

#36258 NEW ONSET COVID-19 RELATED THROMBOCYTOPENIA IN THE IMMEDIATE POSTPARTUM PERIOD: A CASE REPORT

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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 Gestational thrombocytopenia (GT) occurs in 5%-10% of women during the 3rd trimester or the immediate postpartum period. Coronavirus disease 2019 (COVID-19) related thrombocytopenia (CT) occurs in 5-40% of non-pregnant patients, and there are reports of its occurrence in pregnancy. GT increases the risk of peripartum haemorrhage and epidural hematoma following neuraxial techniques.

Methods We describe the management of a postpartum woman with CT and an epidural catheter in situ.

Results A 37-year-old primigravida, 37w+5d, was admitted to the labour ward. Pregnancy was uneventful and laboratory results of the admission were normal (table 1). An epidural catheter was placed for labour analgesia. Nine hours later, due to non-reassuring fetal status, an emergency C-section was performed under general anaesthesia, with an unremarkable intra-operative period. In the recovery unit, the patient started complaining of dyspnea and cough. Laboratory test results showed a positive PCR test for SARS-CoV-2 and new onset thrombocytopenia (56,000/ μ l). She required oxygen by nasal cannula for 48 hours and was closely monitored for the onset of neurological symptoms. The epidural catheter was removed when the platelet count became normal (72 hours later). The remaining postpartum period was uneventful.

Abstract #36258 Table 1 Laboratory investigations over time (third trimester, on admission and postpartum)

| | Third trimester | Admission | Postpartum (1h later) | Postpartum (24h later) | Postpartum (48h later) | Discharge (72h later) |
|--------------------------------|-----------------|-----------|-----------------------|------------------------|------------------------|-----------------------|
| Hemoglobin (g/dL) | 13,2 | 13,3 | 10,4 | 10,3 | 9,4 | 10,5 |
| Leukocytes ($\times 10^9$ /L) | 6,66 | 6,45 | 5,86 | 16,00 | 11,34 | 11,63 |
| Lymphocytes (%) | 18,8 | 18,6 | 2,7 | 6,9 | 13,4 | 12,6 |
| Platelets ($\times 10^9$ /L) | 237 | 209 | 56 | 89 | 94 | 143 |
| aPTT (sec) | | | 40,9 | 39,3 | 32,8 | |
| PT (sec) | | | 15,7 | 14,4 | 12,1 | |
| Fibrinogen (mg/dL) | | | 311 | 472 | 539 | |

Conclusions This case emphasizes that CT may develop quickly and present before respiratory symptoms. In this case, the existence of a normal complete blood count on admission helped establish the onset of thrombocytopenia. A falling platelet count indicates a worsening of COVID, thus reinforcing the importance of close monitoring and follow-up. Other causes of thrombocytopenia, both pregnancy and non-pregnancy related should be ruled out.

#35960 ACCIDENTAL DURAL PUNCTURE IN A MORBIDLY OBESE PREGNANT WOMAN: WHAT NOW? – CASE REPORT

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Background and Aims Spinal-epidural anesthesia is a well-established technique for performing cesarian-section. Accidental dural puncture during this procedure is a possible complication, especially in obese obstetric patients.

Methods A morbidly obese 30-year-old with a body mass index of 59 was proposed for elective cesarian-section and myomectomy. We performed a spinal- epidural technique, and there was an accidental dural puncture with a Tuohy needle 18G. Given her phenotype, we had previously discussed the possibility of introducing the catheter in the intrathecal space if this complication took place. We followed up with our plan B, which allowed the administration of continuous spinal anesthesia. At the end of surgery, we administered intrathecal morphine, and the catheter was removed.

Results The surgery lasted one and half hours, and the patient was always hemodynamically stable. The newborn had an Apgar score of 9/10/10. We explained the potential complications to the patient, and she was evaluated daily during her hospital stay, without developing headache or other symptoms. There was no record of her visiting urgent care in the following days.

Conclusions We need to be alert for the higher possibility of accidental dural puncture in obese pregnant women, the complications that might arise, and, as such, always have a plan B. In this case, we were able to provide optimal surgical conditions and effective post operative analgesia.

#36212 POST-PUNCTURE HEADACHE RECURRENCE (PPHR) AFTER A BLOOD PATCH – A CLINICAL CASE

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Background and Aims Post-Puncture Headache Recurrence (PPHR) is a complication of performing neuraxial techniques. Performing a blood patch is a recognized treatment with a high success rate, however, recurrence of headaches after it has been described.

Methods Clinical case: 33 years pregnant. Admitted for induction of labor. An epidural block was performed for labor analgesia, which complicated with accidental perforation of the

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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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 preeclampsia intrapartum.docx

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

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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