Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC78

Near Death Experience of Maternal Cardiac Arrest Survivor
Niekoo Abbasion, M.D., Heather Nixon, M.D., Department of Anesthesiology, University of Illinois at Chicago, Chicago, IL.
A near death experience (NDE) is a state of consciousness occurring during a period of impending or actual death. The experiences can involve a number of different components including a feeling of well-being or peace, out of body experiences, seeing a bright light, and entering another realm. We report the first case of an NDE during a cardiac arrest of a patient undergoing Cesarean delivery. During her recovery after successful resuscitation, the patient was able to correctly identify the individual who performed chest compressions even though this would have been impossible secondary to the surgical drape and taping of the eyes.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC79

Anesthetic Considerations for an Exit Procedure
Richard S. Abraham, M.D., Jacqueline Tutiven, M.D., Bruce Saltzman, M.D., Anesthesiology, University of Miami, Miami, FL.
In this presentation, we will discuss the anesthetic management of a 38 week fetus with a large anterior neck teratoma, undergoing an initial attempt at fetoscopic intubation and later an EXIT procedure. We will briefly review the anesthetic implications of providing fetoscopic anesthesia. The anesthetic management of the EXIT procedure will be discussed, including preoperative preparation, necessary monitors, important personnel and equipment, techniques for maintaining and evaluating placental circulation, and other anesthetic considerations.
Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC80
A Case of Lumbar Subarachnoid Hemorrhage in Pregnancy Revealed Yet Unrelated to Spinal Anesthesia
Adam C. Adler, M.D., Poornachandran Manikantan, M.D., Anesthesiology and Pain Medicine, Baystate Medical Center, Springfield, MA.
A 32 year-old female with pre-eclampsia presented for cesarean delivery and was found to have leg weakness reported after spinal attempts. MRI revealed lumbosacral subdural and subarachnoid blood felt to be unrelated to the neuraxial anesthesia attempts. The main cause of spinal subarachnoid/subdural hemorrhage in pregnancy is generally a result of neuraxial anesthesia. However, in this case, the patient revealed that the lower extremity symptoms began days before the spinal anesthesia attempts. The subarachnoid blood was felt to have an alternative etiology, prompting a thorough review of the differential diagnosis of lumbar subarachnoid hemorrhage in the parturient.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC81
Adventures in OB Anesthesia: Cesarean Delivery in a Patient With Biventricular Masses With Standby ECMO
Arielle D. Butterly, M.D., Nadya M. Dhanani, M.D., Fumito Ichinose, M.D., Meredith A. Albrecht, M.D., Ph.D., Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston, MA.
A 38 year-old G2P0 at 34 wks GA was admitted with headaches, vision loss, neck pain, fever and multiple embolic strokes. She had peripheral eosinophilia of 33%. A TTE revealed biventricular masses (partially obliterating the LV cavity) with a preserved EF. The right ventricle was aneurysmal and akinetic. Two days after admission she developed signs of preeclampsia necessitating cesarean delivery. ECMO was on standby in case of precipitous cardiac collapse. The delivery was completed under epidural anesthesia with an arterial line. Postoperative workup revealed severe iron deficiency anemia leading to soil ingestion and parasitic eosinophilic myocarditis (Toxocara and Trichinella).

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC82
Anesthetic Management of a Parturient With Thrombotic Thrombocytopenic Purpura
Saravanan P. Ankichetty, M.D., M.B.A., Marcos Silva, M.D., Pamela Angle, M.D., Stephen Halpern, M.D., Anesthesia, Sunny Brook Health Sciences Centre, Toronto, ON, Canada.
A 41 year-old multiparous parturient with PIH, requested labour analgesia. Her physical and systems examination were unremarkable. On admission, her platelet count was 85,000/cu.mm. After informed consent, PCEA was administered and delivered healthy baby. However, her platelet count dropped to 60,000/cu.mm 6hrs after delivery and then to 23,000/cu.mm subsequently. Petechia was noted over her arms and trunk. Hematologist was consulted and TTP was diagnosed. Plasmapharesis was instituted, blood and products were transfused with close monitoring of neurological status and signs of sepsis. The epidural catheter was left insitu and removed with platelet count of 105,000/cu.mm. She had an uneventful recovery and advised regular follow up.
Saturday, October 13, 2012  
11:00 AM - 12:30 PM  
MC83  
A Case Report: Post-Partum Intracranial Subdural Hematoma Following Epidural Anesthesia in a Scleroderma Patient  
Funmi Ayanbule, M.D., Sam Hankins, M.D., Uma Munnur, M.D., Anesthesiology, Baylor College of Medicine, Houston, TX.  
A 21-year-old primigravid with scleroderma presented for scheduled C/S. Pre-operative evaluation revealed 35kg cachectic female with difficult airway. RI CVC was placed with ultrasound guidance. Epidural was initiated with 3cc lidocaine and then 4ml of 0.125% bupivacaine with 2ug/ml fentanyl was given. Patient became somnolent, complained of whole body numbness and weakness. Symptoms resolved and labor continued with delivery within 5hrs. On post-partum day 2, patient became lethargic, developed right sided weakness and aphasia. She was electively intubated. CT scan revealed 9mm parafalcine subdural hematoma, which was treated conservatively. On post-partum day 4, patient was extubated and had complete recovery.

Saturday, October 13, 2012  
11:00 AM - 12:30 PM  
MC84  
The Perioperative Management for the Removal of a Massive Ovarian Cyst  
Joshua C. Bailey, M.D., Sher-Lu Pai, M.D., Anesthesiology, Mayo Clinic, Jacksonville, FL, USA, Mayo Clinic, Jacksonville, FL.  
A 59-year-old, post-menopausal female presented with 1-year history of abdominal distention, post-menopausal vaginal bleeding, and shortness of breath. An emergent paracentesis yielded 10 liters of fluid to relieve her difficulty with breathing. In the operating room, the patient was positioned in the left lateral decubitus position to prevent supine hypotensive syndrome. An awake arterial line, two large bore peripheral IVs, and a subclavian central line were placed for close hemodynamic monitoring. Rapid sequence induction was used to prevent aspiration. The cystic cavity fluid was drained slowly to avoid acute cardiovascular collapse. A 57.6 kg cystic mass was removed.

Saturday, October 13, 2012  
11:00 AM - 12:30 PM  
MC85  
Anesthetic Management of Early Septic Abortion  
Michael T. Bangert, Charles Smith, M.D., MetroHealth Medical Center, Cleveland, OH.  
Complications from retained fetal tissue include endometritis, septic shock, ARDS, and death. We report a case of a 30-year-old G8P0025 who presented at 15 1/2 weeks gestation with fever, tachycardia, anhydramnios, purulent cervical discharge, and leukocytosis. Antibiotics were started. Induction of labor was unsuccessful, and she required dilation and evacuation. Anesthesia consisted of monitored anesthesia care (MAC) with propofol, midazolam, and fentanyl, and standard monitoring. She required intermittent jaw thrust and tolerated the procedure without complication. The benefits and risks of MAC versus general anesthesia will be discussed.
Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC86
Not Your Typical Sleep Apnea
John Beelitz, M.D., Bridget Marroquin, M.D., Anesthesia, University of Rochester, Rochester, NY.
33 year-old for cesarean delivery at 33 weeks for intrauterine growth failure and chronic hypertension with pre-eclampsia. History was significant for obstructive sleep apnea worsening with the pregnancy. She was unable to lie supine due to apnea. A “mock” cesarean delivery proved significant respiratory distress in the supine lateral tilt position. She became cyanotic. Saturation quickly returned to 100% with sitting. Flow-volume loops revealed a “restrictive pattern.” We performed an awake intubation. She was extubated uneventfully after the procedure. The following day she developed dyspnea and increasing oxygen requirement. Neurology consultation offered the diagnosis of myotonic dystrophy.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC87
OB Patient With Severe Postpartum Cardiomyopathy Presents in Breech Position
John Beelitz, Magdy Takla, Cooper University Hospital, Camden, NJ.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC88
Epidural Analgesia for Delivery in a Parturient With Lumbar Syringomyelia, Thalamic Tumor and Morbid Obesity
Miles Berger, Cory Maxwell, M.D., Terrence Allen, M.D., Anesthesiology, Duke University Medical Center, Durham, NC.
We present the labor analgesia management of a parturient with lumbar syringomyelia, thalamic brain tumor and morbid obesity. We discuss the role of multidisciplinary consultation and ultrasound guidance for the safe placement of epidural catheters in parturients with complex medical comorbidities, who are at increased risk of complications from epidural placement.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC89
Labor Analgesia Using Epidural Clonidine in an Opioid-Dependent Parturient Taking Suboxone
Miles Berger, M.D., Ph.D., Abimbola Faloye, M.D., Cheryl A. Jones, M.D., Ashraf Habib, M.D., Anesthesiology, Duke University Medical Center, Durham, NC.
Opioid dependent parturients may be treated with the partial mu opioid agonist buprenorphine. Labor analgesia is challenging to provide for these patients, and high opioid doses may increase addiction relapse risk. We report the labor analgesia management of an opioid-dependent parturient taking
suboxone, with an epidural clonidine bolus and an epidural infusion of bupivacaine and fentanyl. This regimen provided excellent analgesia, hemodynamic stability, and did not trigger an addiction relapse.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC90
**Neuroaxial Anesthesia for a Cesarean Section in the Setting of Sever Aortic Stenosis**
*Elird Bojaxhi, M.D., Ronak Desai, D.O., Anesthesiology, Cooper University Hospital, Camden, NJ.*
Neuroaxial approach towards patients with aortic stenosis presents unique challenges due to the sudden changes in their systemic vascular resistance. A 35 year-old woman G3P0202 at 31 weeks of gestation presented to the hospital for pre-syncope, lethargy, dyspnea on exertion, and increased leg swelling. On further evaluation, she was found to have a bicuspid aortic valve with severe aortic stenosis (AVA 0.82 cm²) and mild-mod aortic regurgitation. The case will demonstrate providing epidural anesthesia via segmentally titrating local anesthetics for a cesarean section on a parturient patient with decompensated aortic valve disease.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC91
**Anesthetic Management of a 19 Week Parturient With a Large Pancreatic Mass**
*Robert B. Bolash, M.D., Jonathan Epstein, M.D., Anesthesiology, St. Luke’s/Roosevelt Hospital, New York, NY.*
A G1P0 at 19 weeks gestation required a laparotomy, pancreatectomy and splenectomy to remove an enlarging pancreatic neoplasm. Both an intraoperative fetal heart rate monitor and a maternal arterial line were utilized during the administration of a general anesthetic supplemented with a thoracic epidural. Upon conclusion of the procedure, the patient was extubated in the operating room and the fetal heart rate was present. A thoracic epidural facilitated surgical resection, eliminated the need for parenteral opioids, and may have reduced the intra-operative and post-operative stress response which could have been deleterious to uterine perfusion and fetal well-being.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC92
**Management of a Ruptured Cavernous Hemangioma in Late Pregnancy Followed by Precipitous Vaginal Delivery Under General Anesthesia**
*Robert B. Bolash, M.D., Jonathan Epstein, M.D., Cortessa Russell, M.D., Anesthesiology, St. Luke’s/Roosevelt Hospital, New York, NY.*
A 39 year-old presented 31 weeks into her second pregnancy with a contained rupture of a hepatic hemangioma resulting in ventilator dependent respiratory failure and a consumptive coagulopathy. A successful embolization was performed in the interventional radiology suite using general anesthesia. Shortly thereafter she complained of labor pain that was unrelieved by parenteral opioids and general anesthesia was again administered for an instrumented vaginal delivery. While hemangiomas can rupture at any time, frequent precipitating factors include sudden hemodynamic changes and increases in intra-abdominal pressure, both of which were mitigated by the use of a general anesthetic for delivery.
Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC93
Chest Pain and Elevation on ST-Segment After Oxytocin Administration During Elective Cesarean Section With Spinal Anesthesia
Guilherme de Moraes Ancora Braga Netto, M.D., Anna Carolina Von Uslar Ferreira Freitas, M.D., Alberto Vieira Pantoja, M.D., Marco Antonio Carvalho Resende, M.D., Ismar L. Cavalcanti, M.D., Ph.D., Anesthesiology, Universidade Federal Fluminense, Niterói, Brazil, Anesthesiology, Universidade Federal Fluminense/Instituto Nacional de Câncer, Niterói/Rio de Janeiro, Brazil.
Spinal anesthesia was induced with hyperbaric bupivacaine (12.5mg) and morphine (60mcg) for cesarean section. After delivery, 10 IU of oxytocin diluted in lactated ringer (500ml) was administered. The patient started complaining about chest pain, shortness of breath and nausea. The anesthesiologist noticed increased HR and MAP of 60mmHg and visualized elevation of ST-segment at the cardioscope monitor. Acetylsalicylic acid, isosorbide dinitrate and O2 were administered. In the recovery room ECG showed a first degree right bundle branch block, diminished R-waves and minimal J-point elevation in V3 and V4 leads. Troponin I and CK-MB were measured at normal levels.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC94
Management of Intrauterine Twin Molar Pregnancy With Complete Placenta Previa
Jason M. Buehler, M.D., Daniel Bustamante, M.D., Anesthesiology, University of Tennessee-Knoxville, Knoxville, TN.
A 31 year-old G1P1 at 14 weeks was admitted with a twin intrauterine pregnancy consisting of a complete hydatidiform mole co-existing with a viable fetus. The patient was counseled on the risks of carrying her pregnancy to term including persistent trophoblastic disease. The pregnancy was further complicated by complete placenta previa and development of pre-eclampsia. She progressed to develop pulmonary edema, oliguria, and vaginal bleeding. Ultimately she underwent successful suction dilation and evacuation with ultrasound guidance with an arterial line in place and multiple units of packed red blood cells on standby. She suffered no further peripartum complications.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC95
Etomidate Does Not Work in the Epidural Space: A Case of Identical Vials in the Anesthesia Cart
Kim Burke, D.O., Pablo Pizarro, M.D., Richard Gist, M.D., Naval Medical Center Portsmouth, Portsmouth, VA.
We present the case of a 30 year female parturient undergoing elective repeat cesarean delivery who received combined spinal epidural anesthesia and subsequently due to a medication swap received 10 mg of etomidate in the epidural space. She had no serious sequelae from the inadvertent administration of the medication into the epidural space and her cortisol level was normal eight hours after the incident. This case underscores the need for very close scrutiny of glass and other medication vials in the anesthesia cart and need for separation of look-alike medications to prevent medication administration errors.

