Results Ultrasound measurement of SPD was equal to Touhy needle in 23/30 (76.7%), while overestimated in 1/30 (3.3%) by 0.2 cm and underestimated in 6/30 (20%) by a mean of 0.5 cm. BMI measurement of SPD was equal to Touhy needle in 0/30 (0%), while overestimated in 25/30 (83.3%) by a mean of 1.14 cm and underestimated in 5/30 (16.7%) by a mean of 0.29 cm. Ultrasound was more accurate than BMI in the measurement of SPD based on Wilcoxon signed-rank test (non-parametric) with a p-value <0.00001.

Conclusions Compared to BMI, ultrasound offers more accurate measurement of SPD.

108 POST-CESAREAN SECTION ANALGESIA WITH QUADRATUS LUMBORUM BLOCK 5 IN A PUERPERAL WOMAN: A CASE REPORT

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Background and Aims A 42-year-old pregnant woman refused neuroaxial anaesthesia for a scheduled cesarean section (c-section), therefore a balanced general anaesthesia was performed. The c-section was uneventful. Before extubation, in a supine position, an ultrasound guided lumbar bilateral quadratus lumborum block (QLB) 5 was performed with a single shot dose of 20 ml, per side, of ropivacaine 0.5%. During the first 24 hours post-operative, the patient remained comfortable, with paracetamol 1g every 8 hours, intravenously, without other analgesic medication.

Methods Different variations of QLB have been performed for analgesia after c-section, but Transmuscular QLB (T-QLB) is frequently chosen, due to long lasting duration and to better visceral analgesia, but the patient must be positioned in both lateral position alternately.¹

Results Recently Almeida *et al*,² described the QLB5 and the LAlat Block, the latter not for abdominal pain, using the same sonoanatomy of the T-QLB, but maintaining the supine position. The anesthetic is injected from anterior/lateral to posterior/medial direction between the psoas major muscle (PMM)

Abstract 108 Figure 1 Ultrasound image showing performance of a modified anterior QLB, a novel QLB 5. ESM, Erector spinae muscle; LA, Local anaesthetic.

and the quadratus lumborum muscle (QLM) (figure 1). The insertion point at QLB5 is anterior to the probe. This approach (QLB5) provides similar dispersion as the T-QLB; the gravid uterus or other abdominal structure are easily avoided as with the T-QLB; this happens because QLM functions as a safe path for the needle.

Conclusions The QLB5 is safe and allows prolonged abdominal (somatic and visceral) analgesia for post-c-section.

109 AN AUDIT OF RESPONSE TIMES TO EPIDURAL REQUESTS ON A BUSY UK LABOUR WARD

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Background and Aims Epidural analgesia is the gold standard for labour analgesia. Recently the availability and timing of an epidural has been topical in the UK news^{3,4,5}. The time from an anaesthetist being informed of epidural request to attendance should be less than 30 minutes; or 60 in exceptional circumstances. This single centre audit aims to assess anaesthetic attendance times according to the standards set by the OAA and AAGBI^{1,2}.

Methods We looked at all epidural requests over 3 months at a busy UK maternity unit. With each epidural, the time of request, the time of anaesthetist being informed and the time of attendance of anaesthetist were noted. Reasons for delays, including delays between the request and informing the anaesthetist were recorded.

Results 31 from 50 epidural requests had the anaesthetist attend within 30 minutes of being informed. The anaesthetist attended 37 times within 60 minutes of being informed.

The most common reasons for delay were unavailability of the anaesthetist, the anaesthetist not being informed, CTG concerns and awaiting blood results.

Conclusions Out of hours, one resident anaesthetist was on call with a non-resident consultant. If a case was on-going in theatre, this potentially delayed discussion for epidural. It highlights the need for additional resident labour ward anaesthetists at busy units in line with GPAS guidelines¹. In our unit we rolled out an educational program aimed at educating

Abstract 109 Table 1

Epidural time data	Total patients = 50
Anaesthetist attending within 30 minutes of being informed	31/50
Anaesthetist attending within 60 minutes of being informed	37/50
Anaesthetist attending within 30 minutes of initial request	27/50
Reason for delay documented in patient notes	35/50

Abstract 109 Table 2

Documented reasons for delay	Total documented reasons for delay = 35
Anaesthetist unavailable	10
Anaesthetist not informed	7
CTG concerns	5
Blood results unavailable	5
Lack of trained midwife	3
Delivery is likely imminent	2
Patient awaiting obstetric review	1
Equipment issues	1
Awaiting uterotonics to start	1

the multidisciplinary team on epidural provision and developed posters for the unit on the need to respond to epidural requests within 30 minutes.

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EARLY ONSET OF POST-DURAL PUNCTURE HEADACHE (PDPH) AND MENINGEAL SIGNS FOLLOWING URGENT CAESARIAN SECTION. A CASE REPORT

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Background and Aims 19-year-old parturient, ASA II, presented for the first time in the Ob/Gyn ER, reporting intense uterine contractions, multiparous (2 previous caesarian sections), 3 days of nausea and vomit, without fever, heavy smoker, and recent food uptake.

