

maintain steady blood sugar levels yet the pain management for parturition is not adapted specifically for this subset.

Methods A combination of systematic literature research in the PubMed database and NCBI database was performed. We compared data regarding metabolic diseases including diabetes and pain management. Consequently, a detailed analysis of the specific impact each pain relief method discussed has on diabetes. A wide range of patient ages were included.

Results The data gathered from the above-mentioned literature describes the efficacy of epidural steroid injections as treatment for pain management in women yet, there are negative side effects related to diabetes and diabetes management. The data gathered from the above-mentioned literature describes the efficacy of epidural steroid injections as treatment for pain management in women yet, there are negative side effects related to diabetes and diabetes management.

Conclusions The studies reflect the efficacy of epidural anesthesia in these patients. The implications of this study could be used to better understand the relationship between epidurals and their effects. More research will be needed to understand the most effective pain management strategy for diabetic OB patients.

EP250 **RECTUS SHEATH BLOCK ADDED TO PARASTERNAL BLOCK IMPROVES RESPIRATORY PERFORMANCE AFTER MEDIAN STERNOTOMY WITH DRAINAGE POSITIONING IN CARDIAC SURGERY PATIENTS**

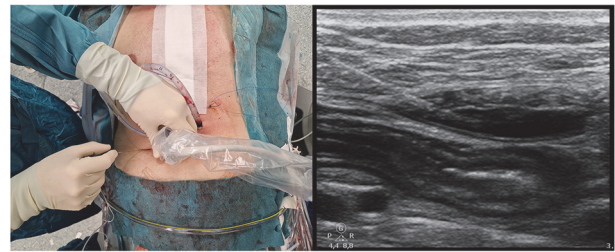
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Background and Aims Pain is usually severe after cardiac surgery and can limit respiratory function. Parasternal block is used to control this pain; anyway, the block effect is limited to the sternal region and do not cover upper abdominal quadrants, where pleural and mediastinal drainages are positioned. Rectus sheath block is an analgesic technique widely used in abdominal surgery.

Methods 5 patients underwent CABG through median sternotomy. With patients consent, we performed ultrasound guided bilateral parasternal block (ropivacaine 0,5% 40 ml + dexamethasone 2 mg) after induction and ultrasound guided bilateral rectus sheath block (ropivacaine 0,25% 20ml + dexamethasone 2mg) at the end of the surgery. Multimodal i. v. analgesia: ketorolac 90mg/24h and acetaminophen 1 gr 3/ die. Data regarded: perioperative pulmonary performance evaluated with the TriFlo Inspiratory Exerciser® and expressed in balls moved up during inspiration, pain during incentive spirometry at extubation/after 12 hours (0-10 NRS scale), opiates consumption.

Results Patients moved up a median of 2 (2-3) balls before surgery and a median of 2 (1-2) balls at extubation. 2 patients completely recovered respiratory function after 12 hours. Pain during spirometry at extubation was a median of 4 (3,5-5,5). Maximum pain in the first 12 hours was a median of 4 (3,5-5,5). Morphine consumption in the first 12 hours was a mean of 1 + 0,9 mg. No pulmonary complications occurred.



Abstract EP250 Figure 1 Rectus sheath block execution and local anaesthetic spread



Abstract EP250 Figure 2 The TriFlo Inspiratory Exerciser®

EP251 **ANESTHETIC MANAGEMENT DURING LABOR AND SUBSEQUENT CESAREAN SECTION OF A PARTURIENT WITH DEVIC DISEASE (NEUROMYELITIS OPTICA): A CASE REPORT**

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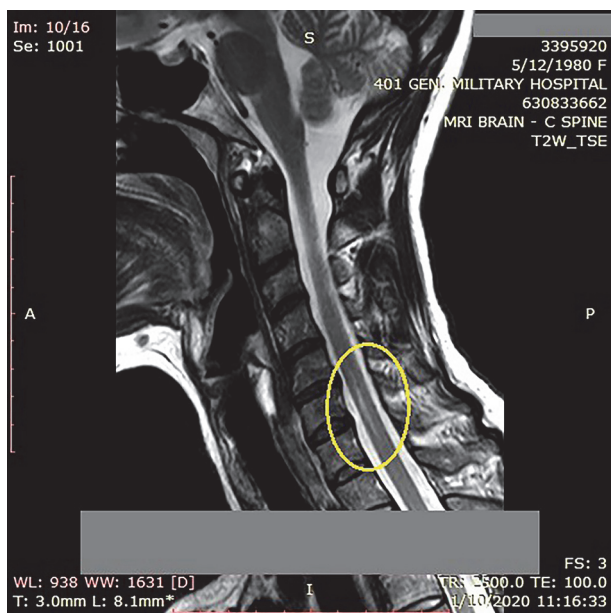
10.1136/rapm-2023-ESRA.311

Background and Aims Devic disease, or neuromyelitis optica, is a rare autoinflammatory demyelinating disease of the central nervous system, characterized by axonal damage, affecting mainly optic nerves and the spinal cord. The anesthetic management of a parturient suffering Devic disease in the delivery room, is presented.

