

(aOR) 4.61, 95%CI 1.19-17.77, $p=0.0266$), pre-operative pain score with movement (aOR 1.65, 95%CI 1.03-2.67, $p=0.0385$), anxiety about upcoming surgery (aOR 1.01, 95%CI 0.99-1.04, $p=0.4056$), higher pre-operative Hospital Anxiety and Depression Scale (HADS) subscale on anxiety (aOR 1.21, 95%CI 0.99-1.48, $p=0.0610$), and higher pre-operative central sensitization inventory (CSI) scores (aOR 1.04, 95%CI 0.99-1.10, $p=0.0915$) were associated with an increased risk of postpartum depression. Anticipated pain medication needs was associated with reduced risk of postpartum depression (aOR 0.59, 95%CI 0.31-1.12, $p=0.1041$). Internal cross validation and external validation AUC is 0.80 (95%CI 0.69-0.90) and 0.81 (95%CI 0.71-0.91) respectively.

Conclusions The proposed model performed well in our local population. Further refinement may be necessary to test the proposed model in other clinical settings of different social and cultural contexts.

EP042 SPINAL ANESTHESIA FOR C-SECTION IN A PATIENT WITH HEMOPHILIA A: CASE REPORT

Francisco Vaz Pereira*, Teresa Rocha Homem, José Guerreiro, Maria Teresa Rocha. *Anesthesiology, CHULC, Lisboa, Portugal*

10.1136/rapm-2023-ESRA.104

Background and Aims Hemophilia A is a hereditary coagulation disorder related to congenitally low levels of factor VIII. Although pregnant women with this condition are at risk of bleeding, these values typically rise during pregnancy. Multiple professional societies recommend factor VIII level above 50% for neuraxial approach and delivery.

Methods We report the successful management of a 35-year-old pregnant woman with hemophilia A (pregestational factor VIII values of 30%) undergoing C-section to minimize fetal vaginal trauma. Preoperative factor VIII level was 84%. After multidisciplinary discussion, spinal anesthesia was performed, using levobupivacaine 8mg, sufentanil 2.5µg and morphine 100µg. Standard ASA monitoring was used. Transient hypotension was managed successfully using phenylephrine 100mcg. Tranexamic acid was administered before the procedure and continued postoperatively. Surgery was uneventful and blood loss was estimated at 250mL. Postoperative intravenous analgesia was provided with paracetamol and ketorolac. The patient was transferred to the recovery room and discharged on postoperative day 3, without any complications.

Results Spinal anesthesia is a viable option for pregnant women with hemophilia A who require a C-section. The use of tranexamic acid and neuraxial techniques can help reduce the risk of bleeding, while avoiding general anesthesia. Epidural catheter was not used in this case due to the potential postpartum decreases in factor VIII levels. Adequate preoperative planning and multidisciplinary are crucial in managing these patients.

Conclusions Pregnant women with hemophilia A can safely undergo spinal anesthesia for a C-section with careful management and monitoring of factor VIII levels.

ePoster session 2 – Station 2

EP043 COMPARISON OF EFFICACY OF ULTRASOUND GUIDED THORACIC PARAVERTEBRAL BLOCK (TPVB) WITH COMBINED PECTORAL NERVE BLOCK (PEC) AND PECTO-INTERCOSTAL FASCIAL BLOCK (PICF) FOR PERIOPERATIVE ANALGESIA IN MODIFIED RADICAL MASTECTOMY: A RANDOMISED CONTROL TRIAL

¹Ajeet Kumar*, ²Adarsh M Shesagiri. ¹Additional Professor, Patna, India; ²Anaesthesia Junior Resident, AIIMS Patna, Patna, India

10.1136/rapm-2023-ESRA.105

Background and Aims TPVB is considered the gold standard for breast surgery but is associated with complications. Though PEC block has been used with good results, it spares the medial part of the breast. PIFB targets the anterior cutaneous branch of the intercostal nerve, which supplies the medial aspect of breast. We hypothesised that USG guided combined pectoral nerve block and pecto intercostal fascial block will provide better perioperative analgesia and less adverse effects in MRM patients as compared to paravertebral block.