Methods Following the first ER screening the parturient underwent spinal anaesthesia (sitting position, 25G Quincke non-traumatic needle, first try, 12 mg chirocaine and 0.0 mg fentanyl). Intraprocedural vomiting, lowered BP, and dizziness were observed. The caesarian section was performed uneventfully.

Results 14h after the woman's re-admission, worsening headache even in prone position, nausea, tinnitus and photophobia were reported. Meningeal signs followed 24h p/o. Lab tests were repeated. Blood culture, cerebral CT scan, pupilloscopy and antibiotic prophylaxis were prescribed because meningitis was suspected. There was no suspicion of an early onset of PDPH despite CT-confirmed signs of intracranial hypotension. The woman was transferred to the nearest university hospital. Neurologists diagnosed iatrogenic PDPH due to intense intracranial hypotension confirmed by cerebral CT and MRI and by excluding bacterial infection (negative blood cultures, CSF testing), and treated the patient accordingly. The continuous supine position of the woman – incompatible with a rapidly worsening PDPH – and our belief in adequate anaesthetic technique, lead us to perform PCR on the remaining blood samples for viral infection markers and they came back positive with EBV infection.

Conclusions Neurologists' early conclusion of iatrogenic PDPH, CT images and early onset of symptoms, were in contrast with the adequate anaesthetic technique. That covered the true cause of the patient's worsening situation: meningeal irritation due to EBV infection.

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SPECIFIC FEATURES OF SPINAL ANESTHESIA DURING CAESAREAN SECTION WITH SEVERE CORONAVIRUS PNEUMONIA

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Background and Aims Spinal anesthesia (SA) is the main type of anesthesia for cesarean section (SC). Severe coronavirus pneumonia, which complicates the course of pregnancy, requires some adjuncts to provide SA.

Methods The safe conduct of SA was ensured by the temporary discontinuation of the use of heparin or low molecular weight heparins in the perioperative period. SA was

performed exclusively in the sitting position, then the patient was transferred to the horizontal position with the head end elevated by 30-45-60 degrees (depending on the needs). Respiratory support was used at all stages of preparation, performance, and administration of anesthesia: insufflation of humidified oxygen, high-flow oxygenation (HFO) through nasal cannula or face mask, and noninvasive mechanical lung ventilation through the face mask. Maintenance of normotension was provided by intravenous boluses of 50 µg phenylephrine.

Results The above-described features of SA were used by us during CS in 30 women in labor with severe coronavirus pneumonia. Compliance with the characteristics of SA caused by coronavirus pneumonia was expressed in the following: 1) sitting position – half sitting at all stages of the perioperative period; 2) constant respiratory support, mainly HFO; 3) early transfer to the pron-position in the postoperative period, accompanied by effective postoperative anesthesia for its provision; 5) a quick return to heparin therapy in therapeutic doses. This approach ensured that there was no need to use general anesthesia with tracheal intubation for CS.

Conclusions Supplemented with HFO, half-sitting SA is the method of choice for providing CS in labor with severe coronavirus pneumonia.

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NEUROFIBROMATOSIS TYPE 1 AND NEUROAXIAL TECHNIQUES FOR LABOUR AND DELIVERY. ARE THEY ALWAYS FEASIBLE AND SAFE? LAST FIVE YEAR EXPERIENCE IN A TERTIARY CENTRE

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Background and Aims Neurofibromatosis type (NF) 1 is an uncommon disease. Up to 9% of asymptomatic patients may have spinal tumours with potential enlargement during pregnancy¹. Its unintentional puncture can lead to bleeding and increased intracranial pressure. Brain tumours are described; scoliosis and preeclampsia are more frequent².

Therefore, the choice of the anaesthetic technique will be guided by risk/benefit ratio, being advisable recent neuroimaging. If any doubt, analgesia with opioids is an option or general anaesthesia if required.

Methods Gregorio Marañón University Hospital (Madrid, Spain) database was searched to identify obstetric patients with history of NF I between January 2016 and June 2021.

Results Two cases and three pregnancies were found:

A 25-yr-old at term was attended at two labours. She had no history of neuroaxial involvement throughout time; first eutocic delivery was done under uneventful epidural anaesthesia (neuroimaging available); 2 years later required episiotomy under local anaesthesia (patient's choice).

A 39-yr-old patient with peripheral neurofibromas history and no neurological follow-up required analgesia for labor, remifentanyl institutional PCA protocol was offered; but labour induction failed and c-section was done under general anaesthesia.

Conclusions Patients with NF-1 are a challenge to the obstetric anaesthesiologist and may complicate the management of labour analgesia. Neuroaxial techniques are not precluded but to be safely performed a case by case assessment and recent