

epidural anaesthesia with 0.25% Bupivacaine+Fentanyl,with standard monitoring and intra arterial line,maintaining hemodynamic stability.Intra-op BP decreased twice,treated with Phenylephrine 50mcg iv bolus & rest was uneventful.Patient monitored in CCU for 48hours;on continuous epidural 0.125% Bupivacaine infusion,with uneventful post operative period.

**Results** During pregnancy the circulatory and haematological changes which occur can lead to increased peri-op mortality and morbidity in patients of IPA.H. The anaesthetic goals are Maintenance of adequate Systemic Vascular Resistance (SVR); Maintenance of intra-vascular volume and venous return; Avoidance of aorto-caval compression;Prevention of pain, hypoxemia,hypercarbia and acidosis which may increase Pulmonary Vascular Resistance(PVR) and avoidance of myocardial depression.The choice of anaesthesia for LSCS in patients with IPA.H is controversial as there is no established anaesthetic protocols to manage such patients and varied reports make it difficult to come to a well-established decision.

**Conclusions** Epidural anesthesia can be safely administered during LSCS in a selected group of patients with IPA.H,using a multi-disciplinary team approach and extreme vigilance leading to a good maternal and fetal outcome.

#### #35887 SUCCESSFUL MANAGEMENT OF LABOR EPIDURAL ANALGESIA FOR A NULLIPAROUS WOMAN WITH PRIOR SPINAL SURGERY OF CONGENITAL SCOLIOSIS AND TIBIAL DEFICIENCY

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10.1136/rapm-2023-ESRA.448

**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 don't wish to apply for the ESRA Prizes

**Background and Aims** Administration of epidural analgesia in a patient with prior spinal surgery is a unique challenge. There may be difficulty of locating epidural space, interference with local anaesthetic spread, and accidental dural puncture. Also, appropriate deliver position is known as one of the key of successful vaginal delivery. It may be difficult for those who has disability of lower extremity.

**Methods** Written informed consent was obtained from the patient for presentation. A 29-year-old nulliparous woman was sent for evaluation of epidural analgesia use in 35th gestational weeks. She took osseointegration limb surgery in infancy, and T3-L1 posterior interbody fusion and L1-L3 lateral interbody fusion at age 13 and 15. MRI showed that lumbar epidural space was intact. There were no neurologic impairments of both upper and lower extremities and she assumed a delivery position with her artificial leg. After review of these evaluation, she was offered labor epidural anaesthesia.

**Results** She presented at 39 weeks in labor. Epidural anaesthesia was successfully placed at L3/4. A total dose of 5.7ml of 0.2% levobupivacaine and 25 µg of fentanyl were injected in increments, and the patient reported Numerical Rating Scale 0. With using programmed intermittent epidural bolus,

epidural anaesthesia provided satisfactory analgesia. She delivered a healthy baby vaginally with no adverse events.

**Conclusions** Although Labor epidural anaesthesia is known to be technically difficult in patients with prior spinal surgery, neuraxial anaesthesia can be performed safely and effectively in this case. An appropriate pre-labor assessment is needed for the patients with those difficulties.

#### #36137 LABOR ANALGESIA IN A PREGNANT WITH SPINA BIFIDA OCCULTA – A CASE REPORT

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10.1136/rapm-2023-ESRA.449

**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** Spina bifida occulta, a relatively common neurologic anomaly (12.4%) (1), presents challenges for neuroaxial anesthesia although, it is not a contraindication to this technique (2).

**Methods** A 25-year-old woman, 39 weeks pregnant in labor was admitted in the hospital. No past medical history was described. The anesthesia team was called in as the patient was experiencing uncontrolled pain but refused the placement of an epidural catheter. During the discussion, she disclosed that she had spina bifida and believed that epidural catheter placement was contraindicated for individuals with this condition. Confirmation of spina bifida at the L5-S1 level was obtained from a CT scan in her digital records. Despite attempts to alleviate her pain with patient-controlled analgesia (PCA) with bolus of 1 ml of remifentanyl (20 mcg/mL), the patient remained with bursts of pain. The PCA was stopped 20 minutes before birth however, the newborn experienced respiratory difficulties with an APGAR 6/7/8, that resolved after measures from the neonatal care.

**Conclusions** Epidural analgesia with lumbar catheter placement is the preferred method for labor pain management, benefiting both the mother and the fetus

(1). This decision should be made in line with the patient, that should be informed of the multiple techniques for labor pain control in advance. Effective communication between obstetric and anesthesia team can provide time and logistic management of the patient namely with a pre-procedural evaluation, ultrasound guidance and consideration of alternative techniques. This approach can provide better care to the patient with better satisfaction and outcomes.