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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC96
A-B-C's: Airway, Bleeding, C-section? Anesthetic Considerations for C-Section in a Jehovah's Witness Patient With Possible Fetal Airway Compromise
Jennifer L. Chang, M.D., Tammy Euliano, M.D., Nicole Dobija, M.D., Anesthesiology, University of Florida, Gainesville, FL.
A 35 year-old Jehovah’s witness at 35 weeks gestation with a fetal goiter possibly causing airway compromise is scheduled for delivery. Members of obstetrics, neonatology, pediatric and obstetric anesthesiology, and pediatric otolaryngology discussed the risks and benefits of a cesarean delivery versus ex utero intrapartum treatment (EXIT). Due to concerns of maternal hemorrhage, a cesarean delivery was planned in a large operating room with a prepared team consisting of pediatric otolaryngologists, pediatric anesthesiologists, and neonatologists to assist with the fetal airway. The delivery proceeded uneventfully with the delivery of a spontaneously breathing infant.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC97
Fetal Bradycardia Leading to Emergency Caesarean Section Following Trans-arterial Embolization of an Intracranial Meningioma in a Pregnant Patient
Young Choi, Frank Stewart, M.D., Elizabeth Unal, M.D., Laura Goetzl, M.D., Raymond Turner, M.D., Medical University of South Carolina, Charleston, SC.
A 40 year-old G3, P2 at 32 weeks of gestation was diagnosed with a meningoia after suffering a seizure. After undergoing an intracranial, trans-arterial tumor embolization, fetal bradycardia to 90 bpm was noted. An emergent Caesarean section was performed for persistent fetal bradycardia with eventual return of the newborn’s heart rate to baseline after one hour of life. A literature review was conducted to investigate possible causes of the fetal bradycardia seen in our patient. Evaluation of the pharmacologic agents administered to the patient highlights the importance of careful planning prior to delivering anesthesia to the pregnant population.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC98
Elective Primary Cesarean Section in a Pseudoachondroplastic Dwarf
John T. Cleaves, M.D., Tiffany Angelo, D.O., Anesthesia, Walter-Reed National Military Medical Center, Bethesda, MD.
Twenty seven year-old G1P0 at 37 weeks gestation pseudoachondroplastic dwarf presented for primary elective caesarian section with no prior medical history. She had an uncomplicated pregnancy course. Physical exam demonstrated 127cm stature, short extremities, MP 3 airway, and accentuated lumbar lordosis. One large-bore peripheral IV was placed in addition to standard ASA monitors. Intrathecal injection was performed at L3-4 with 7.5mg of bupivicaine, 200mcg of morphine, and 10mcg of fentanyl. Attained T1-2 spinal level with resultant hypotension treated with ephedrine and phenylephrine. The caesarean section was uneventful resulting in a viable delivery with APGARS 9,9.
MC99
Anaphylaxis to Penicillin Based Antibiotic During Elective Caesarian Section
Ruthra Sarma, M.B., B.Ch., Douglas Coventry, M.B., Ch.B., Department of Anaesthesia, Aberdeen Royal Infirmary, Aberdeen, United Kingdom.

44 year-old female presented for elective Caesarian section, under spinal anesthesia. IV antibiotics administered after spinal anesthesia but prior to surgical incision. Patient developed acute tachycardia with significant hypotension, refractory to medical therapy until baby was delivered. Anaesthetic management prior to delivery included conversion to general anaesthesia, expedited delivery and fluid challenges. In addition to this IV meteraminol (alpha 1 agonist) boluses were given and then IV epinephrine 50microgram boluses and then 100microgram boluses. Following delivery, baby taken to NICU, patient stabilized and then extubated. Anaphylaxis confirmed with serial tryptase testing.

MC100
Ultrasound Saves the Night: A Potentially Difficult Labor Epidural, Made Easy, in a Severely Scoliotic Parturient With Excessive Scarring on her Back
Edward Kosik, D.O., Andrew Crabbe, M.D., Anesthesiology, University of Oklahoma HSC, Oklahoma City, OK.

We describe a case where ultrasound was used, by an anesthesiologist with limited ultrasound experience, to locate the bony landmarks of a parturient whose typical landmarks were difficult to locate because of severe scoliosis, obesity and scarring of the majority of the back surface area. The patient had ten previous skin grafts for a congenital nevus that covered 100% of the skin in the lumbar back area. Marking of the landmarks with ultrasound, horizontally and vertically, were made before sterile prep and drapes were placed. The first attempt was successful and excellent analgesia was provided in this rather complex epidural.

MC101
Postpartum Preeclampsia vs. Late Onset Postdural Puncture Headache
Madhumani Rupasinghe, Arjun Dalal, M.D., Anesthesiology, UTHSC Houston, Houston, TX.

A 23 year-old G3 P2 with no past medical history underwent a scheduled repeat CS under combined spinal epidural anesthesia. She presented to triage 6 days later with complaints of bilateral frontal headache, photophobia, nausea, blurry vision, and vomiting. Headache was positional. Her blood pressure was elevated at 158/99 with trace protein in urine; hence she was treated with labetalol and started on Magnesium for seizure prophylaxis. Headache seemed to resolve but it became worse, so a CT head was obtained which was normal. An epidural blood patch was performed without complications, and resulted in complete resolution of symptoms.
Ultrasound-Guided Labor Epidural for a Parturient With Metastatic Spinal Leiomyosarcoma: A Case Report
Torijaun Dallas, M.D., Terrance Allen, M.D., Abigail Melnick, M.D., Anesthesiology, Duke University Medical Center, Durham, NC.
We report the management of a 36 year-old parturient with leiomyosarcoma metastases to the lumbar vertebrae who received an ultrasound-guided labor epidural. MRI revealed a destructive L3 vertebral body lesion with extension into the spinal canal. The intercrystal line was determined to be at L4/L5 by palpation but was found to be at L3/4 by ultrasonography. Ultrasonography was used to locate the L4/5 interspace for catheter placement. The neurological exam on postpartum day 1 and 2 revealed no neurological deficits. Ultrasonography allowed us to accurately indentify the L4/L5 interspace and institute epidural analgesia.

Anesthetic Management Considerations in a Parturient With Noonan's Syndrome: A Case Report
Sean M. DeChancie, D.O., Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.
37 year-old G2P1 39w for repeat cesarean section with history of Noonan’s syndrome, difficult airway, Tetralogy of Fallot repair(1979), severe thoracolumbar scoliosis s/p repair with Harrington rods (1987 and 1989) and asthma. Failed spinal x2 despite aspiration of CSF. GA with awake fiberoptic intubation performed. Routine c-section, extubated and taken to PACU without complication. Urgently returned to OR for exploration for bleeding. Unable to intubate with fiberoptic scope despite earlier successful attempt. Nasal intubation by ENT was performed. Patient taken to ICU intubated incase that the patient was taken back to the OR.

