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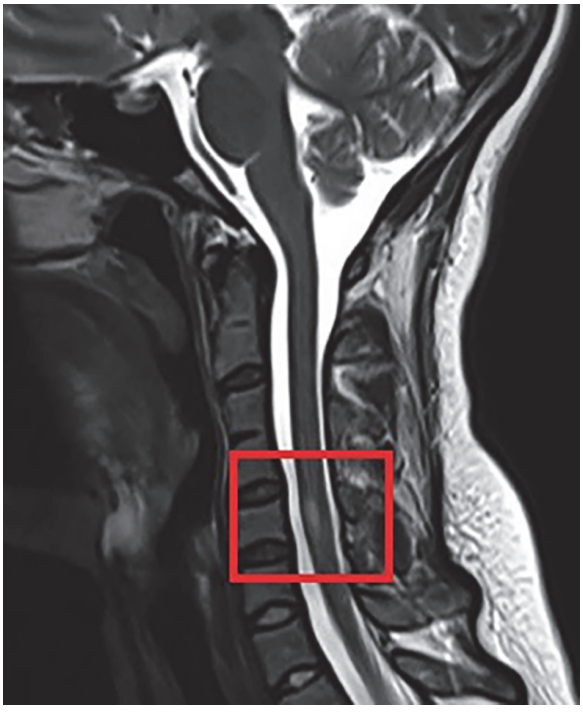
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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

Conclusions TM has occasionally been attributed to the use of NA and GA. It is also controversial whether patients acutely affected by or recovered from TM are at risk for disease recurrence when NA is administered. Nevertheless, GA is the most reported technique for CS and NA has increasingly been regarded as safe. To our knowledge, this is the first report of NA failure in a patient with history of TM and we cannot discard TM as the reason for failure. This report reaffirms the need for further investigations and the careful consideration of the risks and benefits of NA for CS of women affected by TM.

#36502 SPINAL ANAESTHESIA FOR CAESAREAN SECTION IN A PATIENT WITH CYSTIC FIBROSIS

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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 Cystic fibrosis (CF) is an autosomal recessive disease with predominant impact on respiratory and gastrointestinal system. Pregnant women with CF have a higher risk of complications during pregnancy and childbirth. We present a case of a successful caesarean section under spinal anaesthesia in a patient with CF with multiple comorbidities.

Methods A 25-year-old female with cystic fibrosis in 34th week of gestation was admitted to the hospital for a planned Caesarean section due to worsening symptoms of underlying disease and general condition. The patient was hospitalized several times due to exacerbation of pulmonary symptoms and was treated with antibiotics. Other diseases include diabetes mellitus type 2, asthma, hypothyroidism, bronchiectasis, chronic colonisation with Pseudomonas aeruginosa and MRSA, celiac disease, tachyarrhythmia and a history of Clostridium difficile enterocolitis. She required continuous corticosteroid therapy, oxygen supplementation with nasal catheter, insulin, thyroid hormones supplementation, inhalations and other medications used in treatment of CF. Latest arterial blood gases were in normal ranges (PaO2 13.465 kPa, PaCo2 5.332 kPa). For C-section, a mixture of 1.9ml 0.5% hyperbaric bupivacaine and 0.4ml fentanyl, based on a patent's height and weight, was applied intrathecally at the L2-L3 level with 27G needle.

Results The operation was successful and a healthy newborn was delivered. The patient's respiratory function was not impaired and she was discharged to the PACU with stable vital signs and no need for intensive care monitoring.

Conclusions In conclusion, we believe that a spinal anaesthesia with 'heavy' bupivacaine is good anaesthetic technique for pregnant women with severe cystic fibrosis.

#36411 MELKERSON ROSENTHAL SYNDROME AND LABOUR ANALGESIA: A CASE REPORT

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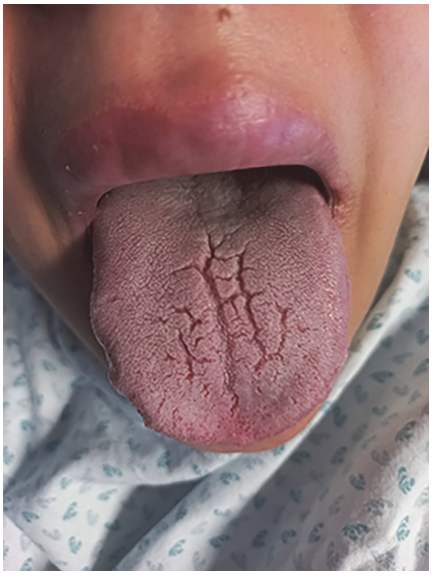
Background and Aims Melkerson rosenthal syndrome (MRS) is a rare condition characterized by recurrent episodes of facial edema, facial paralysis and fissured tongue. The anaesthetic concerns include increased risk of difficult airway caused by airway edema. Therefore, avoidance of triggers of histaminic release and use of regional anaesthesia whenever possible should be conducted. Corticosteroids and antihistamine drugs may be administered when facing airway instrumentation. Only a few published case reports of anaesthetic management were found, hence, we present a case of labour analgesia in a patient with confirmed diagnosis.

Methods A primiparous 28-year-old woman at term was admitted for labour induction. She had been diagnosed with MRS nine years ago and treated with oral deflazacort for two years, leading to remission ever since. Since then, mild exacerbations were resolved with topical corticotherapy. There were no known pharmacological triggers. She denied exacerbations during pregnancy. Airway examination showed no signs of difficult airway. She requested epidural analgesia, which was placed with no complications, followed by an initial bolus of 10 mL ropivacaine 0,2% and 10 mcg of sufentanil. Analgesia was maintained with 10 mL of 0,2% ropivacaine on demand.

Results Patient remained comfortable, hemodynamically stable, without signs or symptoms of exacerbation. Vaginal delivery occurred without complications.



Abstract #36411 Figure 1 Airway of the pregnant woman with Melkerson rosenthal syndrome