Methods 30 ASA I and II patients posted for MRM under general anaesthesia were included in this double blinded RCT. Patients in Group A received US guided TPVB, whereas Group B received a combined PEC with PICF block. Post-operatively patients were administered intravenous morphine via patient-controlled analgesia (PCA) pump. Time to first rescue analgesia, total opioid consumption, NRS at various time intervals, Total rescue dose required, Patient satisfaction score were noted.

Results There was no difference in intraoperative opioid consumption. The time to first rescue analgesia was more in TPVB group (GA 673 min +/- 496) than PEC-PICF group. (GB 518 min +/-413). P value:0.18. The 24-hour opioid consumption (162+/-41.7mcg Vs 149+/-44.5mcg), median NRS scores (GA Rest2/Motion2 Vs GB Rest2/Motion3) and patient satisfaction (GA 2.6 vs GB 2.8) was similar in both the groups. There was no adverse effects in either groups. (vascular puncture, pneumothorax, vomiting).

Conclusions PECS block provides similar analgesia in terms of 24 hours opioid consumption, NRS scores and PSS in MRM patients. Further increase in sample size will validate our results.

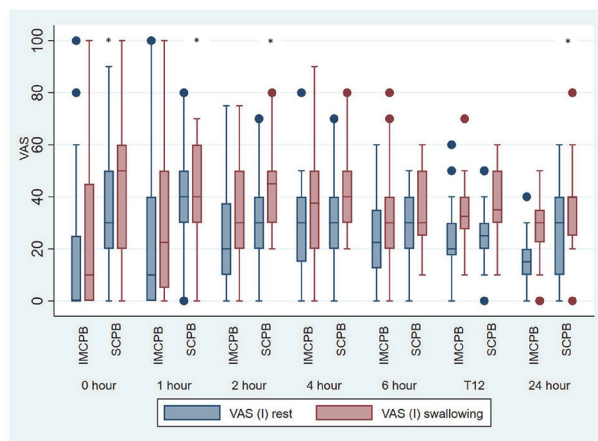
EP044 COMPARISON OF ULTRASOUND GUIDED BILATERAL INTERMEDIATE CERVICAL PLEXUS BLOCK AND SUPERFICIAL CERVICAL PLEXUS BLOCK IN PATIENTS UNDERGOING THYROID SURGERY UNDER GENERAL ANAESTHESIA

¹Abhinav Sharma, ¹Anjolie Chhabra*, ¹Debash Bhoi, ¹Bikash Ranjan Ray, ¹Rakesh Kumar, ²Anurag Srivastava, ³Karan Madan, ⁴Kalaivani Mani. ¹Anaesthesiology, All India Institute of Medical Sciences, New Delhi, New Delhi, India; ²Surgery, All India Institute of Medical Sciences, New Delhi, New Delhi, India; ³Pulmonary Medicine, All India Institute of Medical Sciences, New Delhi, New Delhi, India; ⁴Biostatistics, All India Institute of Medical Sciences, New Delhi, New Delhi, India

10.1136/rapm-2023-ESRA.106

Background and Aims Thyroid surgery maybe associated with mild-moderate pain, with 66-90% patients requiring opioids on the first postoperatively. This study compared superficial cervical plexus block (SCPB) [USG subcutaneous local anaesthetic (LA) injection at Erb's point] and intermediate CPB (IMCPB) [USG LA injection below posterior SCM border] for thyroid surgery under general anaesthesia. Primary outcome was 24-hr postoperative fentanyl requirement; secondary outcomes included time to first analgesic, 24-hr pain at rest and swallowing, pre and 20 min post block diaphragmatic excursions (normal, deep breathing, sniffing), diaphragmatic thickening fraction (TFdi), PFT (phrenic nerve function), hoarseness (RLN nerve function), Horner's syndrome and dermatomes blocked.

