A54 **(Poster 44)**

WHAT DO PREGNANT WOMEN KNOW ABOUT PAIN RELIEF AND EPIDURAL ANALGESIA? *Celesia, M.C.[1]; Scavuzzo, H.G.[2]; Fernández, C.L.[1] 1. Hosp. R. Sardá, Bs As, Argentina; 2. Hosp. Alemán, Bs As, Argentina* **Introduction:** Pregnant women often do not have complete knowledge of the modalities available for pain relief during labor. In the current study, we evaluated the awareness of pregnant women for labor to be painful and the methods available for pain relief. **Method:** A confidential survey form was administered to 80 pregnant women who attended the pre-natal classes at the Maternidad del Hospital Alemán (Paid Private hospital, Group "A" = 40 patients) and at the Maternidad R. Sardá (Free Public Hospital, Group "B" = 40 patients). **Results:** 89% of the patients from Group "A" and 80% of the patients from Group "B" recognized that labor and delivery could be a painful process. About 92% of the patients from Group "A" and 72% from Group "B" considered that pain relief was suitable. About 82% of the patients from Group "A" and 67% from Group "B" were generally aware of the existence of epidural analgesia for delivery. However, the information they had been given only allowed 44% of the patients in Group "A" and 25% in the Group "B" to have specific knowledge about the techniques, risks and benefits of epidural analgesia. Indeed, an overwhelming proportion of women, 98% of the patients from Group "A" and 88% from Group "B" requested additional specific information on epidural analgesia. **Conclusions:** Both groups acknowledged that labor and delivery could be painful. However, patients often had little information about the existing methods of pain relief during labor and the information they had was not always correct. The anesthesiologist, by attending childbirth preparation classes, can provide patients with more specific information about options for pain relief during labor. **Reference:** Reynolds Felicity. Labour pain and analgesia in Pain Relief in Labour. BMJ 1997; pp. 1–13 (more references available)

A55 **(Poster 45)**

DELAYED ADRIAMYCIN-INDUCED PERIPARTUM CARDIOMYOPATHY *Pan, P.H.; Moore, C.; Ross, V.; Justis, G. Anesth, MCV, Richmond, VA* The authors present 3 case reports in 2 otherwise asymptomatic pts with delayed adriamycin-induced peripartum cardiomyopathy. GP is a 30 y/o G1 WF with IUP 34 wks and Hx of osteosarcoma treated with hemipelvectomy and adriamycin 20 yrs ago; and severe scoliosis. She has been very active and asymptomatic with good exercise tolerance until pregnancy. She was admitted to ICU by cardiologist for pulmonary edema and cardiomyopathy with EF 15%, CO 3.5, PA 50/20, PCWP 18 and SVR 950 and moderate MR. She was optimized by diuresis and requiring max dose of milrinone, dobutamine and lidocaine to maintain stability. To prevent CV deterioration, semi-urgent C/S was planned. Given her stable status on inotropes, a low dose CSE technique(intrathecal 6mg bupiv, 25 ug fentanyl, 50ug epi, followed by titrating epid 8 cc 2% lido with epi)was used to obtain a T6 level. Instead of usual LR preload, 100 cc 25% albumin was titrated in during & after the CSE. Pt and fetus tolerated anesth and surg procedure with no complication; and pt was weaned off iontropes in 24 - 48hrs and discharged on 3rd day. ID is a 35 y/o G3P1 WF with IUP 35 wks with similar Hx as GP. She was active and asymptomatic until last pregnancy (3yrs ago), during which she developed pul edema with EF 35%. She was tx with diuresis followed by labor induction. A low conc labor epidural with narcotic was administered successfully. During the present pregnancy, she presented with pul edema and EF of 25%; again improving upon diuresis followed with labor induction. A CSE with intrathecal sufenta 7.5ug, bupiv 1.25mg & 50 ug epi was administered. Pt and fetus tolerated anesth and delivery without complications and home on 3rd day. Pregnancy can unmask the CV damages caused by adriamycin even from the remote past in otherwise asymptomatic pts. Regional anesthesia can be administered cautiously in these pts with excellent outcomes if we perform it with precision and careful attentions to details in volume, block level, drug dose and hemodynamics.

