P.17 Post-dural puncture headache: data from a UK tertiary centre 2018–2021 and the effect of the SARS-CoV-2 pandemic
A. Hassan, C. McGlennan, T. Christmas
Addenbrooke’s and The Rosie Hospitals, Cambridge University Hospitals NHS Trust, UK

Introduction: Post-dural puncture headache (PDPH) is caused by cerebrospinal fluid (CSF) leakage through an accidental or intentional dural puncture. It is typically positional and accompanied by neck stiffness and auditory symptoms. It can cause significant morbidity and, in the 2009–2012 MBRRACE-UK report, was linked to the death of two women [1]. The risk of accidental dural puncture with epidural analgesia is widely quoted as 1% [2]. PDPH following spinal anaesthesia is more variably quoted as 0.5–1% but subject to unit variation. We assessed PDPH rate in our UK tertiary obstetric unit for the four years 2018–2021, to determine if we were providing accurate risk data to women and to ascertain whether the pandemic had had an effect on local complication rates.

Methods: Following audit department approval, a Microsoft Excel database was collated for all anaesthesia complications in our obstetric unit from January 2018 to December 2021 inclusive. Denominator data were taken from our Trust Births and Deliveries database. Statistical analysis was performed using percentages and chi squared tests with significance set at P < 0.05.

Results: In the four years 2018–2021, the overall rate of PDPH was 1.28% for all neuraxial blocks. PDPH occurred after epidural analgesia in 1.45%, with 46% requiring an epidural blood patch (EBP) and 6% requiring repeat EBP. The rate of PDPH after spinal anaesthesia was 0.92%, with 31% requiring an EBP, with no repeated EBP. Further sub-analysis looked at PDPH rates pre-(2018–19) and post- (2020–21) pandemic. There was no significant difference between overall rates of PDPH (p = 0.93), the rate after epidural analgesia (P = 0.95) or the rate after spinal anaesthesia (P = 0.86).

Discussion: Our current local practice is to quote a 1 in 100 (1%) and 1 in 500 (0.2%) risk of PDPH after epidural and spinal procedures, respectively. Our actual rates of PDPH exceed these, particularly for spinal anaesthesia. Further analysis would need to be undertaken to identify contributing factors. Amending the quoted risk rates should be considered and consideration given to the wider use of spinal needles smaller than our standard 25G. EBP is performed in less than half of those with a PDPH and very few require repeat procedures. The SARS-CoV-2 pandemic appears to have had no influence on our PDPH rates and is a testament to the Trust’s recognition that preserving the safe delivery of maternity services was paramount during the pandemic.

References
2. OAA Epidural Information Card. www.labourpains.com/Epidural-Information-Card


P.18 Evaluating the impact of intrathecal morphine during the COVID-19 pandemic on category 4 caesarean delivery with respect to enhanced recovery outcomes
K. Makam, T. Namik, R. Jayaraj
University Hospitals of Leicester, UK

Introduction: Enhanced recovery after surgery protocols for elective caesarean section (CS) have been in place in our institution since 2017. The intrathecal opioid of choice was diamorphine, however due to a national shortage this was switched to morphine for all elective patients, in the background of a global pandemic. We evaluated whether this switch had any bearing on ERAS outcomes. In addition, we looked at consumption of opioids, anti-emetics and anti-pruritics. All patients received prophylactic anti-emetics intraoperatively.

Methods: Data were collected across the two maternity sites at the University Hospitals of Leicester Trust over the month of January 2021. Using the Euroking system we identified 76 patients, 10 of whom were excluded from the analysis due to incorrect coding. We interrogated the medical notes and online prescription system to obtain relevant data. Postpartum opioid use was calculated in mg-morphine equivalents (MMEQ).

Results: Data from the 66 patients were analysed. The Table shows rates of discharge and readmission were improved compared to a previous audit in 2018. The majority of those staying as an inpatient for >48 h were due to neonatal reasons. Two patients required a prolonged stay due to pain and anaemia. Only one patient required readmission. Mean time for requesting first opioid analgesia was just over 5 and half hours with a mean opioid requirement over 24 h of 17 mg MMEQ. 7 patients required anti-emetics and 12 required anti-pruritics.

Table: Comparison of outcomes.

<table>
<thead>
<tr>
<th>March 2017*</th>
<th>January 2018</th>
<th>January 2021</th>
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</thead>
<tbody>
<tr>
<td>Electives CS</td>
<td>109</td>
<td>90</td>
</tr>
<tr>
<td>Mean length of stay (h)</td>
<td>67</td>
<td>53</td>
</tr>
<tr>
<td>Readmissions</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Urinary catheter duration (h)</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>Re-catheterisation</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

*Pre enhanced recovery

Discussion: The switch to intrathecal morphine did not cause a detrimental effect in discharge rates or readmissions. Results show that the time to urinary catheter removal was shorter and discharge earlier with no increase in readmissions. Opioid consumption was similar to results in other studies [1], with shorter length of stay compared to other published data [2]. Improvements are due in part to greater familiarity of staff with enhanced recovery protocols and a greater drive during the pandemic for discharge.

References