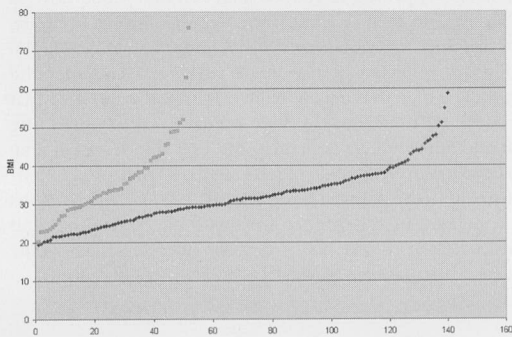


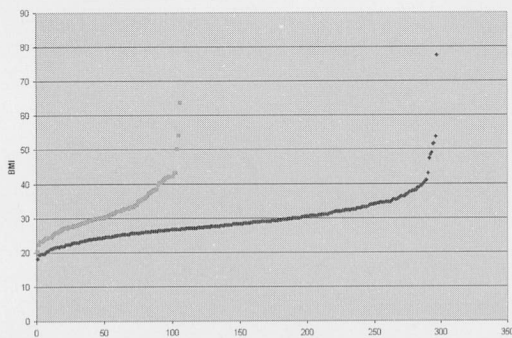
A33

DOES ETHNIC ORIGIN AFFECT RELATIONSHIP OF BMI AND INCIDENCE OF CS? *Bell, E.¹; Olufolabi, A.¹; Hartle, A.²* 1. *Anesthesiology, Duke University Medical Center, Durham, NC;* 2. *Consultant Anaesthetist, St Mary's Hospital, London, United Kingdom* **Introduction:** A prospective cohort of US adults demonstrated significant racial differences in mortality among whites compared to blacks with high BMIs. Could racial differences alter the relationship of BMI to CS as well? **Methods:** A prospective cohort of all patients presenting in the same two weeks at four centers (two academic and two community hospitals) were followed. Data on mode of delivery, BMI, estimated gestational age, single versus multiple gestation, age, race and weight were analyzed. **Results:** Data were collected on 1,007 patients. The overall relationship of BMI to CS was similar in each major racial group represented (African, Caucasian, Hispanic and Asian Americans). **Conclusions:** The relationship of BMI to CS appears to apply to major US ethnic groups. Larger studies may explain the difference in magnitude of effect among groups.

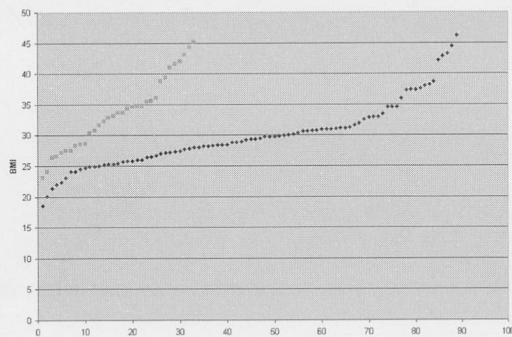
African American BMI and CS



Caucasian American BMI and CS



Hispanic American BMI and CS



A34

SPINAL IS SAFER THAN GA FOR LSCS IN ECLAMPTICS *Razzaque, M.¹; Rahman, K.²; Sasbidbaran, R.¹* 1. *Anesthesiology, The Royal London Hospital, London, United Kingdom;* 2. *Anaesthesiology, Medical College Hospital, Dhaka, Bangladesh* **Introduction:** Complications of GA for LSCS remains the leading cause of anaesthetic related maternal mortality(1). Most experts consider GA as a safer option for LSCS in severe pre-eclampsia and eclamptics(2),(3). DMCH is a tertiary referral teaching hospital in Bangladesh. In this institute, spinal is the technique of choice for LSCS in eclamptic women. **Method:** The audit data for eclamptic having LSCS between 1 Jan 1998 and 31 Dec 1999 was reviewed. **Results:** The data shows that the eclamptic having LSCS done under spinal have a lower mortality rate than those who have GA. No incidence of epidural haematoma was reported in women having spinal. **Conclusion:** We conclude that the audit data from DMCH show that the eclamptic patients having caesarean done under spinal block have a lower mortality rate than those who have GA. **Reference:** 1. Hawkins P. IJOA 1979-1990, Anaesthesiology 1997;86: 277-284 2. Howell P. IJOA 1998;7:217-219 3. Brodie H. IJOA 1998; 8:110-124

	Number	%
Total Obs Admission	21,744	
Antepartum eclampsia	1846	9%
Eclamptics having LSCS	1185/1505	79%
Spinals	915/1185	77%
GA	270/1185	23%
Deaths in eclampsia	176/1846	10%
Deaths - LSCS	58/1846	3%
Deaths - spinal	31/915	3%
Deaths - GA	27/270	10%

POSTER REVIEW #2

A35

(Poster 25)

EC80-EC95 OF BUPIV AND ROPIV PLUS FENT FOR LABOR EPIDURAL ANALGESIA *Campbell, D.C.; Zwack, R.M.; Breen, T.W.; Yip, R.W.* *Anesthesiology, University of Saskatchewan, Saskatoon, SK, Canada* **Introduction:** 20 ml of either 0.08% ropiv (R) or 0.08% bupiv (B) combined with 2 µg/ml fentanyl (F) effectively initiates labor epidural analgesia (LEA) in >95% of women (1). The conc of 20 ml of either B or R (without F) necessary to initiate LEA in "50%" of women (EC50 or MLAC) are significantly different, suggesting a difference in potency, thereby questioning the validity of studies comparing equimolar solutions of B and R for LEA (2,3). However, clinically relevant conc (i.e. EC80 - EC95) of 20 ml of R and B combined with F have yet to be determined. The EC50 (MLAC) of 20 ml of B combined with 2 µg/ml F is reportedly 0.05% for initiation of LEA (4). This P, R, D-B study was designed to determine the conc of B and R, combined with 2 µg/ml F, that represent their respective EC80-EC95 for initiation of LEA. **Methods:** Following IRB approval and informed consent, laboring women, < 5 cm dilated, were randomized to receive 20 ml of study solution. Each study solution contained 2 µg/ml F combined with 0.08%, 0.07%, or 0.06% B or R. Analgesic Outcome was defined as follows: Analgesic Success: VASP ≤10/100 at 20 min Analgesic Failure: VASP >10/100 at 20 min Unable to Assess: VASP >10/100 at 20 min + Perineal Press + Cx ≥7 cm Technical Failure: VASP >10/100 at 20 min +/- Unilat., Patchy or No Block with additional 10 ml 2% Lido **Results:** 119 women have been enrolled. 45 received 0.08%, 4 (1 BF; 3 RF) Unable to Assess; 1 BF Technical Failure; 100% remaining BF (20/20) and RF (20/20) Analgesic Success (i.e. 0.08% BF = EC100; 0.08% RF = EC100). 41 received 0.07%, 1 BF Unable to Assess; 90% BF (18/20) and 90% RF (18/20) Analgesic Success (i.e. 0.07% BF = EC90; 0.07% RF = EC90). 32/40 received 0.06% to date. **Discussion:** This RCT indicates that 20 ml of BF and RF are equipotent for initiation of LEA at clinically relevant concentrations. **Reference:** 1) *Anesth Analg* 90:1384-9,2000; 2) *BJA* 82:371-3,1999; 3) *Anesthesiology* 90:944-50,1999; 4) *BJA* 78:493-7,1997