgrave. *Galway University Hospital, Galway, Ireland*

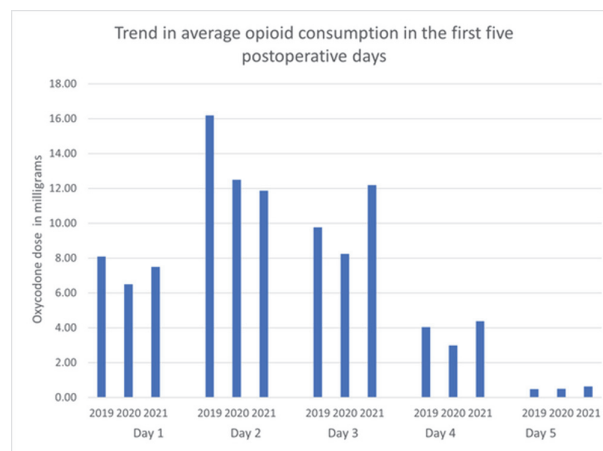
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**Background and Aims** Caesarean sections are associated with moderate to severe pain in the post-operative period.<sup>1</sup> Inadequate pain relief may cause delayed recovery, impair mother-child bonding and newborn care, impact maternal psychological well-being,<sup>1</sup> and can lead to persistent pain following caesarean section delivery.<sup>2</sup>

The 2020 PROSPECT guideline for elective caesarean section outlines optimal pain management following elective caesarean sections.<sup>3</sup> Our aim was to review our own analgesic protocols prior to a quality improvement project to institute compliance with these recommendations. We also evaluated opioid use over a three-year period.

**Methods** Ethical approval was granted for this audit, allowing for data collection and analysis of 60 anonymised patients (20 each from November of 2019, 2020 and 2021) who underwent elective caesarean section with neuraxial anaesthesia. Data were collected on intra-operative anaesthesia and analgesia, post-operative prescribing and administration of regular paracetamol, NSAID, long-acting opioid, and PRN short acting opioid. Using Excel v.2204 we analysed data from each year to assess for changes in analgesic prescribing.

**Results** Mean patient age was 36.2 year (+/-0.7 years), ranging from 23 to 47 years. Median length-of-stay was 4.0 days (+/-0.3 days), ranging from 3 to 21 days.



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**Conclusions** While more than 60% of our cohort had appropriate regular adjunct analgesia charted, we found an increase in prescribed long-acting opioid from 24% to 50% from 2019 to 2021. To achieve the framework provided by PROSPECT we have initiated a quality improvement project, with a standardised drug prescription kardex, and an extensive education programme for medical and nursing staff on-site.

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#### BLOOD PATCHES IN OBSTETRIC POPULATION – SINGLE CENTRE EXPERIENCE

O Babaua\*, A Qureshi, V Venkatesh. *University of Birmingham Hospitals NHS Foundation Trust, Birmingham, UK*

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**Background and Aims** Post dural puncture headache is relatively common in obstetric patients who have received central neuraxial anaesthesia<sup>1</sup>. Symptoms of PDPH are often severe, debilitating and potentially long lasting<sup>2</sup>. Treatment options for PDPH are limited and the only treatment which has been shown to be effective is an epidural blood patch<sup>3</sup>. EBP carries risks in itself and the decision to perform this is not taken lightly. Performing an EBP requires appropriate assessment of the patient, consenting of the procedure and follow up among other recommendations.

**Methods** We anonymously retrospectively looked collected data regarding all epidural blood patches performed in a single centre over a 4 year period. Details of the dural puncture, onset of symptoms, consent, documentation of risks, procedure details and follow up were all recorded. We have compared this to the OAA recommendations.

**Results** 23 blood patches in 20 patients, 8 patients had only spinal, 2 had an epidural followed by spinal while 10 had only epidural procedure. Headache developed within 48h in 17 cases, Blood patch was performed between day 2 and day 6 in 18 patients. There is one patient that had blood patch day 10 and 13 with complete resolution of symptoms day 14 from initial epidural, and another patient that had blood patches day 3 and 23 post initial spinal. In the epidural group 8 were recognised as dural taps on insertion.