Methods Following ethics committee approval, 57 consenting ASA I-II, 18-75-year patients undergoing thyroidectomy were randomly allocated to IMCPB (n=28) or SCPB (n=29) groups. Ropivacaine 10ml, 0.375% was injected bilaterally, pre-induction in both groups.



P<0.05% is statistically significant

Abstract EP044 Figure 1 Incisional pain VAS (0-100mm) at rest and swallowing at 0,1,2,4,6 and 24 hours postoperatively

Abstract EP044 Table 1 Perioperative fentanyl requirement

Table 1: Perioperative fentanyl requirement.

Fentanyl requirement (mcg)	IMCPB [median (IQR)]	SCPB [median (IQR)]	P value
Intraoperative supplementary	0 (0-22.5)	30 (0-35)	0.0051*
Postoperative upto 24 hours (PCA+ clinical bolus)	380 (237.5-500)	630 (450-825)	0.0016*
Total peri-operative 24 hours	380 (242.5- 530)	690 (500-845)	0.0008*
Time for first rescue analgesic after surgery (mins)	120 (60-240)	30 (10-60)	0.003*

*P<0.05 is statistically significant.

Abstract EP044 Table 2 Diaphragmatic excursion and other adverse effects

Table 2: Diaphragmatic excursion and other adverse effects

Group	IMCPB	SCPB	P value
Right deep breathing			
Pre	3.46±1.05	3.30±0.81	0.509
Post	2.87±0.79	3.25±0.65	0.055
P value	0.005*	0.764	
Left deep breathing			
Pre	3.28±0.92	2.97±0.89	0.196
Post	2.91±0.95	3.16±0.96	0.330
P value	0.030*	0.804	
PEFR			
Pre	3.64±1.32	3.35±1.24	0.397
Post	3.35±1.22	3.23±1.33	0.713
P value	0.005*	0.366	
Ear lobe numbness	16	4	0.001*
Hoarseness	13	1	0.000*
Homer's syndrome	9	1	0.005*

* P<0.05 is statistically significant

Results C2-C4 dermatomes were blocked in both groups. 24-hr postoperative fentanyl requirement was significantly lower and time to first rescue analgesic was shorter in the IMCPB group. (table 1) VAS on rest and swallowing was significantly lower in the IMCPB group for 2-hrs and at 24-hrs. (figure 1) 53% IMCPB patients developed a sympathetic haemodynamic response 5min post-block that lasted for 30-45min. Diaphragmatic excursions on deep breathing and PEFR were significantly reduced in the IMCPB group. Incidence of hoarseness, ear lobe numbness, Horner's syndrome was significantly higher in the IMCPB group. (table 2)

Conclusions IMCPB resulted in better analgesia but more adverse effects. Further studies need to ascertain optimal LA dose for IMCPB in patients undergoing thyroid surgery.

EP045 A SURVEY OF REGIONAL ANAESTHETIC/ANALGESIC PRACTICES FOR ONCOLOGICAL BREAST SURGERY ACROSS THE UNITED KINGDOM

¹Matthew Brown, ¹John Schutzer-Weissmann, ²Haren Jothiraj, ¹Candice Ramdin, ¹Smita Lisa Alwin Almeida*. ¹Anaesthetics/Pain Medicine/Intensive Care, The Royal Marsden NHS Foundation Trust, London, UK; ²Anaesthetics/Pain Medicine/Intensive Care, Imperial College London, London, UK

10.1136/rapm-2023-ESRA.107

Background and Aims In 2020, 11.7% of cancers diagnosed were female breast cancers, making it the most common cancer worldwide(1). With alarming incidence, surgery remains the main modality of management of resectable breast cancer. Despite the PROSPECT(2) guidelines, the regional anaesthetic /analgesic practices for breast surgery vary greatly. This survey aims to determine the current regional anaesthetic/analgesic practices for oncological breast surgery across several centres of the UK.