dura mater with a Touhy needle. Six hours after delivery, headache typical of PPHR started, so conservative treatment was instituted. Due to the lack of symptoms improvement, a sphenopalatine block was carried out with no symptomatic improvement. For that reason, a blood patch was decided upon, resulting in complete resolution of the symptoms and the patient was discharged the following day. That night, she returned to the hospital due to a relapse of severe headache. After discussing the case with a Neurology specialist, a Magnetic Resonance Imaging performed that showed no signs of cerebral spine fluid hypotension. Conservative treatment was decided. The patient was discharged 4 days later with partial improvement of her condition.
Results PPHR after performing a blood patch has been described. The risks and benefits of performing a new blood patch or conservative treatment must be weighed. Before starting treatment for PPHR, it is necessary to make a differential diagnosis with other causes of headache in the puerperium after performing neuraxial techniques.

#36452 PULMONARY EDEMA AS A FIRST PRESENTATION OF PREECLAMPSIA INTRAPARTUM

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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 We will attempt to review the pathophysiology of preeclampsia, the relevant literature and up-to-date guidelines regarding the appropriate measures for effective treatment of both preeclampsia and pulmonary edema and research the association of the aforementioned events with the newborn's pathology.
Methods We are going to present a singular case of a woman with preexisting, untreated, moderate hypertension before conception that developed preeclampsia during caesarian section under spinal anesthesia with acute pulmonary edema as the first presentation. The patient remained hemodynamically stable with minimal fluctuation of her blood pressure up until thirty minutes after delivery when she complained about dyspnea and severe headache with a concurrent spike in her blood pressure and auscultatory crackles in her lungs.
Results The patient was diagnosed early and treated successfully with diuretics, hypertensive therapy, supplementary oxygen and anti-Trendelenburg position with no further incidents until her discharge from PACU. The newborn developed ARDS minutes after birth requiring intubation and mechanical ventilation despite exhibiting no symptoms at the time of delivery.
Conclusions Pulmonary edema is a rare complication of pregnancy usually associated with preeclampsia and requires the immediate intervention of the anesthesiologist team when it occurs during delivery. Preeclampsia requires vigilant monitoring even after postpartum and the contribution of different specialists to ensure a positive outcome for both the mother and the infant.
Attachment Abstract – Pulmonary edema as a first symptom of preeclapmsia intrapartum.docx

#36240 ACUTE TRANSVERSE MYELITIS DURING PREGNANCY – IS NEURAXIAL ANAESTHESIA SAFE AND EFFECTIVE FOR CAESAREAN SECTION?

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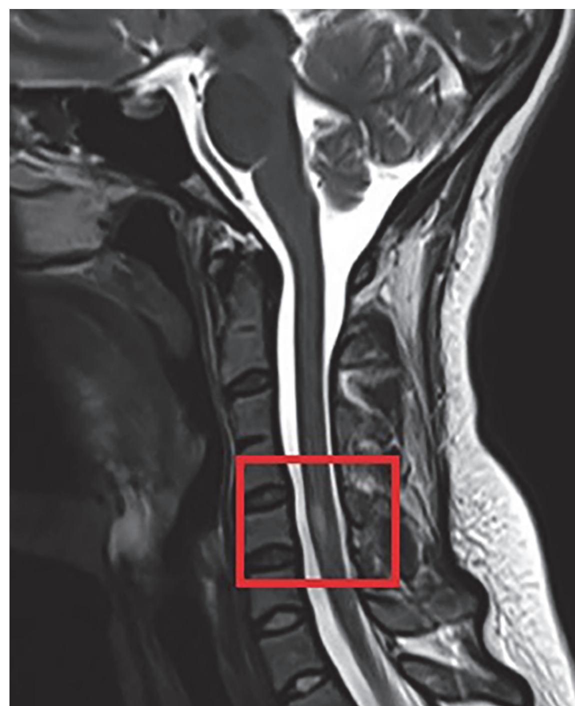
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)
Background and Aims Transverse myelitis (TM) is a rare immune-mediated spinal cord disorder. Acute TM during pregnancy is poorly described in the literature and anaesthetic management of these women is still conflicting.
Methods A 28-year-old patient was diagnosed with idiopathic TM at 15-weeks gestation. She had no medical history besides a previous caesarean section (CS) with neuraxial anaesthesia (NA). Symptoms began with paresthesias in the left lower limb and imaging of the spine revealed a medullary lesion at C5.
Results At 39 weeks, she was proposed for an elective CS. She had no neurological symptoms at the time. An epidural anaesthesia was performed by a senior anaesthesiologist at first attempt. A total of 14mL of 0.75% ropivacaine and 10ug sufentanil were administered. There was no sensory block after 20 minutes. The technique was considered failed and a general anaesthesia (GA) was performed, uneventfully.



Abstract #36240 Figure 1 Magnetic resonance imaging of the spine with medullary lesion at C5 level

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