Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

infusion. Elective forceps use at delivery aimed to avoid tumour compression by fundal pressure. The patient remained hypertensive post-delivery until switched from doxazosin to phenoxybenzamine. PDPH required an epidural blood patch. Laparoscopic adrenalectomy was performed nine weeks postpartum, with histology confirming phaeochromocytoma.

Discussion: Phaeochromocytoma is an important differential in atypical severe hypertension in pregnancy. Misdiagnosis as pre-eclampsia can easily occur with disastrous results; with deaths featuring in MBRRACE reports [1]. Doxazosin has a lower feto-maternal ratio than phenoxybenzamine so may be the preferred option for alpha blockade in pregnancy [2]. Anaesthetic considerations include hypertensive crises from catecholamine release and alpha/beta blockade producing resistance to vasopressors with potential for uncontrolled hypotension in response to regional anaesthesia.

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Int J Obstet Anesth, 50 (2022) 103380
doi:10.1016/j.ijoa.2022.103380

P.85 Severe SARS-CoV-2 in pregnancy

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Introduction: Pregnant women appear no more or less likely to contract SARS-CoV-2 infection than the non-pregnant population [1]. However, similar to other viral illnesses, they are at increased risk of developing severe disease, particularly in the third trimester of pregnancy. With patient consent we describe a case of severe SARS-CoV-2 in pregnancy, resulting in respiratory failure associated with a protracted and tumultuous intensive care (ICU) admission.

Case Report: A 30-year-old primigravida (non-smoker, booking BMI 50 kg/m^2) presented at 32 weeks gestation with cough, fever and tachycardia. A viral PCR swab was positive for SARS-CoV-2. She received supportive therapy and steroids. On day 4 (D4), an MDT decision was made to deliver due to increasing oxygen requirement. A caesarean section under spinal anaesthesia was uneventful. Despite initial post-op improvement, she deteriorated further with increasing oxygen requirements and was transferred to ICU. She received remdesivir. Unfortunately, her condition worsened and she was intubated on D6. Her ICU course was complex and protracted and included: failed trial of extubation on D28, cardiac arrest on D29 while in the prone position, bacterial pneumonia, pulmonary embolism, kidney injury and filtration, Clostridium difficile infection, critical care neuropathy, venous thromboembolism, pulmonary hypertension (RV pressures 55–60 mmHg, dilated right ventricle with reduced systolic function) and low mood. Her case was discussed with the local ECMO unit but she did not meet criteria for transfer. She underwent a surgical tracheostomy on D45. After a prolonged respiratory wean, she was eventually decannulated on D96 and stepped down to a medical ward on D101. She was discharged for rehabilitation on D113 and discharged home on D139. A year from the initial presentation, she has returned to her pre-morbid activity level.

Discussion: The MBRRACE-UK rapid COVID-19 report found that 10% of pregnant patients admitted to hospital with symptoms of SARS-CoV-2 were admitted to ICU, and 0.4% died [2]. Despite receiving treatment strategies available at the time of her illness, our patient suffered multiple complications of COVID-19. Since the start of the pandemic, there have been significant advances in treatment strategies for COVID-19. Pregnant women must receive the same therapeutic interventions as non-pregnant to minimise the risk of severe complicated infection. The RCOG recommends that all women should be offered vaccination.

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Int J Obstet Anesth, 50 (2022) 103381
doi:10.1016/j.ijoa.2022.103381

P.86 Arachnoiditis following epidural blood patch

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Introduction: Epidural blood patch (EBP) is a common and effective treatment for post-dural puncture headache (PDPH) in obstetrics and is recommended in UK national guidelines [1]. Serious neurological complications following EBP are rare and not well understood. We report a further case of arachnoiditis in a patient having undergone EBP for PDPH following epidural analgesia for labour.

Case Report: A nulliparous 40-year-old woman attended Delivery Suite for induction of labour. She requested epidural analgesia which was sited by a senior anaesthetist around midday. Insertion was difficult, requiring attempts at two different spinal levels. Analgesia was inadequate and the epidural needed re-siting a few hours later. Five days post-delivery, the patient presented to the maternity assessment unit with symptoms consistent with low pressure headache. An epidural blood patch was successfully and uneventfully performed that same day by two consultant anaesthetists. On day 10 the patient re-presented with severe back pain and left sided sciatica. An urgent lumbar MRI scan was sought, which showed intrathecal haematoma with a subdural collection and marked clumping of the distal cauda equina nerve roots from L4 down, in keeping with arachnoiditis. After urgent consults with neurology, neurosurgery and microbiology, the patient was started on IV linezolid. Over the next three days the patient developed increasing intensity of back pain as well as a headache with mild pyrexia but repeat MRI showed marginal improvement of the haematoma. By day 14 the patient's symptoms were much improved and she was discharged home with oral analgesics and oral linezolid. At her 6-week outpatient review she had mild residual symptoms and repeat MRI showed only mild persistent clumping at L5.

Discussion: A recent case report and literature review described seven further cases of arachnoiditis following EBP for PDPH in obstetric patients [2]. The cause of the arachnoiditis is presumed (as in this case) to be inadvertent intrathecal injection of autologous blood causing inflammation of the nerve roots. Management strategies include antibiotics, intravenous steroids and analgesia, though no consensus