Cesarean Delivery Under General Anesthesia With TAP Catheters for Post-Operative Analgesia in a Patient With Osteogenesis Imperfecta
Emily Dinges, M.D., Clemens Ortner, M.D., Joanna Davies, M.B., B.S., Laurent Bollag, M.D., Ruth Landau, M.D., Anesthesiology and Pain Medicine, University of Washington, Seattle, WA.
Osteogenesis imperfecta (OI) is a congenital disease most often caused by a defect in the gene that produces type-1 collagen. Cesarean deliveries in OI patients have been reported under both general anesthesia and combined spinal-epidural. We will discuss the case of a 37 year-old G1P0 African American with osteogenesis imperfecta type III or IV, weighing 36 kgs and 111 cm, with a history of over 100 fractures, a known difficult airway, and kyphoscoliosis, among other complications. The patient was admitted at 26 weeks gestation for worsening respiratory status caused by her gravid uterus.
Placenta Percreta Necessitating Termination of Pregnancy, Methotrexate, Expectant Management, Chorioamnionitis, Urgent Embolization and Hysterectomy

Emily Dinges, M.D., Joanna Davies, M.B., B.S., Ruth Landau, M.D., Anesthesiology and Pain Medicine, University of Washington, Seattle, WA.

A 35 year-old G4P2 Hispanic woman with 2 previous C-sections was diagnosed at 25 weeks by MRI with an extensive placenta percreta involving the bladder, upper vagina, anterior abdominal wall, distal sigmoid and rectum, and right sciatic neurovascular bundle of the right lateral pelvic sidewall as well as a complete previa, extending anteriorly up the entire anterior wall of the uterus and with a posterior succenturiate lobe circumferentially around the uterus. Management options and anesthetic considerations and preparations for a bleeding catastrophe will be discussed.

Management of Placenta Percreta

Anjali Dogra, M.D., SUNY at Stony Brook, Selden, NY.

EG is a 29 year-old F carrying twins at term gestation with 4 previous cesarean deliveries, diagnosed with placenta previa and possible percreta with invasion into the urinary bladder and small bowel. Patient past medical and surgical history: Remote asthma; previous abdominoplasty; four prior CS including twice unsuccessful epidural and once unsuccessful spinal. The patient was late to prenatal care, presenting at 27 weeks and with a history of post-operative wound infection following her abdominoplasty and one of her prior CS. This case explores preplanning for complicated delivery with abnormal placentation and importance of communication between surgical and anesthetic teams.

Anesthetic Management of Congenital Central Hypoventilation Syndrome in the Parturient

Amber L. Dunn, M.D., Department of Perioperative Medicine, University Hospitals Case Medical Center, Cleveland, OH.

29 year-old parturient with recent diagnoses of LO-CCHS presented for TOLAC and scheduled induction. Patient became symptomatic during previous delivery after receiving narcotic. Both previous children had been diagnosed with CCHS. After induction of labor, anesthesia was provided via lumbar epidural infusion. A bolus of local anesthetic and epinephrine was administered, in divided doses, followed by a continuous infusion. A T8 level to pinprick was noted bilaterally, and the patient was comfortable though the uncomplicated spontaneous vaginal delivery. There were no maternal complications. Apgar’s were 9 and 9, and there were no signs of neonatal respiratory distress at delivery.
Autonomic Hyperreflexia in an Obstetric Patient
Kelly Eaton, M.D., Katarzyna Luba, M.D., M.S., Anesthesiology and Critical Care, University of Chicago, Chicago, IL.
34 year-old female with T6 paraplegia secondary to a gunshot wound 13 years ago was admitted at 38 weeks gestation for induction of labor. On admission, BP was 145/97. Her risk for autonomic hyperreflexia was recognized by anesthesiology and an epidural recommended prior to initiation of Pitocin. Upon skin wheal placement, her BP increased to 161/112, HR 63 and she complained of diaphoresis and hand tremors. After starting her epidural infusion, her tremors improved. No further complications were observed. The risk of autonomic hyperreflexia in patients with spinal cord lesions was discussed with our obstetric colleagues and early epidural placement encouraged.

COPD in Pregnancy and Labor
Michael F. Esposito, M.D., Barbara M. Scavone, M.D., Anesthesia and Critical Care, University of Chicago Medical Center, Chicago, IL.
Parturients experience increased oxygen and metabolic demands, which are further increased during labor and delivery. Hormonal changes and mechanical effects of the enlarging uterus alter maternal anatomy and respiratory physiology to accommodate these increased demands. As patients with pulmonary disease use a greater share of their respiratory capacity for work of breathing, parturients with pulmonary disease may lack the reserve to meet respiratory and metabolic requirements of labor and delivery. We present a case of chronic obstructive pulmonary disease, a rare comorbidity in the parturient as it is not usually a disease of women of childbearing age.

CSF Exchange for Inadvertant Intrathecal Test Dose
Jodi Galla, M.D., Peter Pan, M.D., Wake Forest Baptist Medical Center, Winston-Salem, NC.
26 year-old. term pregnant female presented at 4cm cervical dilation following SROM. An epidural catheter was placed for labor analgesia. The spinal test dose was negative. Immediately following IV test dose she began to experience symptoms of a high spinal. Aspiration of the epidural catheter revealed continuous CSF flow. To minimize potential long term neurotoxicity from high dose lidocaine, CSF exchange was performed by removing CSF and replacing it with saline. A total of 25cc of fluid was exchanged over 15 minutes. The patient’s symptoms improved significantly and she delivered a normal fetus. She suffered no complications.
Vaginal Delivery in the Intensive Care Unit for a Super Morbidly Obese Patient With Respiratory Failure

Jacqueline M. Galvan, M.D., Heather Nixon, M.D., Anesthesiology, University of Illinois at Chicago Medical Center, Chicago, IL.

Patient is a nulliparous female with a history of asthma, HTN, super-morbid obesity (BMI -90), OSA and pulmonary embolism, admitted at 37 weeks in respiratory distress. Dyspnea initially treated with nebulizers, oxygen, corticosteroids, and BiPAP. Respiratory status continued to deteriorate necessitating awake fiberoptic intubation. Labor induced secondary to pre-eclampsia. A team including anesthesiologists, obstetricians and intensivists created plan for successful vaginal delivery with Cesarean delivery in the ICU as contingency plan. During delivery ICU ventilator inadequate with patient in lithotomy position due to increased peak airway pressures. The anesthesia team assisted ventilation by hand and titrated sedation.

Management of a Parturient With Severe Interstitial Lung Disease

Liane Germond, M.D., Thomas Bate, Jonathan Epstein, M.D., Deborah Stein, M.D., Thomas Maliakal, M.D., Anesthesiology, St. Luke’s Roosevelt Hospital, New York, NY.

A 44 year-old G5P3 presented to the labor floor with a medical history significant for right sided lobectomy and left sided VATS, currently on continuous O2, with poor exercise tolerance, an O2 saturation of 94%, and a history of bilateral upper extremity DVTs. PFTs demonstrated both obstructive and restrictive disease. She also presented with labile blood pressures to the 160s/100s and Type 2 diabetes. She was in labor and requested labor analgesia. An uncomplicated CSE was performed. The FHR was non-reassuring 2 hours post-CSE and she was taken for an emergent C-section using her epidural for surgical anesthesia.

Anaphylactic Reaction to Platelet Transfusion During Cesarean Section in the Setting of Multiple Autoimmune Disorders

Courtney A. Ghiassi, M.D., Adrienne Ray, M.D., John Downing, M.B., B.Ch., Anesthesiology, Vanderbilt University Medical Center, Nashville, TN.

23 year-old G6P0141 at 34.4 weeks gestation presents for elective cesarean section in the setting of ITP associated thrombocytopenia, Sjogren’s Disease and liver cirrhosis secondary to autoimmune hepatitis. Anesthetic plan included intra-operative pre-incisional regional anesthesia via single-shot spinal. Airway management consisted of 2L via nasal cannula. Standard ASA monitors applied. Delivery of healthy infant proceeded without incident. Approximately ten minutes after delivery, and several minutes into the infusion of a second unit of packed platelets, patient became confused, combative, quickly going into cardiopulmonary arrest requiring emergent intubation and brief ACLS before becoming stable enough for transfer to surgical ICU.
**Anesthetic Considerations for a Parturient With a BMI of 110 kg/m²**

Wayne Godfrey, M.D., Heather Graver, M.D., Emily J. Baird, M.D., Ph.D., Renyu Liu, M.D., Ph.D., Linda Chen, M.D., Anesthesiology and Critical Care, University of Pennsylvania, Philadelphia, PA.

A 33 year-old woman with past medical history of super morbid obesity (BMI 110 kg/m²), obstructive sleep apnea, mild pulmonary hypertension, and asthma was admitted to the labor floor for preterm labor at 36 weeks and 5 days gestational age. We discuss the implications of such a large body habitus on the anesthetic considerations for this patient including airway management, intravenous access, neuraxial anesthesia, patient positioning, and labor planning.

**Cesarean Section in a Patient With Arnold Chiari Type I Malformation: General versus Regional Anesthesia?**

Andrea D. Gomez Morad, Stephen Williams, D.O., Mark Lovich, M.D., Martin Acquadro, M.D., Anesthesiology, Anesthesiology and Pain Medicine, Saint Elizabeth Medical Center, Boston, MA.

A 36 year-old female, G3P2 at 37 weeks with breech presentation was admitted in labor. Five days prior she presented to the ED with stroke like symptoms and MRI results consistent with Chiari type I malformation with 12 mm tonsillar herniation. She was discharged when her symptoms resolved. Anesthesia was requested for epidural during labor. Neurosurgery suggested avoidance of neuraxial anesthesia. General anesthesia for C-section was provided with rapid sequence induction using propofol and rocuronium, maintenance with volatile agent, with TAP block and IV analgesics for postoperative pain. Patient was discharged home a few days later after an uneventful perioperative course.

**Congestive Heart Failure Secondary to Subvalvular Aortic Membrane Presenting as Postpartum Dyspnea After Preterm Labor**

Sumeet R. Gopwani, M.D., David L. Reich, M.D., Anesthesiology, Mount Sinai School of Medicine, New York, NY.