Methods A 43-year-old, 90 kg, 167cm, G2P1 woman, diagnosed with Devic disease, presented for labor induction at 39 weeks of gestation. Initial neurologic symptoms, diplopia and facial nerve palsy, had developed during her first pregnancy and were diagnosed as brain stem syndrome in remission; the parturient received then uneventful epidural labor analgesia. A year later, Devic disease was diagnosed, further confirmed by

positive NMO – IgG/anti-AQP4 antibody. Currently, during pre-anesthesia assessment, the risk of potential neurological symptoms deterioration after labor epidural was weighed against the risk of a labor stress-induced disease relapse. Anesthesiologist and Obstetrician communicated the planned procedure and its risks and the parturient opted for labor epidural analgesia.

Results An indwelling epidural catheter was placed uneventfully in the delivery room, ropivacaine 0.2% was administered and an adequate sensory block was established. An enhanced sensitivity to the local anesthetic, presumably deriving from spinal cord damage, was postulated, due to unilaterally denser sensory block. Length of catheter insertion into the epidural space was optimal. Several hours later, the parturient underwent cesarean section for obstetric indications after successful epidural top-up.



Abstract EP251 Figure 1 Sagittal T2-weighted magnetic resonance imaging (MRI) of the spine showing hyperintense region in the spinal cord, consistent with syringohydromyelia, extending from C6 to C7 with a cephalocaudal diameter of 16mm

Conclusions This case illustrates the safe and effective use of epidural labor analgesia and anesthesia in a patient with Devic disease; thorough pre-anesthetic and obstetric counseling is vital.

EP252

PAIN MANAGEMENT IN OFF-PUMP CORONARY ARTERY BYPASS: A SYSTEMATIC REVIEW AND META-ANALYSIS OF THE BILATERAL ERECTOR SPINAE PLANE BLOCK VERSUS CONTROL

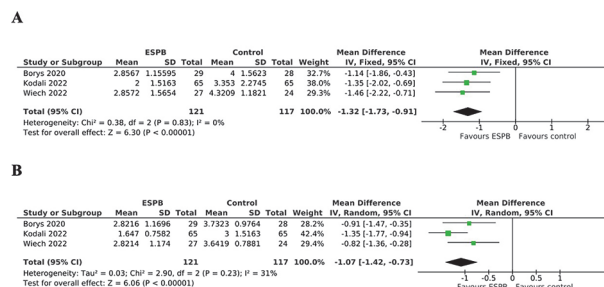
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10.1136/rapm-2023-ESRA.312

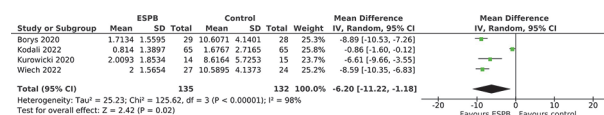
Background and Aims Off-pump coronary artery bypass (OPCAB) surgery is a widely performed surgical procedure for coronary artery disease. Adequate postoperative pain management is crucial for patient overall recovery. The erector spinae plane block (ESP) has gained recognition as a promising regional anesthesia technique. Our aim is to compare standard pain management with the ESP in patients undergoing OPCAB.

Methods Pubmed, EMBASE, and Cochrane were searched for randomized controlled trials (RCTs) comparing bilateral ESP to control. We assessed pain scores, opioid consumption, and duration of mechanical ventilation, intensive care unit (ICU) and hospital stay. Data was analyzed with RevMan 5.4.

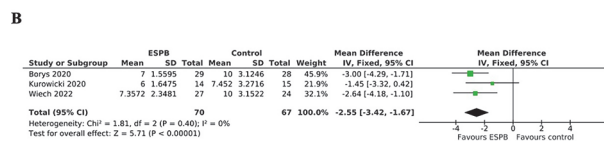
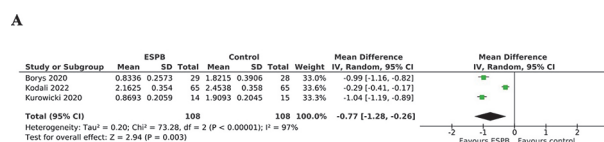
Results We analyzed 4 RCTs with 267 patients, of whom 50.56% underwent the ESP. The pain scores at 6 and 12 hours after extubation were significantly decreased in the ESP group (figure 1) but not at 24 hours (MD -1.37; 95% CI -2.95 to 0.20; p < 0.09; I2 = 93%, 3 RCTs, 238 patients). Opioid consumption also favoured the ESP group (MD -14.30; 95% CI -21.39 to -7.22; p < 0.0001; I2 = 98%, 3 RCTs, 238 patients). Time to extubation was significantly shorter for the ESP intervention (figure 2), as well as the ICU and hospital lengths of stay (figure 3).



Abstract EP252 Figure 1 Pain scores at 6h (A) and 12h (B) were significantly lower in the ESP group



Abstract EP252 Figure 2 Time-to-extubation was significantly lower in the ESP group



Abstract EP252 Figure 3 There was a significant difference in length of stay in the intensive care unit (3A) and in the hospital (3B), favouring the ESP intervention