examinations in the long term (third month) in the caudal group may indicate the preference of the transforaminal approach.

EP130 EPIDURAL LABOUR ANALGESIA IN A PATIENT WITH NEUROFIBROMATOSIS – HOW MUCH RISK IS TOO RISKY?

Maria José de Barros e Castro Bento Soares*, Verónica Tomé de Carvalho Eckardt, Nuno de Almeida Cordeiro, Telma Caria. *Serviço de Anestesiologia, Centro Hospitalar Lisboa Ocidental, Lisboa, Portugal*

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Background and Aims Neurofibromatosis is a multisystem genetic disorder which manifests with pigmentary skin changes, neurofibromas, increased risk of central nervous system gliomas and other malignant tumors and learning disabilities. Performing an epidural technique in patients with neurofibromatosis is subject to careful consideration due to potential challenges including the presence of neurofibromas involving the spinal cord.
Methods Description of a case of an epidural performed for labour analgesia in a patient with neurofibromatosis.
Results We present a case of a 31-year-old woman, ASA II, 40 weeks pregnant, diagnosed with neurofibromatosis, who was admitted at our hospital in active labour. The patient expressed the will to receive epidural analgesia. She was asymptomatic except for the presence of café-au-lait spots and cutaneous neurofibromas. Her magnetic resonance imaging (MRI) of the brain and spine showed thickening of the optic chiasm and hypothalamus and absence of spinal lesions. There was no history of back pain, headache, neurological deficits or hypertension. Neurological examination was normal, with no sensory or motor deficits. She had normal curvature of the spine. We proceed with the epidural technique. An epidural catheter was placed at L3-L4 level in the midline after finding the epidural space using a loss of resistance to saline technique. There were no complications associated with the technique and the patient had adequate level of analgesia. The patient had a vaginal birth with no complications.
Conclusions The report suggests that epidural labour analgesia may be a suitable option when spinal cord neurofibromas have been ruled out by magnetic resonance imaging and clinical examination.

EP131 IN VITRO EVALUATION OF THE EFFECT OF DEXMEDETOMIDINE ON OXYTOCIN PRE-TREATED PREGNANT HUMAN MYOMETRIUM

Mrinalini Balki, Leland Ustare*. *Department of Anesthesia and Pain Medicine, Mount Sinai Hospital, Toronto, Canada*

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Background and Aims Postpartum hemorrhage (PPH) remains to be one of the leading causes of maternal morbidity and mortality attributed to the rising rate of uterine atony. Dexmedetomidine, a highly-selective alpha-2 agonist, has been used in obstetric practice due to its desirable effects. It has applications as an adjunct during neuraxial anesthesia, as well as in general anesthesia (GA) for caesarean delivery. Information on dexmedetomidine's effect on the contractility of human myometrium remains limited.
Methods Term pregnant patients scheduled for elective CD under regional anesthesia were included. Myometrial tissues were collected by the obstetrician after the delivery of the fetus and placenta and were immediately placed in buffer solution and transferred to the laboratory. Tissue samples were divided into 3 strips and were mounted individually in organ bath chambers filled with physiological salt solution (PSS). Myometrial contractions recorded and were used for analysis as baseline equilibration contractions. The myometrial strips were pre-treated with oxytocin 10-5M for 2 hours and assigned to 3 groups: 1) Dex group (subjected to dose-response testing with increasing concentrations of dexmedetomidine10-9M to 10-4M), 2) Dex + Oxy group (received oxytocin at 20nM along with dexmedetomidine 10-9M to 10-4M), and 3) Control (only oxytocin 20nM).
Results There is a 363% increase in relative motility index recorded in the Dex group at 10-4M concentration. There is also an increase in relative MI in Dex

+ Oxy group however it was not significant (196%) owing to the desensitization phenomenon.
Conclusions Dexmedetomidine significantly caused an increase in myometrial contractility of pregnant human myometrium at 10-4M concentration.

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EP132 ORAL DEXAMETHASONE AS AN ADJUNCT TO A BRACHIAL PLEXUS BLOCK: A RANDOMISED, BLINDED, PLACEBO-CONTROLLED, CLINICAL TRIAL

[1]Mathias Maagaard*, [2]Morten Zacharias Plambech, [3]Kamilia Shami Funder, [4]Ida Tryggedsson, [5]Peter Toquer, [6]Pia Jæger, [1]Jakob Hessel Andersen, [1,7]Ole Mathiesen. *[1]Centre for Anaesthesiological Research, Department of Anaesthesiology, Zealand University Hospital, Køge, Denmark, None, Køge, Denmark; [2]Department of Anaesthesiology, Næstved-Slagelse-Ringsted Hospitals, Slagelse, Denmark, None, Slagelse, Denmark; [3]Department of Anaesthesiology, Copenhagen University Hospital, Bispebjerg Hospital, Copenhagen, Denmark, None, Copenhagen, Denmark; [4]Department of Orthopaedic Surgery, Copenhagen University Hospital, Bispebjerg Hospital, Copenhagen, Denmark, None, Copenhagen, Denmark; [5]Department of Orthopaedic Surgery, Zealand University Hospital, Køge, Denmark., None, Køge, Denmark; [6]Department of Anaesthesia, the Juliane Marie Centre, Copenhagen University Hospital, Rigshospitalet, Copenhagen, Denmark, None, Copenhagen, Denmark; [7]Department of Clinical Medicine, University of Copenhagen, Copenhagen, Denmark, None, Copenhagen, Denmark*

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Background and Aims To our knowledge, the effect of oral dexamethasone on block duration has never been assessed. Previous trials used subanalgesic doses of dexamethasone (≤10 mg), and it is unclear if there is a ceiling effect.
Methods We randomised 180 participants undergoing osseous surgery of the hand or forearm to one oral dose of 24 mg dexamethasone, 12 mg dexamethasone, or placebo prior to performing a lateral infraclavicular block with 30 ml of 5 mg/ml ropivacaine. The primary outcome was the duration of analgesia assessed by the time to first sensation of pain in the surgical area. We pre-defined a 33% increase in the duration of analgesia as clinically important.
Results The duration of analgesia was 1256 ± 395 minutes with 24 mg dexamethasone, 1171 ± 318 with 12 mg dexamethasone, and 841 ± 327 minutes with placebo (figure 1). When compared with placebo, the duration of analgesia was greater with 24 mg dexamethasone (mean difference (MD) 412 minutes, 98.33% CI 248 to 577) and with 12 mg dexamethasone (MD 330 minutes, 98.33% CI 186 to 474). There was no significant difference between 24 mg and 12 mg