39 year-old female underwent IVF resulting in quadruplet pregnancy reduced to twins. At 26 weeks she presented with complaints of URI and in preterm labor. Treatment with bed rest, IV hydration, and tocolytics failed, and patient was taken for cesarean section under spinal anesthesia. Postoperatively she developed acute dyspnea, history of childhood heart murmur was elicited, and TTE showed sub-aortic membrane with gradient 63mmHg. After stabilization, cardiac catheterization showed outflow gradient 26mmHg. She arrived 70 days postpartum for resection of subaortic membrane and septal myectomy under GA with CPB. Postoperative course was uneventful, and patient was discharged home on POD5.
Monday, October 15, 2012
8:00 AM - 9:30 AM
MC474
**Spinal Anesthesia for Cesarean Delivery in a Super Obese Woman With Neuromyelitis Optica**

Nathaniel Greene, M.D., Emily Dinges, M.D., Margaret Sedensky, M.D., Ruth Landau, M.D., Anesthesiology, University of Washington, Seattle, WA.

NMO, or Devic’s disease, is an idiopathic severe demyelinating disease of the CNS that preferentially affects the optic nerve and spinal cord. The safety of neuraxial anesthesia in multiple sclerosis has been established, but scarce reports in NMO are available and spinal anesthesia has even been associated with NMO (causality is however highly debated). We report on the safe use of spinal anesthesia with supplemental N2O for an elective Cesarean delivery at 32 weeks in a morbidly obese G1P0 with an acute flare of NMO, with excruciating allodynia and weakness likely caused by pregnancy.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC475
**Magnesium Toxicity in Severe Pre-Eclampsia**

Deepak Gupta, Rima Rahal, Vitaly Soskin, Detroit Medical Center, Detroit, MI.

28 year-old-gravida-2 female 27-4/7 weeks presented with severe preeclampsia. The patient was initiated on standard magnesium bolus and maintenance infusion. Forty-eight hours later, patient became lethargic and drowsy. Her GFR was 74 mL/min/1.73m2; her magnesium levels were 9.6 mg/dL. Magnesium infusion was discontinued and stat cesarean section was called for ensuing fetal bradycardia. The patient underwent general endotracheal anesthesia. Rest of the peri-operative period was uneventful. Postoperative magnesium therapy was re-started; however the levels became supratherapeutic (8.0 mg/dL) and hence magnesium was discontinued. The present case highlights relative renal dysfunction in pre-eclampsia prepondering the incidence of magnesium toxicity despite standard dosing.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC476
**Anesthetic Management of a Parturient With Type I Arnold-Chiari Malformation**

Wendy A. Haft, M.D., Thomas M. Chalifoux, M.D., Manuel C. Vallejo, M.D., Anesthesiology, UPMC, Pittsburgh, PA, Anesthesiology, Magee-Womens Hospital of UPMC, Pittsburgh, PA.

A 17 year-old parturient with type I Arnold-Chiari malformation (ACM) and 9 millimeter tonsillar herniation presented for delivery. Despite the important anesthetic and obstetric implications of ACM, no standard delivery strategy exists. A multidisciplinary team convened to determine a plan for the optimal delivery technique. Concerns included increased intracranial pressure during labor and possible worsening herniation with dural puncture from neuraxial anesthesia. Elective cesarean section under general anesthesia was chosen for this patient. Anesthetic goals included avoidance of straining during intubation and extubation and prevention of hypercapnia. Multidisciplinary cooperation and careful planning resulted in an uneventful delivery.
Monday, October 15, 2012
8:00 AM - 9:30 AM
MC477
Management of a Carrier of Factor IX Deficiency During Labor and Delivery
Wendy A. Haft, M.D., Thomas E. Lace, M.D., Jonathan H. Waters, M.D., Anesthesiology, UPMC, Pittsburgh, PA, Anesthesiology, Magee-Womens Hospital of UPMC, Pittsburgh, PA.
A 32 year-old carrier of Factor IX deficiency presented in labor at 38 weeks gestation. Testing demonstrated 45% Factor IX activity. Many Hemophilia B carriers have decreased factor levels secondary to lysisation, and are at increased risk for peripartum hemorrhage. On arrival, thromboelastogram (TEG) was performed to identify bleeding risk and determine the anesthetic technique. Initial TEG was normal, thus neuraxial anesthesia was performed. Prior to incision for cesarean section, the patient was given 3,000 units of Factor IX concentrate due to concerns for postpartum hemorrhage. The patient had an uncomplicated spinal, delivery, and postoperative course without peripartum hemorrhage.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC478
Congenital Unilateral Absence of a Pulmonary Artery in Pregnancy
Tom Hayes, Tiffany Angelo, D.O., Mike Paul, M.D., Walter Reed National Military Medical Center, Bethesda, MD.
Isolated unilateral absence of a pulmonary artery is a rare congenital anomaly associated with a high risk for development of pulmonary hypertension and/or massive pulmonary hemorrhage, which may be precipitated by the physiologic changes of pregnancy in a previously asymptomatic patient. We review the relevant literature and report the successful anesthetic management of labor in a patient with UAPA using invasive monitoring, an early, dense epidural, and passive second stage of labor.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC479
A Rare Cause of Syncope and Hemorrhagic Shock in Pregnancy
Nadia Hernandez, M.D., Christina L. Jeng, M.D., Anesthesiology, Mount Sinai School of Medicine, New York, NY.
A 28 year-old previously healthy 35-week primigravida presented to our labor floor w/ persistent lightheadedness. There she had a syncopal episode, consistent with hypovolemic shock but w/o evidence of vaginal bleeding. Her trachea was intubated, resuscitation begun and she was brought to the OR. Emergent C-section was necessary to improve the quality of CPR. Upon laparotomy profuse hemorrhaging, secondary to a ruptured splenic artery was found. Massive transfusion protocol was initiated and splenectomy performed. The patient was transferred to SICU. The neonate required PALS after Apgars of 2/4/4 and was transferred to the PICU.
Management of Labor and Vaginal Delivery in Patient With Repaired Aortic Coarctation

Amanda K. Hester, M.D., Ray Paschall, M.D., Department of Anesthesiology, Vanderbilt University, Nashville, TN.

32 year-old G1P0 female with history of aortic coarctation presented for induction of labor at term. She had primary end-to-end anastomosis repair at age three. Prior to pregnancy, she had small residual coarctation gradient and small outpouching of the aortic arch. There is risk for aortic dissection during pregnancy in patients with coarctation, and this risk increases in patients with hypertension or with aneurismal dilatation of the aorta. Plan was for early labor epidural with excellent pain control and minimal expulsive efforts by the patient. Forceps-assisted delivery was accomplished with minimal pain, and hemodynamic stability was maintained without complications.

Superficial Postoperative Hematoma as a Novel Proposed Mechanism for Iatrogenic Femoral Nerve Injury

Jeffrey T. Hopcian, M.D., Barbara Scavone, M.D., Department of Anesthesiology and Critical Care, University of Chicago, Chicago, IL.

We present the case of a patient status post cesarean section presenting post op day 4 with hematoma over the lateral aspect of her incision with a clear femoral neuropathy. Her neuropathy resolved completely with incision and drainage of her hematoma/clot. The timecourse and absence of other risk factors (i.e. no trial of labor) make her neuropathy very unlikely to be explained by established mechanisms of femoral nerve injury. To date, no case reports exist of superficial hematoma causing a femoral neuropathy. We propose a connection between this patients hematoma and symptoms as a novel mechanisms of femoral nerve injury.

Parturient With Moyamoya Syndrome and Sickle Cell Disease

Olakunle Idowu, M.D., Ivan Velickovic, M.D., Anesthesiology, SUNY Downstate, Brooklyn, NY.

We describe a 20 year-old female with Sickle cell SS disease and the Moyamoya Syndrome at 34 weeks gestation going for elective cesarean section under combined spinal epidural anesthesia.

Anesthetic Management of a 22-Year-Old Term Pregnant Female With Severe Pulmonic Stenosis and Anticipated Difficult Airway in Labor With Fetal Malposition

Dustin Jackson, M.D., University of Pittsburgh, Pittsburgh, PA.

A 22 year-old female with term intrauterine pregnancy presents in labor with fetus in right occiput posterior position. She has a history of severe pulmonic stenosis, and airway examination reveals a potential difficult airway. Obstetricians desire to attempt forceps-assisted rotation of the fetus. Pudendal block is unsuccessful in providing analgesia for the rotation. Saddle block is performed which provides complete perineal anesthesia, but fetal rotation and delivery is unsuccessful. Obstetricians wish
to proceed with cesarean delivery. General anesthesia is induced, endotracheal intubation is achieved using a video laryngoscope, and an invasive arterial monitor is placed. Delivery and emergence is uneventful.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC484
Mesenteric Ischemia Presenting as Preterm Labor
Danny Joseph, M.D., Stanlies D'Souza, M.D., F.R.C.A., Anesthesiology, Baystate Medical Center, Tufts University School of Medicine, Springfield, MA.
A 41 year-old, G2 P0 was admitted with suspected preterm labor at 23 weeks. With worsening abdominal pain anesthesia was asked to evaluate for the placement of a labor epidural. At the time of assessment patient was afebrile, tachycardic and diaphoretic. An epidural was placed at L3-4 level. Pain did not subside with epidural, subsequent WBC count showed significant elevation and patient developed abdominal rigidity. General surgery was consulted for the evaluation of nonobstetric surgical causes of pain. Patient had emergency laparotomy which showed necrotic bowel secondary to mesenteric ischemia and 240 cm of necrotic small bowel was resected.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC485
Urgent C-Section for a Patient on Chronic Methadone With Acute Aortic Root Aneurysm, NSTEMI, and Hypertensive Crisis
Jeremy Joyal, Swarup Varaday, M.D., Washington University in St. Louis, St. Louis, MO.
38 year-old G7P5015 at 37 weeks on methadone maintenance for poly-substance abuse presents to labor and delivery with angina and hypertensive emergency. Evaluation reveals evolving NSTEMI, aneurysmal aortic root without dissection, and a bicuspid aortic valve with severe aortic insufficiency. Urgent C-section is recommended after multidisciplinary consultation. Following placement of arterial and central venous lines, a lumbar epidural is placed in a cardiothoracic OR with a cardiovascular surgery team on standby. Surgical anesthesia is obtained with lidocaine 2% 5 mL, 5 mL, 8 mL boluses. The procedure is successfully completed without major complication to patient or baby.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC486
Primigravida With Gaucher Disease Presents With Unexpected Fetal Demise
John A. Judd, Aurel Neamtu, M.D., Marjorie E. Robinson, M.D., Department of Anesthesiology and Perioperative Medicine, University of Louisville, Louisville, KY.
We present a 19 year-old obese primigravida with Gaucher’s disease admitted at 40.2 weeks gestation for artificially induced labor due to fetal demise. On admission, the patient had no symptoms or signs of neurological complications, no bone or joint injury, or bleeding diathesis. Platelets and coagulation tests were normal. Epidural was attempted and after a dural puncture was eventually placed at a different level resulting in good analgesia. Shortly after placement the patient complained of headaches that were conservatively treated resulting in adequate pain relief. We present the management of this case and literature review.
Monday, October 15, 2012
8:00 AM - 9:30 AM
MC487
Penetrating Trauma in a Peripartum Patient and Management With Massive Transfusion and Thromboelastography
Shinjiro C. Kamaya, M.D., James M. Packer, M.D., Michael M. Sawyer, M.D., Department of Anesthesiology, University of Colorado, Aurora, CO, Department of Anesthesiology, Denver Health and Hospital, Denver, CO.
A 31 year-old female in her second trimester of pregnancy was the victim of a gunshot wound to the abdomen, and was rushed emergently to our institution for treatment. Intraoperatively, she was found to have a tear of the IVC, as well as lacerations of the liver, colon, and small bowel. During the case, an emergent C-section was performed, and she received 83 units of PRBCs. We report the management this patient and her fetus in a penetrating trauma situation including use of our massive transfusion protocol, and correction of trauma-induced coagulopathy by following serial rapid thromboelastograms (r-TEGs).

