Conclusions There are many cases in literature where the ETD was ineffective and even associated with adverse events. These three case reports show that the ETD does not prevent the occurrence of adverse outcomes. More studies are required to establish which strategy is valid for early detection of EC misplacement.

#36514 CESAREAN SECTION IN A PREGNANT WOMEN WITH ADHESIVE ARACHNOIDITIS AND CHRONIC PAIN – A CASE REPORT

[1]Filipa Farias, [2]Ana Mendes Duarte*, [1]Teresa Rocha. *[1]Anesthesiology, Centro Hospitalar Lisboa Central, Lisboa, Portugal; [2]Centro Hospitalar Lisboa Central, Lisboa, Portugal*

10.1136/rapm-2023-ESRA.445

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 Adhesive arachnoiditis (AA) is a chronic, rare and debilitating disease. Characterized by persistent arachnoid inflammation leading to intrathecal scars and dural adhesions, resulting in ischemia, encapsulation, and atrophy of nerve roots. Clinical manifestations include chronic back pain and variable neurological deficits. Anaesthetic challenges include chronic pain management, baby withdrawal syndrome and difficult neuraxial approach.

Methods A 39-year old pregnant woman was scheduled for elective cesarean section due to maternal pathology. Presented with adhesive arachnoiditis, severe lumbosciatalgia, and treated pregestationally with hydromorphone, morphine, baclophene, gabapentine and diazepam. Showed neurologic deficits such as gait impairment, urinary incontinence, spasticity and paresthesia of the lower limbs. Other relevant history included: Chron's disease, asthma, obesity, gestational diabetes and multiple previous vertebral procedures. General anesthesia was induced using propofol and rocuronium, and maintained with sevoflurane. Tracheal intubation accomplished through videolaringoscopy. Intraoperative analgesia included fentanyl, paracetamol and ketorolac. Multimodal postoperative analgesia was ensured, combining a bilateral TAP block using ropivacaine, paracetamol, ketorolac and a fentanyl Patient Controlled Analgesia (PCA).

Results Successful cesarian section performed under general anesthesia, with no complications for mother or baby. Postoperative daily evaluation revealed mild pain and nausea, treated effectively with ondansetron. Fentanyl PCA was suspended 48 hours postoperatively.

Conclusions AA patients can be challenging for the anaesthesiologist due to limitations in the neuraxial approach – an especially important anaesthesia technique in labour – and the management of postoperative acute pain in a patient with chronic pain. The described approach may be a safe and effective choice for AA patients undergoing cesarian section.

#35898 PLACENTA PERCRETA: A NEAR MISS

Rita Morato, Marco Dinis*, Muriel Lerias, Filipa Lança. *Anesthesiology, Centro Hospitalar Universitario Lisboa Norte, Lisbon, Portugal*

10.1136/rapm-2023-ESRA.446

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 Placenta percreta is a severe form of placental accretism in which the placenta penetrates the entire uterine wall and attaches to other organs, raising the risk of obstetric haemorrhage, peripartum hysterectomy, along with maternal and fetal mortality. We report a challenging case of a multidisciplinary approach to massive bleeding following a placenta percreta diagnosed during the cesarian section.

Methods A 35-year-old, G2P1 (previous cesarean) and 30 weeks gestation pregnant woman was diagnosed with placenta percreta during an emergent cesarean under spinal anaesthesia due to imminent premature labour. General anaesthesia was performed, and as the caesarean began, a massive haemorrhage survene. The multidisciplinary team and the transfusion protocol were activated and guided by viscoelastic tests. The transfusion therapy included: 5 red blood cell transfusions (5UCE), fibrinogen (4g), tranexamic acid (2g) and crystalloids (4L). Vasopressor support under invasive monitoring (30mcg/min) and, ultimately, the hysterectomy were required to control the bleeding. A total blood loss of 2500mL was estimated.

Results The patient was transferred under invasive mechanical ventilation to an intensive care unit. On the third postoperative day, the patient developed a post-hysterectomy hematoma, and thromboembolism prophylaxis was not started. Two days after, she developed pulmonary thromboembolism and started anticoagulation, receiving hospital discharge on the seventh postoperative day.

Conclusions Placenta percreta is a life-threatening clinical entity where multidisciplinary teamwork and a careful preoperative plan are crucial to success. Our case was handled with a prompt and effective response during an unforeseen event with success.

Attachment Isabel Ramalho (1).pdf

#36501 ANAESTHETIC MANAGEMENT OF A PARTURIENT WITH IDIOPATHIC PULMONARY ARTERY HYPERTENSION (IPAH) POSTED FOR LOWER SEGMENT CAESAREAN SECTION (LSCS) – A CASE REPORT

Raju Jadhav*. *Department of Anesthesia and Intensive Care, West Cumberland Hospital, North Cumbria Integrated Trust NHS, Whitehaven, UK*

10.1136/rapm-2023-ESRA.447

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

Application for ESRA Abstract Prizes: I apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims IPAH corresponds to sporadic disease without any family history of PH or known triggering factor with mPAP > 25 mm Hg or more at rest after excluding left sided heart disease and certain other disorders[1].Pregnancy in IPAH patients is associated with very high peri-partum mortality and conception is not advised and if detected early in pregnancy, then termination is advised[2].

Methods Parturient,37years,at 35 weeks gestation,in premature labour was referred to us being diagnosed as IPAH;NYHA Class III,on Tab.Sildenafil 12.5mg BD and Inj.Enoxaparin 40mg s.c. Post high risk consent,LSCS done under lumbar