#### #36209 THE ART OF DELIVERING A BABY .. WHEN YOUR HEART IS NOT YOURS

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10.1136/rapm-2023-ESRA.450

**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** An 18-year-old female, presented to labour ward, G2P0 36+6 weeks pregnant, with history of cardiac transplant for idiopathic dilated cardiomyopathy diagnosed at age of 13 and transplanted at age 13, with dual chamber pacemaker, with good exercise tolerance. Due to worsening acute kidney injury, secondary to a combination of Tacrolimus and obstructive hydro nephrosis of the right kidney, urgent category 2 caesarean section delivery was needed to avoid sepsis.

**Methods** Prior to theatre, pacemaker was checked, preoperative ECG showed a pacemaker dependant rhythm and USS of renal tract showed a moderate hydronephrosis of right kidney. Preoperative potassium was raised, treated with a dextrose-insulin infusion. Irradiated blood was crossmatched. Two wide bore cannulas and arterial line were inserted. Patient was consented and a spinal anaesthetic was administered. Intraoperative cell salvage was used due to anaemia in pregnancy. Postoperatively, patient was managed in labour ward HDU with strict fluid balance. Kidney functions gradually improved and Tacrolimus levels was monitored.

**Results** Preconception counselling is paramount. pregnancy should be delayed at least 1 year after a heart transplant. Higher incidence of pre-eclampsia, eclampsia and gestational diabetes have been reported. Monitoring of immunosuppressant levels is vital.

**Conclusions** Pregnancy after heart transplantation brings many new considerations to the anaesthetist especially as this is a rare occurrence! this case report shows the importance of a multidisciplinary team approach whilst keeping the patient at the centre of combined decision making. Patients require a tailored anaesthetic plan and careful perioperative preparation to ensure safe patient care. Punnoose, L.R. et al. (2020) 'Pregnancy outcomes in heart transplant recipients,' *The Journal of Heart and Lung Transplantation*, 39(5), pp. 473–480.

**Attachment** Poster version 2.0.pdf

### #36282 HIGH SPINAL BLOCK AFTER COMBINED SPINAL-EPIDURAL ANESTHESIA FOR CESAREAN SECTION

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10.1136/rapm-2023-ESRA.451

**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** Unrecognized spinal placement of an epidural catheter is a serious complication. It can cause a high/total spinal block which can lead to a catastrophic outcome.

**Results** A 37 year old woman was admitted to elective cesarian section at 39 weeks of gestation. Previous history includes an uneventful cesarian section 7 years ago. A combined spinal-epidural block in the sitting position through the L3/L4 intervertebral space using a median approach was achieved after 3 attempts by loss of resistance to normal saline. A needle-through-needle technique was performed. CSF flow was confirmed by glucose testing and 1.6ml 0,5% Bupivacaine and 2 µg sufentanyl were administered. The epidural catheter was then inserted and negative aspiration was confirmed. Due to incomplete block for surgery, 9.5mL of 2% lidocaine was

injected through the epidural catheter after negative aspiration. During the following minutes, the patient gradually complained a feeling of imminent death and upper limb paresthesia, and rapidly progressed to apnea. A rapid sequence induction was immediately performed, with mechanical ventilation. A double check of the epidural catheter uncovered a positive aspiration of LCR. The cesarian section was uneventful and the patient was extubated at the end of surgery, forty minutes later. No other complications developed. She remained stable and after 4 hours both motor and sensitive blocks were fully reversed.

**Conclusions** The most likely mechanism responsible for the high spinal block was the migration of the epidural catheter while the patient was repositioned, perhaps through the dural puncture caused by the spinal needle.

### #35890 REFRACTORY ELECTRICAL CARDIAC STORM DURING A TWIN PREGNANCY DELIVERY: A CHALLENGING CLINICAL CASE

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10.1136/rapm-2023-ESRA.452

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**Background and Aims** Electrical storm (ES) is a state of cardiac electrical instability characterized by multiple episodes of ventricular arrhythmias. It is a very rare condition during pregnancy, especially without a history of heart disease. We present a clinical case of a woman with a twin pregnancy who developed a very challenging and refractory ES.

**Methods** A 28-year-old woman with a bicorionic/biamniotic twin pregnancy and a history of anxiety presented to our center at 32 weeks of gestation due to dysuria and diarrhea, which started one day after she began taking quetiapine. She was admitted for evaluation and started on nifedipine for tocolysis. After one hour, the patient developed polymorphic ventricular tachycardia (VT) with significant hemodynamic instability. Due to the inefficacy of pharmacological and synchronized cardioversion, an emergent cesarean section was performed. The twins were born without complications. However, she maintained the VT and was admitted to the intensive care unit. After six days of numerous attempts at synchronized cardioversion and pharmacological therapy, a successful ablation of the apical focus of the left ventricle was performed, resulting in a return to sinus rhythm.

**Results** This case occurred in a pregnant woman with no previous heart disease. Ablation was not immediately available as a specialized team was required in our department. The only way to achieve hemodynamic improvement was through the use of isoproterenol. All the other drugs and synchronized cardioversion had no significant effect. She recovered after a few weeks with no significant morbidity.

**Conclusions** A structured, team-based management approach is paramount for these clinical cases