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC488
Patient With Multiple Sclerosis, Lumbar Spine Surgery and Ehlers Danlos Syndrome for Labor Analgesia/Anesthesia
Amanpreet Kaur, M.D., Obstetric Anesthesiology, Yale New Haven Hospital, New Haven, CT.
A 31 year-old female G2P0 at 27 weeks of singleton gestation with relapsing-remitting multiple sclerosis, Ehlers Danlos syndrome-hypermobility type, chronic lower back pain and lumbar spine surgery was consulted at our high risk clinic for formulation of a labor analgesia/anesthesia plan. Our team decided to avoid spinal anesthesia, hyperthermia, succinylcholine and epinephrine containing solutions. History of back surgery increased the chances of epidural failure and exacerbation of back pain. Attempt to place an epidural by the most experienced anesthesiologist was recommended. Remifentanil PCA for labor and general anesthesia for cesarean deliver was kept as back up plan.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC489
A Case of Facioscapular Humeral Dystrophy (FSHD) in an Obstetric Patient
Shannon Klucarits, M.D., Megan Way, M.D., Irina Gasanova, M.D., Anesthesiology, Parkland Health and Hospital System, Dallas, TX, Anesthesiology, UT Southwestern, Dallas, TX.
28 year-old G1P0 with hx of FSHD, HTN, OSA, CHF presented at 37w1d for elevated BPs. She was admitted for BP management. Due to difficulty controlling BP, labor was induced. Anesthesia was consulted for epidural placement. Anesthetic concerns in this patient included the following: possible difficult airway, increased risk of malignant hyperthermia, possible difficult neuraxial placement related to FSHD, and risks associated with OSA. Epidural was successfully placed, after multiple attempts, utilizing ultrasound. Patient was allowed to labor, but went for cesarean section secondary to failure to progress. The epidural worked well for C/S, and mother and baby did well.
Anesthesia for Cesarean Section With Severe Uterine A-V Malformation: A Case Report
Sudheera Kokkada Sathyanarayana, M.D., Jing Song, M.D., Anesthesiology, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY.
33 year G4P1021, 35wk pregnant with large uterine AV malformation, innumerable tortuous vessels presented for c-section. Her previous vaginal delivery was complicated by significant bleeding requiring uterine artery embolization. In anticipation of massive bleeding, multi-disciplinary meeting was held. The perfusionist and vascular surgeon were available to achieve controlled hemorrhage. Pre-operative aortic and hypogastric artery catheter balloon were placed. C-section was performed under GA with pre-induction arterial line and large bore central venous catheter placement. Baby girl was delivered by c-section with careful separation of uterine vessels with ultrasound guidance. Post operative uterine artery embolization was unsuccessful because of extensive collateral circulation.

Perioperative Management of a Parturient With a 32 Week Abdominal Pregnancy Requiring Hysterectomy Under General Anesthesia
Brian P. Kornrumpf, M.D., Newell A. Daly, D.O., Jessica L. Booth, M.D., Anesthesiology, Wake Forest University School of Medicine, Winston Salem, NC.
43 year-old G2P1 with chronic hypertension and bicornate uterus admitted to the hospital at 32 weeks after a follow-up ultrasound showed a complete placenta previa and possible interstitial pregnancy with abdominal presentation. An abdominal MRI was obtained which was interpreted as an intrauterine pregnancy with a thin uterine rim encompassing fetus. Due to uncertainty of the fetal location a scheduled cesarean section was performed under spinal anesthesia. Upon surgical entry to the abdomen an abdominal pregnancy was discovered with placenta adherent to small bowel mesentery. A conversion to a general anesthetic occurred to facilitate an urgent total abdominal hysterectomy.

Anesthetic Management of Cesarean Section in Protein S Deficiency
Vikas Kumar, M.B.,B.S., Yi Hua, M.D., Anesthesiology, Georgia Health Science University, Augusta, GA.
We present a 23 year-old female, G2P3113 at 38 weeks presented for cesarean section. Her medical history included hereditary protein S deficiency, multiple episodes of pulmonary embolism and deep vein thrombosis, IVC filter, on subQ heparin 10000 units bid, morbid obesity with BMI 57 kg/m2, asthma, chronic hypertension, and previous cesarean section. Patient had combined spinal epidural using intrathecal 10 mg of 0.75% bupivacaine and 200 mcg of preservative free morphine and epidural 2% lidocaine. The surgery and post-operative recovery was uneventful. We will discuss anesthetic management options of protein S deficiency in pregnancy.
Monday, October 15, 2012
8:00 AM - 9:30 AM
MC493

Electroconvulsive Therapy for the Management of Catatonic Schizophrenia in a Pregnant Patient
Kathleen Kwiat, D.O., Dhiren Soni, D.O., Magdy Takla, M.D., Department of Anesthesiology, Cooper University Hospital, Camden, NJ.
22 year-old G1P0 patient with a history of asthma and depression presented with catatonic schizophrenia. She had minimal response to medication except high dose benzodiazepines, placing the fetus at risk. Electroconvulsive therapy was performed under general anesthesia with rapid sequence induction. Complications included bronchospasm, increased pharyngeal secretions, inadequate seizure duration and prolonged seizure duration. Anesthetic management was adjusted to minimize these complications, including premedication with albuterol and glycopyrrolate, and inducing with methohexital versus propofol. The patient responded to therapy and was discharged without apparent fetal adverse effects.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC494

A Case of Neuraxial Analgesia in a Patient With Antithrombin III Deficiency Receiving Antithrombin III Supplementation During Labor
Elizabeth M. Lange, M.D., Heather Nixon, M.D., Anesthesia, University of Illinois Chicago, Chicago, IL.
32 year-old G2P0000 at 37weeks, diagnosed with antithrombin III deficiency during coagulation workup following IUFD at 40weeks. Initiated on LMWH at 7weeks. IOL scheduled at 37weeks to allow for heparin bridging and ATIII supplementation during labor, goal ATIII level of 80-120%. At time of neuraxial analgesia, ATIII was 110%, platelets and PTT wnl. Uneventful labor epidural was placed and the patient had an uncomplicated labor course resulting in a vaginal delivery. Epidural catheter was removed one hour after delivery. Close follow up of the patient’s neurologic and hematologic status were continued for 48 hours following delivery.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC495

Postpartum Uterine Rupture
Jason Lau, New York University, Manhattan, NY.
A 43 year-old G13 P11 Female presented to the hospital in labor with an initial exam of 4/50/-2 with contractions q7 minutes and no evidence of vaginal bleeding. Labor proceeded augmented with pitocin with NSVD. EBL was noted to be ~400cc with a firm fundus and no vaginal lacerations present. At 10:29, an obstetrics response code was called for new-onset postpartum hemorrhage. After a physical exam of the uterus suggestive of uterine rupture, ultrasound revealed a uterine fundal rupture, and the decision was made to go to the OR.
Monday, October 15, 2012
8:00 AM - 9:30 AM
MC496
A Case of Evan's Syndrome in Pregnancy Complicated by Eclampsia
Lisa K. Lee, M.D., Mary J. Im, M.D., Anesthesiology and Perioperative Medicine, Drexel University College of Medicine, Philadelphia, PA.
A 19 year-old G1P0 at 34 weeks presented after a tonic-clonic seizure. The patient’s medical history was significant for Evan's syndrome, which required systemic steroids and IVIG during pregnancy. Her blood pressure was mildly elevated. Laboratory tests revealed severe thrombocytopenia and proteinuria. The decision was made for patient to undergo emergency cesarean section under general anesthesia, and a viable male infant was delivered without complication. The clinical impression was eclampsia complicated with Evan’s syndrome. The patient was closely monitored while on a magnesium sulfate infusion for 24 hours after delivery. Patient was discharged in stable condition on postpartum day 4.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC497
Neuraxial Blockade: A Viable Option in a Patient With Arthrogryposis Multiplex Congenita
Lisa K. Lee, M.D., Kesavan Sadacharam, M.D., Mian Ahmad, M.D., Anesthesiology and Perioperative Medicine, Drexel University College of Medicine, Philadelphia, PA.
A 28 year-old female, G1P0, was admitted for trial of labor at 37 weeks. Her medical history was significant for severe arthrogryposis, gestational diabetes mellitus, history of seizures and GERD. Physical examination revealed severe scoliosis of thoracic and lumbar spine, with contractures in all four extremities. After a discussion with the patient, a combined spinal-epidural was performed with considerable difficulty. Good analgesia was achieved for both labor pain and subsequent c-section. To our knowledge, this is the first successful performance of combined spinal-epidural anesthesia for labor analgesia and subsequent anesthesia for c-section in a patient with AMC.