A56 **(Poster 46)**

POSTDURAL PUNCTURE HEADACHE: USING THE DATABASE AS A QI TOOL TO CHANGE PRACTICE *Olufolabi, A.; Bell, E.; Muir, H. Anesthesiology, Duke University, Durham, NC* **Introduction:** Headache (PDPH) following dural puncture (DP) is a recurring morbidity in obstetric anesthesia. Could patient characteristics and practice patterns be identified and changes made to reduce its incidence? **Method:** Retrospective analysis of patients' weight, operator, technique (difficulty encountered), time of epidural placement, period from DP to EBP and duration and pattern of symptoms were undertaken for the period including 09/99–12/2000. **Results:** Incidence - 50 of 3200 (1.6 %) blocks were associated with either DP or PDPH. Operator - Most DP occurred with residents - 39/45 (86%) Patient - 75% weighed < 200 lbs. Technique -1st attempt at LOR and immediate dural puncture occurred in 15/50 (30%) -9 /15 were <200Lb, with 70% of DP occurring with multiple attempt Time - time of placement was available for only 31 patients, 20/31 (60%) of blocks were placed at end of shift or at night. Symptoms -24/50 patients had an EBP with 4/24 requiring a 2nd EBP, all on day 4 post DP- 4/7 who had EBP on day1or 2 required a 2nd patch. 18/50 (36%) patients identified continued to have significant symptoms at or after day 5. 20% of patients had persistent non-positional symptoms following an EBP. **Conclusions:**Operator experience and level of fatigue are factors associated with DP. Patient size does not seem to be a factor, but perceived technical difficulty may be. Based on these findings we recommended and instituted the following changes to improve outcome of care: We altered the anesthesia record to identify the operator at time of DP.Operators with persistent complications are identified for closer supervision. Attendings are encouraged to rescue blocks from residents when >2 attempts are made. Performing EBP before day 3 increases risk of 2nd EBP. An extended telephone follow-up (minimum 7days) was initiated to identify persistent symptoms. Maximum shift length on OB is 12 hours.

A57 **(Poster 47)**

QUALITY IMPROVEMENT USING AN OBSERVATIONAL DATABASE: TREATMENT OF PDPH *Olufolabi, A.; Bell, E.; Muir, H. Anesthesiology, Duke Medical Center, Durham, NC* **Introduction:** Headache (PDPH) following dural puncture (DP) is a recurring morbidity in obstetric anesthesia. Could patient characteristics and practice patterns be identified and changes made to reduce its incidence? **Method:** Retrospective analysis of patients' weight, operator, technique (difficulty encountered), time of epidural placement, period from DP to EBP and duration and pattern of symptoms were undertaken for the period including 09/99–12/2000. **Results:** Incidence - 50 of 3200 (1.6%) blocks were associated with either DP or PDPH. Operator - Most DP occurred with residents - 39/45 (86%). Patient - 75% weighed < 200 Lb. Technique - 1st attempt at LOR and immediate dural puncture occurred in 15/50 (30%) - 9 /15 were <200Lb, with 70% of DP occurring with multiple attempt. Time - time of placement was available for only 31 patients, 20/31 (60%) of blocks were placed at end of shift or at night. Symptoms - 24/50 patients had an EBP with 4/24 requiring a 2nd EBP, all on day 4 post DP- 4/7 who had EBP on day 1 or 2 required a 2nd patch. 18/50 (36%) patients identified continued to have significant symptoms at or after day 5. 20% of patients had persistent non-positional symptoms following an EBP. **Conclusions:** Operator experience and level of fatigue are factors associated with DP. Patient size does not seem to be a factor, but perceived technical difficulty may be. Based on these findings we recommended and instituted the following changes to improve outcome of care: We altered the anesthesia record to identify the operator at time of DP. Operators with persistent complications are identified for closer supervision. Attendings are encouraged to rescue blocks from residents when >2 attempts are made. Performing EBP before day 3 increases risk of 2nd EBP. An extended telephone follow-up (minimum 7days) was initiated to identify persistent symptoms. Maximum shift length on OB is 12 hours.

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