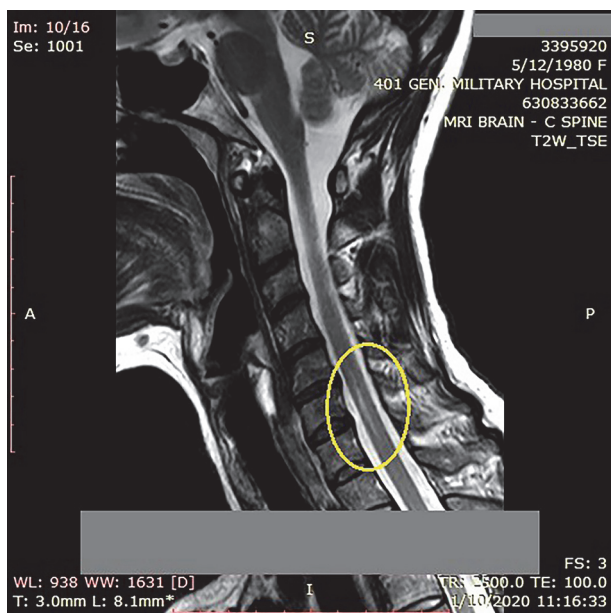


positive NMO – IgG/anti-AQP4 antibody. Currently, during pre-anesthesia assessment, the risk of potential neurological symptoms deterioration after labor epidural was weighed against the risk of a labor stress-induced disease relapse. Anesthesiologist and Obstetrician communicated the planned procedure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

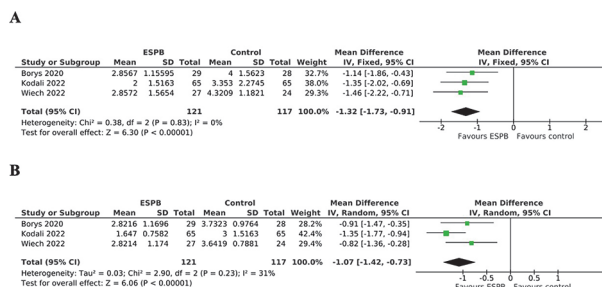
¹Marcela Tatsch Terres, ²Maria Luísa Assis, ³Rita Gonçalves Cardoso*, ⁴Sara Amaral. ¹Anesthesiology, Universidade do Sul de Santa Catarina, Palhoça, Brazil; ²Anesthesiology, Hospital das Clínicas de Porto Alegre, Porto Alegre, Brazil; ³Anesthesiology, Hospital da Senhora da Oliveira – Guimarães, Guimarães, Portugal; ⁴Anesthesiology, Hospital Regional Deputado Afonso Guizzo, Araranguá, Brazil

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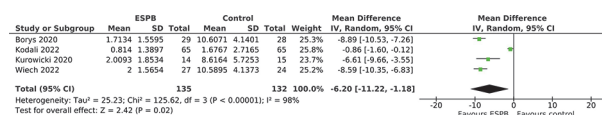
Background and Aims Off-pump coronary artery bypass (OPCAB) surgery is a widely performed surgical procedure for coronary artery disease. Adequate postoperative pain management is crucial for patient overall recovery. The erector spinae plane block (ESPB) has gained recognition as a promising regional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

Methods Pubmed, EMBASE, and Cochrane were searched for randomized controlled trials (RCTs) comparing bilateral ESPB 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.

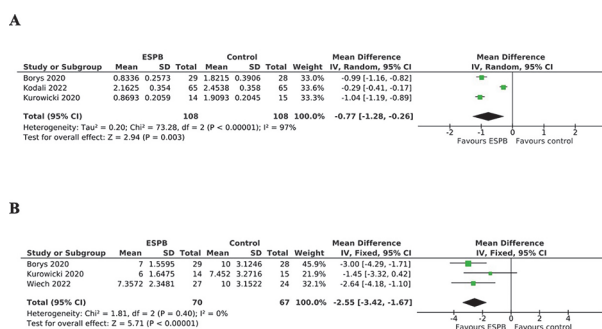
Results We analyzed 4 RCTs with 267 patients, of whom 50.56% underwent the ESPB. The pain scores at 6 and 12 hours after extubation were significantly decreased in the ESPB group (figure 1) but not at 24 hours (MD -1.37; 95% CI -2.95 to 0.20; p < 0.09; I2 = 93%, 3 RCTs, 238 patients). Opioid consumption also favoured the ESPB 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 ESPB 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 ESPB group



Abstract EP252 Figure 2 Time-to-extubation was significantly lower in the ESPB 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 ESPB intervention

Conclusions ESPB may reduce opioid consumption, extubation time, ICU and hospital stay after OPCAB. It effectively reduces pain at 6 and 12 hours post- extubation, but not at 24 hours, probably due to its duration. Larger studies are needed for comprehensive conclusions.