Monday, October 15, 2012
8:00 AM - 9:30 AM
MC498
The Use of Remifentanil During General Anesthesia for Emergency Cesarean Section in a Patient With Marfan Syndrome Complicated by Ascending Aortic Aneurysm and Heart Failure: A Case Report
Byung Gun Lim, Ph.D., Jea Yeun Lee, M.D., Hye Yoon Park, M.D., Myoung Hoon Kong, Ph.D., Il Ok Lee, Department of Anesthesiology and Pain Medicine, Korea University Guro Hospital, Seoul, Korea, Republic of.
The choice of anesthetic technique should be focused on minimizing hemodynamic fluctuations during cesarian section (c/sec) in pregnant women with Marfan syndrome. Increased failure of spinal anesthesia and dural puncture during epidural anesthesia have been reported in Marfan patients. Also, because anesthesiologists refrain from using high concentrations of volatile anesthetics during c/sec, the resulting shallow depth of anesthesia challenges achieving hemodynamic stability. We report a successful management of a 31-year-old pregnant woman with Marfan syndrome complicated by aortic aneurysm and heart failure without any hemodynamic complications or neonatal depression with the use of remifentanil during general anesthesia for c/sec.
Monday, October 15, 2012
11:00 AM - 12:30 PM
MC587
Post - CSE Seizure in a Parturient: Is it Eclampsia?
John K. Liu, M.D., Kalpana Tyagaraj, M.D., Jason Yu, M.D., Anesthesia, Maimonides Medical Center, Brooklyn, NY.
A 20 years primigravid parturient, after receiving a CSE developed tonic-clonic movements of the upper extremities, LOC, apnea and masseter rigidity. CSE was performed with minimal difficulty despite severe scoliosis. The patient became hypoxic and bradycardic. She was manually ventilated with some difficulty with recovery of FHR and intubated after administration of atropine, succinylcholine and propofol. After stabilizing the patient and her baby in L&D, C-Section was performed in OR uneventfully. Patient was extubated awake and following commands. Review of documentation revealed that the patient received 100 mcg of fentanyl intrathecally, which is the probable etiology for this event.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC588
Management of a Patient With Twin Gestation and Velamentous Cord Insertion With Large Post Delivery Hemorrhage During Cesarean Section
Yuan-Feng Carl Lo, M.D., Colin Wilson, M.D., West Virginia University, Morgantown, WV.
A 24 year-old primagravida with twin gestation was diagnosed with velamentous cord insertion on ultrasound. A cesarean section was scheduled at 30 weeks gestation to prevent laboring through a potential undiagnosed vasa previa. Velamentous cord insertion and vasa previa are risk factors for fetal hemorrhage, but not usually a cause of maternal hemorrhage. A spinal anesthetic was used. Despite the uncomplicated delivery of both the twins and the placenta, the site of placental insertion continued to bleed resulting in 2500mL over a 20 minute period. We describe the management of unexpected intense hemorrhage during spinal anesthesia.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC589
Orofacial Cleft Malformation Secondary to CellCept Use During the First Trimester of Pregnancy
Yuan-Feng Carl Lo, Andrew Criser, M.D., Anesthesiology, West Virginia University, Morgantown, WV.
This is a 35 year-old G1P0 admitted for polyhydramnios and IUGR at 30 6/7 WGA. The fetal ultrasound revealed bilateral cleft lip and palate, and a left facial cleft, directly resultant from CellCept use during the first trimester for stage III CKD s/p renal transplant. A multidisciplinary approach to maternal and neonatal care was enacted. An uncomplicated primary LTCS was performed under lumbar spinal anesthesia. After delivery, multiple airway maneuvers were considered, including laryngoscopy, fiberoptic intubation, and tracheostomy. Direct laryngoscopy was successful. However, due to underdeveloped lung tissue, gas exchange couldn’t be established. The neonate was made comfort care.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC590
Pregnant Diaphorphic Dysplastic Dwarf With Malignant Hyperthermia and a Known Difficult Airway
Tanya Lucas, M.D., Anesthesia, UMass Memorial Medical Center, Worcester, MA.
The patient is diaphorphic dysplastic dwarf presenting emergently for primary cesarean section for breech presentation. DDD is a disorder of cartilage leading to short stature and scoliosis. The patient had
difficult intubations reported in seven previous anesthetics and an episode consistent with malignant hyperthermia. The severe curvature of her spine precluded use of regional anesthesia. She was sedated with midazolam and propofol while maintaining spontaneous ventilation. Multiple fiberoptic intubation attempts failed and a #4 LMA was placed. With the patient breathing spontaneously anesthesia was maintained with propofol and nitrous oxide. She delivered a healthy male and suffered no complications.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC591
A Case of Septic Shock in a Parturient
Praneeth Madabhushi, M.D., Stanlies D’Souza, M.D., Department Of Anesthesiology, Baystate Medical Center/Tufts University School of Medicine, Springfield, MA.
A 40 year-old female, diabetic presented with acute abdominal pain. She was diagnosed as pregnant in active labor with a gestational age of 24-28 weeks by ultrasonography. Patient subsequently developed hypoxia, hypotension and tachycardia and presumptive diagnosis of pulmonary embolism/amniotic fluid embolism was made. A rapid sequence induction was done with etomidate and succinylcholine and airway was secured. During induction patient had a cardiac arrest with pulseless electrical activity and was successfully resuscitated according to ACLS protocol. A nonviable fetus was delivered with purulent discharge. A final diagnosis of septic shock with ARDS secondary to chorioamnionitis was made.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC592
Neurologic Deficit Following Epidural
Dipty Mangla, M.D., Mary Im, M.D., Anesthesia, Hahnemann University Hospital, Philadelphia, PA.
Incidence of neurologic deficits following regional is 0-1.2/10000 patients. 30 year-old healthy and pregnant patient received uncomplicated epidural for L&D. However, second day postpartum she complained of unsteady gait and paresthesia on her feet. Neurologic exam revealed decreased sensory deficit in left L4, L5 distribution and power of 4/5 in left lower extremity. MRI revealed disc disease. Patient’s neurologic symptoms improved over next 2 days. Follow up with neurology was recommended. A careful history, physical exam, laboratory testing and use of imaging techniques will help to ensure an accurate diagnosis and good outcome after epidural.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC593
Anesthesia Management for Super-Obese Case (Body Mass Index, 61.4) Undergoing Open Uterectomy
Takashi Matsusaki, Mako Kosaka, Hideki Taninishi, Hiroshi Morimatsu, Kiyoshi Morita, Okayama University Hospital, Okayama, Japan.
Recently, even in Japan, we are tending to have such "super obese" cases as compared to previous years. We conducted anesthesia on a 36-year-old woman with body weight 150kg (height 159cm) and body mass index (BMI) of 61.4 kg/m who was undergoing open uterectomy by using ultrasound-guided Transversus abdominis plane (TAP) block. Fortunately, it was easy to secure her airway and intubate with an endotracheal tube (inter diameter 7.0 mm) using a conventional Macintosh laryngoscope by one anesthesiologist. Ultrasound-guided transversus abdominis plane block might be useful for super-obese patients.
Monday, October 15, 2012
11:00 AM - 12:30 PM
MC594
Anesthetic Management of Parturient With Dural Ectasia Due to Marfan’s Syndrome: Successful CSE
Matthew C. Mauck, John Lemm, M.D., Cathleen Peterson-Layne, M.D., Ph.D., Duke University, Durham, NC.
Marfan’s syndrome patients have high incidence of dural ectasia. The additional volume of sacral/lumbar CSF impairs local anesthetic spread decreasing the success of neuraxial anesthesia, the preferred technique for elective Cesarean delivery (CD). We describe a patient with Marfan’s syndrome and history of failed spinal for CD, likely due to dural ectasia, successfully managed with combined spinal epidural (CSE). After initial spinal proved inadequate for surgery (T10 level) the epidural catheter in situ allowed for incremental dosing to achieve adequate block. Dural ectasia was the likely cause of patchy initial block; and successful CSE allowed for avoidance of general anesthesia.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC595
Cesarean Section in a Parturient With Severe Muscular Dystrophy, Scoliosis, and Malignant Hyperthermia
Anne P. McConville, M.D., Lindsay P. Attaway, M.D., Nicole Weiss, M.D., Robert Hansen, Jr., M.D., Jonathan Weed, M.D., Anesthesiology, Tulane University School of Medicine, New Orleans, LA.
The parturient with muscular dystrophy and its associated multi-system effects pose many anesthetic challenges. These multi-system effects may include scoliosis, with or without prior back surgery, which may preclude successful neuraxial anesthesia. It may also include cardiovascular abnormalities, chronic lung disease, and increased incidence of malignant hyperthermia. We present a case of the successful anesthetic management of a parturient with muscular dystrophy, thoracolumbar fusion secondary to severe scoliosis, severe restrictive lung disease, and history of malignant hyperthermia for cesarean section.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC596
Massive Hemorrhage During Repeat Cesarean Section in a Parturient With Placenta Previa Increta: Do Balloon Occlusion Catheters Decrease Blood Loss?
Anne P. McConville, M.D., Brent Dilts, M.D., Michael A. Tahir, M.D., Anesthesiology, Tulane University School of Medicine, New Orleans, LA.
Placenta accreta is the leading cause of cesarean hysterectomy due to the increasing cesarean section rate. The potential for massive, life-threatening hemorrhage is high in the presence of placenta accreta. Predicting which parturients are at risk for placenta accreta and planning the delivery offer the best outcomes. Balloon occlusion embolization catheters are gaining popularity to aid in blood loss reduction. We present a case of repeat cesarean section with complete placenta previa and placenta increta. Balloon catheters were placed appropriately pre-operatively. However, blood loss exceeded twice the patients blood volume, requiring transfusion of 25 units PRBC's and 15 units FFP.
Monday, October 15, 2012  
11:00 AM - 12:30 PM 
MC597  
**Epidural Blood Patch in a Jehovah's Witness**  
*Matthew McDaniel, M.D., Duke University, Durham, NC.*  
A 31 year-old G3P2 Jehovah’s Witness presented for a scheduled repeat C-section. She reported a history of difficult spinal placement with her first C-section, with a failed SAB necessitating a GA. CSE placement for this case was difficult, with multiple attempts prior to placing the epidural catheter and a separate SAB. The SAB again failed and a GA was required. The patient reported severe postural headache on POD2 and after failing conservative measures an epidural blood patch was performed on POD4 using a novel technique that was agreed upon after discussion with the patient and our Center for Blood Conservation.

Monday, October 15, 2012  
11:00 AM - 12:30 PM 
MC598  
**Obstetrical Anesthesiology: From Induction of Labor to Arachnoiditis - An Unfortunate Sequence of Events for One Parturient**  
*Brian A. Mirante, M.D., Balazs Horvath, M.D., Michael DiLuna, M.D., Anesthesiology, Neurosurgery, Yale University, New Haven, CT.*  
The patient is a 37 year-old G2P1 at 41+4 weeks who presented for induction of labor. She sustained an unintentional dural puncture during epidural placement, eventually leading to delayed (12 days) postdural puncture headache. Her symptoms prompted admission and an epidural blood patch was performed. Upon presentation, she was found to be hypertensive and new onset delayed postpartum preeclampsia was recognized. The patient was treated and discharged home but returned four days later with low back pain, unsteady gait, and leg weakness. Arachnoiditis was later diagnosed and treatment with high dose steroid therapy was initiated, eventually leading to resolution.

Monday, October 15, 2012  
11:00 AM - 12:30 PM 
MC599  
**Occult Spinal Dysraphism in an Obstetric Patient**  
*Daria M. Moaveni, J. Sudharma Ranasinghe, M.D., Anesthesiology, University of Miami-Jackson Memorial Hospital, Miami, FL.*  
A 37 year-old G3P0020 at 37 weeks gestation, with history of a large lipoma overlying the lumbar region of her back, was scheduled for cesarean delivery. Anesthesia was consulted to evaluate for the use of neuraxial anesthesia for surgery. According to the patient, the lipoma had been present since birth without causing symptoms or neurological deficits. Lumbar MRI showed a lipomyelomeningocele at L2-3, a lipoma that contained nerve roots. The low lying conus medullaris ended at L3. The dorsal spinal cord was tethered to the intradural lipoma at L1-2. Elective general anesthesia was done for cesarean delivery without complications.
Monday, October 15, 2012
11:00 AM - 12:30 PM
MC600
**Postdural Puncture Headache and Hemorrhagic Stroke in an Obstetric Patient**

*Joseph J. Mueller, M.D., Kuntal Jivan, M.D., Kannupillai Vinayakom, M.D., Anesthesiology, Georgetown University Hospital, Washington, DC.*

37 year-old presented on Day 1 with postdural headache following labor epidural placement. She developed postural headaches following delivery so an epidural blood patch was placed. On Day 4 symptoms returned and a second epidural blood patch was done. The same day, a third patch was completed due to refractory symptoms. She was admitted for continued observation and conservative management. On Day 5 head CT showed no intracranial abnormalities. On Day 6 she experienced acute neurologic deficits; urinary incontinence, slurred speech, and decreased strength in her left extremities. MRI showed a large intraparenchymal hemorrhage that required surgical decompressive craniectomy.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC601
**Survival After Undetectable Hemoglobin in a Parturient With Massive Postpartum Hemorrhage**

*Shweta Narang, M.D., Ramsis F. Ghaly, M.D., Piotr Al-Jindi, M.D., Ned F. Nasr, M.D., Gennadiy Voronov, M.D., Anesthesiology, John H. Stroger Jr. Hospital of Cook County, Chicago, IL.*

27 year-old G7P3 parturient with 3 elective abortions, presented in preterm labor, when she received an uneventful labor epidural, underwent spontaneous vaginal delivery and then difficulty in placental delivery and brisk hemorrhage. She became hypotensive, was rushed to the OR and GETA was induced. Due to continued bleeding, hysterectomy was done. Patient’s hemoglobin was undetectable on i-Stat. EBL was 6000 ml, and she received 10L of IV fluids and 28 units of blood products. On surgery completion, patient was taken to the ICU, extubated after 7 hours and discharged home on postoperative day 5. Biopsy of the specimen confirmed placenta accreta.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC602
**Massive Transfusion in a Patient With Placenta Percreta**

*Tuyet Ha Nguyen, Benjamin Wallisch, D.O., UTHSCSA, San Antonio, TX.*

A 31-year-old G2P2 female presented with placenta percreta invading the urinary bladder. After thorough preoperative planning, she underwent an uneventful delivery under general anesthesia. However, due to the extent of the placental tissue, intense blood loss started with delivery. Our institution’s MTP was initiated early. After nine hours of placental debulking and hemostasis, a total of 205 units of pRBCs, 205 units of FFP, 24 units of six-pack platelets, and 5 units of cryoprecipitate had been transfused. After several days in the ICU, she was extubated 6 days later and discharged to home 33 days later.
Management of a Patient with Cervical Varices and Planned Cesarian Section  
Eric Pan, Frederik Rebling, Anesthesia and Critical Care Medicine, George Washington University, Washington, DC.

A 26-year-old G2P1 with no PMHx, whose pregnancy was complicated by vaginal bleeding and the presence of cervical varices, presented for elective C/S at 39 weeks. She underwent uterine artery balloon placement x2 by Interventional Radiology on the day of surgery. Additional setup included two large-bore IV’s, arterial line placement after induction, Level 1 Blood Warmer was primed and connected, and she was typed and crossmatched for 4 units of PRBCs. Fortunately, the operation went smoothly and both the patient and newborn tolerated the procedure well without incident.

Cesarean Section for a Parturient With Hereditary Angioedema and a History of Difficult Airway  
Algenon M. Parson, M.D., Thomas Mort, M.D., Anesthesiology, University of Connecticut, Farmington, CT, USA, Anesthesiology, Hartford Hospital, Hartford, CT.

A 35-year-old parturient with a medical history significant for hereditary angioedema resulting in multiple difficult intubations, including one incident where her mandible was fractured during an intubation attempt presented in labor and eventually required cesarean section. Triggers for angioedema in this patient have included anxiety, sympathetic stimulation, and pain. The goal in management of this patient was to avoid sympathetic stimulation by providing a sympathectomy via neuraxial blockade, as well as to be prepared to manage her airway in the event of an attack of angioedema.

Labor Analgesia in Hereditary Neuropathy With Pressure Palsy (HNPP)  
Andrew M. Parsons, M.D., Walter Reed National Military Medical Center, Bethesda, MD.

31-year-old G1P0 at 38 weeks with history of Hereditary Neuropathy with Pressure Palsy (HNPP) presented for induction of labor due to gestational diabetes. Physical exam revealed a 112 Kg, 69 inch female with a MP 1 airway and TM distance of 2 FBs. The anesthetic plan involved a continuous lumbar epidural with 0.0625% Bupivacaine and 2mcg/ml of Fentanyl. Our goal was to prevent prolonged pressure applied to a nerve that could lead to a painful neuropathy taking up to 6 months to resolve. The patient underwent uncomplicated cesarean section for failed induction of labor, producing a viable male.

Anesthetic Management of a Parturient With Congenitally Corrected Transposition of the Great Arteries for Scheduled C-Section  
Lucia Parvan, M.D., Tammy Euliano, M.D., Anesthesiology, UF Gainesville, Gainesville, FL.

A 19-year-old P0 at 38w gestation with CCTGA, severe dynamic subpulmonic stenosis, small VSD, and mild-moderate systemic ventricular dysfunction presented for delivery. The team opted for scheduled C-
section under GETA with TEE and TAP blocks for post-op pain. Post-delivery hypotension was treated with fluids and vasopressin. After extubation she became hypoxic, 100% O₂ with CPAP was applied. CXR showed pulmonary edema. Lasix and BiPAP restored saturations to 90+. An arterial line was placed, ABG showed PaO₂ 50mmHg. She was reintubated. ICU course was favorable with resolution of pulmonary edema, weaning and extubation by POD #3 with no further complications.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC607

Perioperative Management of Parturient With HELLP Syndrome

Mary Przybysz, Anesthesia, Case Western University/MetroHealth Medical Center, Cleveland, OH.

A 31 year-old G1P0, presented to the emergency room in her 30th week of pregnancy with right upper quadrant abdominal pain, hemolysis, elevated liver enzymes, and low platelets. With the presentation of abdominal pain, recommendations are to obtain abdominal imaging to rule-out hepatic hematoma and/or rupture and laboratory values including PT, PTT, INR, platelet count, LDH, and liver enzymes to assess the degree of liver dysfunction. This patient can be classified as Class I, with a pre-operative platelet count less than 50,000, placing her at the greatest risk maternal and fetal morbidity and mortality.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC720

Acute Liver Failure in the Peri-Partum Period Requiring Liver Transplantation

Melissa Rader, M.D., Grant Lynde, M.D., Department of Anesthesiology, Emory University, Atlanta, GA.

A 23 year-old G1P0 female at 34 weeks presented for abdominal pain, nausea, and vomiting. The patient demonstrated worsening liver and kidney function necessitating cesarean section. Her post-partum course was complicated by coagulopathy, anemia, leukocytosis, acidosis, hypoglycemia and encephalopathy. The patient’s condition continued to worsen. On POD#4, the patient was listed on the liver transplant list and underwent transplantation the next day. Acute liver failure in the parturient normally resolves with the baby’s delivery. In the rare instance in which there is no clinical improvement, it is important to consider transplantation as part of the treatment algorithm.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC721

Incessant Supraventricular Tachycardia (SVT) in a Parturient

Harish Ramalingappa, M.B.,B.S., Jason Degani, M.D., Lida Trillos, M.D., Nivine Doran, M.D., Anesthesiology, University of New Mexico, Albuquerque, NM.

A 36 year parturient presented with SVT. Medical management included Esmolol, Adenosine, Metoprolol and Amiodarone with no significant response. Cardiology recommended attempting Adenosine, Metoprolol, Verapamil, Calcium chloride and Procainamide but SVT continued. Vaginal delivery proceeded uneventfully and electrical cardioversion (75J) restored sinus rhythm. SVT recurred in about three hours. Repeat cardioversion restored sinus rhythm. SVT recurred again in twenty minutes and was resistant to medical measures necessitating an immediate EP mapping. EP study revealed an aberrant conduction pathway as a cause of her SVT, likely precipitated by the stress of labor. Ablation was successful.
Peripartum Cardiomyopathy: A Case Report
Mangu H. Rao, Sr., Rajnish K. Jain, Sr., M.D., Ravindran Kuppanan, Sr., M.D., Anesthesiology, SVIMS Hospital, Tirupati, India, Anesthesiology, BMHRC, Bhopal, India, Anesthesiology, Salem Polyclinic, Salem, India.
Peripartum Cardiomyopathy (PPCM) is rare and life threatening condition. It may occur in peripartum period in previously healthy woman. PPCM can be lethal. Its etiology is not clear. Diagnosis is mainly by echocardiographic evidence of left ventricular dysfunction. The management is multidisciplinary and should receive treatment for heart failure. Subsequent pregnancies should be managed in high risk perinatal centers. We report an interesting case of PPCM in a 24 year-old lady undergoing emergency lower segment cesarean section under spinal anesthesia. The diagnosis was confirmed by echocardiographic examination. We wanted to share our successful experience of managing PPCM.