Central nerve blocks

#35700 USE OF INTRALIPID FOR THE REVERSAL OF LOCAL ANAESTHETIC BLOCKADE FOLLOWING NEURAXIAL ANAESTHESIA – A CASE SERIES

¹Zheng Jie (Zee) Lim*, ²Ebony Selers, ²Shaktivel Palanivel, ²Siju Abraham. ¹Anaesthesia, Grampians Health Ballarat, Ballarat, Australia; ²Anaesthesia, Grampians Health Ballarat, Ballarat Central, Australia

10.1136/rapm-2023-ESRA.313

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

Background and Aims Neuraxial anaesthesia for caesarean section (CS) with local anaesthetics is frequently performed, however these procedures can cause high-level blockade or Local Anaesthetic Systemic Toxicity (LAST). Evidence supporting the use of intralipid as a reversal agent following high-spinals is scarce.

Methods This case series presents the reversal of two patients with high spinal blocks with intralipid emulsion. Written consent was obtained.

Results Case 1: A 27-year-old primigravid at 40 weeks 3 days of gestation was referred for a CS following foetal distress and slow labour progression. 2% lignocaine was given epidurally in 5ml aliquots (Total 20ml over 45 minutes). Postoperatively, the patient had increased work of breathing, hypotension, and bilateral upper arm weakness. This persisted for 50 minutes with block to ice at C2 bilaterally. Intralipid emulsion was given in 5-10ml aliquots (Total 50ml). Rapid block recession to T4 bilaterally within 15mins. Case 2: A 26-year-old primigravid at 38 weeks and 2 days gestation was referred for a CS due to obstructed labour. An epidural performed earlier only provided a unilateral block. A spinal neuraxial was performed. Block to ice was noted at C7 after delivery, with hypotension and increased work of breathing. 20ml of Intralipid was given, with block recession to T1. A second 20ml intralipid bolus was given and the block recessed to T4.

Conclusions Early intralipid administration rapidly reverse neuraxial anaesthesia and prevent LAST. This study supports the safe use of intralipid. Future research is required to investigate the appropriate timing and dosing of intralipid when used in such circumstances.

#36336 INTRODUCING AN AMBULATORY SPINAL SERVICE FOR ORTHOPAEDIC SURGERY AT A DISTRICT GENERAL HOSPITAL

Natalie Shields*. Anaesthetics Department, Princess Royal University Hospital, King's College Hospital NHS Trust, Orpington, UK

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Background and Aims Short-acting intrathecal local anaesthetics, such as prilocaine, have advantages for ambulatory day-case surgery due to rapid onset and offset of anaesthesia, rapid recovery of protective reflexes, mobility and micturition. Intrathecal prilocaine for day-case unicompartamental knee replacement (UKR) has been introduced at an orthopaedic hospital in the UK. The study aims are: 1. To assess feasibility of an ambulatory spinal service for elective UKR 2. To introduce prilocaine for day-case UKR

Methods Stage 1 was a retrospective review of 29 UKRs in 2020 recording time from anaesthesia to surgery end to demonstrate feasibility of prilocaine use. Stage 2 recommended using heavy prilocaine 20% with fentanyl. Data collected for UKR cases between Jan – May 2023 included anaesthetic dose, time from anaesthesia to surgery end, post-operative pain scores, analgesic requirements, length of stay and patient satisfaction.

Results Stage 1 found that mean procedure time was 72mins. Stage 2 found that 80% were discharged within 24h, 0% had urinary retention, pain scores were between 2-10/10, they all required oral opiate analgesia, time to mobilisation was poorly documented, patient satisfaction was between 4 and 5 out of 5.

Conclusions UKR can successfully be achieved as a day-case procedure with intrathecal prilocaine. To facilitate this patients should be first on the theatre list and receive pre-operative education regarding physiotherapy and post-operative analgesic requirements. Good analgesia is required with regular paracetamol, NSAIDs if not contraindicated and opiates. A guideline for all multidisciplinary teams, including physiotherapy, pharmacy and the ward nurses will further support same day discharge.

Attachment Ethics approval not required.pdf

#36197 REGIONAL ANAESTHESIA FOR LAPAROSCOPIC SURGERY

Ofelia Grimaud*. Anesthesiology, Centre Hoepitalier Louis Girgi, Aix-en-Provence, France; **Please confirm that an ethics committee approval has been applied for or granted:** Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

10.1136/rapm-2023-ESRA.315

Background and Aims Laparoscopy is a procedure requiring total muscular relaxation, traditionally performed under GA. Regional anaesthesia provides total analgesia and muscle relaxation with complete preservation of consciousness and rapid postoperative recovery. Spinal and combined spinal-epidural blocks have been used for laparoscopic general surgery in patients with relevant medical pathologies including coexisting pulmonary disease. This study shows the feasibility of all types of laparoscopic surgery under CSE, on awake patients.

Methods 655 ASA I to III patients between 30 and 80 years old scheduled for different laparoscopic surgery (cholecystectomy, appendectomy, colectomy, sigmoidectomy, inguinal hernia, prostatectomy and hysterectomy) were included in this protocol after informed consent. After monitoring preloading and light sedation, with the patient in left lateral decubitus epidural space was identified by the loss of resistance to air technique between L1-L2. A 27G spinal needle was