Peripartum Cardiomyopathy: Heightened Suspicion, Heart Failure and the Risk of Relapse
Jesse M. Rohde, Agnes Miller, M.D., Keric Menes, M.D., Anesthesiology, Maimonides Medical Center, Brooklyn, NY.
A 30 year-old F, G2P001, admitted to high risk labor and delivery at 36 wks 5 days for repeat c-section. Previous pregnancy complicated by peripartum cardiomyopathy, diagnosed post-partum. Echo revealed an EF of 30% and severe decrease in LV function. Patient developed dyspnea, tachycardia and hypotension upon spinal anesthesia. The high risk of peripartum cardiomyopathy relapse, the complexity of heart failure in the pregnant female, the life-threatening nature of the condition, and the absence of recognizable heart disease prior to the final month of pregnancy make the perioperative management of this case challenging.

Anesthetic Management of Labor in a Parturient With Hyperkalemic Periodic Paralysis
Scott M. Ross, D.O., Manuel Vallejo, M.D., Department of Anesthesiology, UPMC, Pittsburgh, PA.
This patient is a 22 year-old G1P0 at 36 weeks and 6 days with Hyperkalemic Periodic Paralysis who presented in labor. With several episodes of paralysis throughout her pregnancy, it was discussed to manage her labor with an epidural early in her course to eliminate a stress response from pain, which could exacerbate her symptoms due to hyperkalemia. An uncomplicated epidural was placed, which managed her labor and allowed for a successful vaginal delivery of twins. There were no episodes of paralysis throughout her peripartum period.
Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC725
Illustrating the Trauma Obstetric Patient: Placental Abruption With a High Cervical Spine Injury
Alecia L. Sabartinelli, M.D., Nicholas B. Nedeff, M.D., Anesthesiology, Jackson Memorial Hospital, Miami, FL, Anesthesiology, University of Miami School of Medicine, Miami, FL.
26 year-old female hit by truck arrives confused with signs of blunt injury but stable vitals. Further evaluation reveals a 33-week gravid uterus with placental abruption and a nondisplaced C2/odontoid fracture with vertebral artery dissection. OB service's initial plans are for urgent C-Section. Upon pre-operative assessment, this lethargic pregnant female status-post trauma with known cervical injury develops painful contractions and late-decelerations now requiring emergent C-section. Anesthesia plans for rapid induction with aslepp fiberoptic intubation which is achieved uneventfully after patient is prepared for incision. A stable infant, APGARs 6/10/10, is delivered, while emergence and subsequent extubation is completed safely.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC726
Oxytocin: Friend or Foe? A Case of New Onset Atrial Fibrillation in a Healthy Parturient During Cesarean Section
Marwa Salman, Roshmi Kumar, M.D., F.R.C.A, Ali Ahsan, M.D., F.R.C.A., Department of Anaesthetics, Queen Mary’s Hospital, London, United Kingdom.
A 28 year-old healthy female with no history of cardiac disease underwent an elective caesarean section under spinal anaesthesia. Shortly after receiving intravenous oxytocin (5 IU) she developed fast atrial fibrillation (AF). Physical examination, serum electrolytes and thyroid function tests were normal. An echocardiogram showed mild tricuspid regurgitation but was otherwise unremarkable. She remained in AF despite intravenous magnesium and amiodarone but subsequently reverted to sinus rhythm 8 hours after the onset of symptoms. Despite an acceptable safety profile, oxytocin has undesirable haemodynamic side effects and may contribute to the development of maternal arrhythmias in the pro-arrhythmogenic state of pregnancy.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC727
An Epidural Catheter for Labor and Delivery That is More Than One Year Old. Is That Really Possible?
Corey Scher, M.D., Anesthesiology, New York University School of Medicine, New York, NY.
A 12 year-old cachetic, and mentally retarded G1P0 appeared in labor. HIV testing revealed a viral load of > 1000 copies/ml. CD4 was 50. C-section under epidural was performed. One year later, she reappeared. When changing into a gown, a stench came from her. The catheter placed a year ago was still in. Lumbar C-T scan was negative. INR was 5.0. The plan was AZT then C-section. The back was cleansed with chlorhexidine. During cleansing, the catheter broke at 15cm G/A for c-section was followed by a 3 hour unsuccessful attempt by neurosurgery to remove the catheter. On POD#1, she was found unarousable.
Management of a Parturient With Lupus Anticoagulant and Suspected Pulmonary Embolus for Caesarian Section

Elizabeth G. Shaffer, Anesthesiology, University of Pittsburgh Medical Center, Morgantown, WV.

A 39 year-old parturient with lupus anticoagulant and prior history of pulmonary embolus presents at 33 weeks GA complaining of dyspnea, reportedly similar to her prior episode of PE. She was prescribed therapeutic heparin but ran out of medication. After admission for suspected pulmonary embolus, decreased fetal movement was noted and the patient was consented for caesarian section. The patient was taken to the main OR, where a rapid sequence induction and endotracheal intubation was performed with Glidescope. Pulmonary artery catheter and TEE were placed post-induction. The patient remained hemodynamically stable and uneventful caesarian section was performed.

Acute Paroxysmal Airway Obstruction in Third Trimester of Pregnancy

Mehul Shah, D.O., Toni Chahla, M.D., Stanlies D’Souza, M.D., Anesthesiology, Baystate Medical Center, Tufts University School of Medicine, Springfield, MA.

A 16 year-old presents in her third trimester of an otherwise uneventful pregnancy with labored breathing and inspiratory stridor. On physical exam via nasal flexible fiberoptic scope, a purple pedunculated mass was found to be ball valving in and out with inspiration and expiration, respectively. After topicalization with lidocaine and patient in supine position, an awake oral fiberoptic intubation was performed with 6.0 cuffed endotracheal tube while maintaining the lesion in constant view. Left uterine displacement was maintained with continuous fetal heart rate monitoring. A thrombosed polyp (pending pathology report) was excised with no perioperative complications.

Acute Pulmonary Edema After Vaginal Delivery

Pranav R. Shah, M.D., Kowe Olajide, M.D., Patricia Dalby, M.D., Department of Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

A 27 year-old female G1P0 with an active history of cocaine and opiate abuse was admitted at 39 weeks gestation in active labor. She underwent vaginal delivery under epidural analgesia with a lumbar epidural catheter infusing bupivacaine 0.0825% with 2 ug/cc fentanyl. Within one hour after delivery, she complained of shortness of breath, expectorated blood tinged frothy sputum, and required 12 liters face mask to maintain 92% oxygen saturation. Evaluation revealed acute pulmonary edema due to acute mitral annular dilatation with severe eccentric mitral regurgitation. After medical stabilization, she underwent mitral valve repair with 24 mm annuloplasty ring.
Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC731
Acute Fatty Liver of Pregnancy, Massive Hemorrhage and Abdominal Compartment Syndrome
Omair Shakil, M.D., Jayant S. Jainandunsing, M.D., Feroze Mahmood, M.D., Robina Matyal, Philip E. Hess, M.D., Anesthesia, Critical Care and Pain Medicine, Beth Israel Deaconess Medical Center, Boston, MA, USA, Anesthesiology and Pain Medicine, University Medical Center Groningen, University of Groningen, Groningen, Netherlands.
A 32 year-old primigravida with twin pregnancy was scheduled for an urgent cesarean section for fetal arrhythmia. After uncomplicated administration of spinal anesthesia, icterus was noted; subsequent intraoperative laboratory investigations were indicative of acute fatty liver of pregnancy (AFLP). Following delivery, the patient developed severe postpartum hemorrhage requiring massive transfusion. Due to coagulopathy and ongoing bleeding she developed abdominal compartment syndrome and underwent an exploratory laparotomy. Concern was also raised for development of Sheehan’s syndrome. Anesthetic challenges in this patient included AFLP and massive hemorrhage in a pregnant patient with a difficult airway (Mallampati class IV).

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC732
Diabetes Insipidus Associated With HELLP Syndrome in Pregnancy
Ashley E. Smith, M.D., Stephen Pratt, M.D., Anesthesiology, Beth Israel Deaconess Medical Center, Boston, MA.
Gestational diabetes insipidus (DI) in association with HELLP syndrome is rare. We present a 24 year-old G4P1 at 34/3 weeks gestation with dichorionic/diamniotic twins. Her chief complaint was blurry vision. Lab values demonstrated Na+ of 164, uric acid of 11.6, platelets of 106 K/uL and AST/ALT of 433/825. She had an emergent cesarean section for fetal indications under GA. DI was confirmed with low urine osmolarity and high serum osmolarity. Her sodium was corrected less than 12 meq/24 hours with IV administration of D5W and low dose DDAVP. Case with discuss implications and management of DI in pregnancy.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC733
Anesthetic Management of a Parturient With Severe Pre-Eclampsia and Ruptured ACOM Aneurysm for Cesarean Section and Simultaneous Cerebral Artery Aneurysm Clipping
George L. Smith, M.D., Daniel Forest, M.D., Anesthesiology, Wake Forest University, Winston-Salem, NC.
A 37 year-old G5P4 parturient at 33 weeks gestation presented with severe pre-eclampsia and SAH with neurologic impairment. PMH included chronic HTN, drug abuse, asthma and obesity. Emergent c-section and simultaneous external ventricular drain placement followed by craniotomy for aneurysm clipping was planned. Pre-induction blood pressure control included incremental nitroglycerin. Oxygen-isoflurane-fentanyl used for maintenance anesthesia with remifentanil started after delivery. The case was complicated by maternal wheezing, oxygen desaturation and post-delivery uterine atony. Labetalol and remifentanil helped facilitate a hemodynamically stable emergence and neurologic assessment, while allowing postoperative ventilation to continue. The patient was extubated the following morning neurologically intact.
The Use of Dexmedetomidine for Awake Intubation in an Achondroplastic Obstetric Patient
Sarah Smith, D.O., Lakshmi Madabhushi, M.D., Ashish Malik, M.D., Baystate Medical Center, Springfield, MA.
A 23 year-old 4’11”, 53 kg achondroplastic dwarf G1, P0 presented in active labor at 39 weeks for urgent cesarean section following spontaneous rupture of membranes. She had prior Harrington rod placement from T2 to sacrum, physiologic fusion of the cervical spine from C1-C6 with question of pseudoarthrosis and instability of C4-5. Physical exam revealed mallampati grade 4 airway with limited neck mobility. An awake fiberoptic intubation was performed using Dexmedetomidine infusion with fetal monitoring. The general anesthesia and delivery of the baby was uneventful. We extubated the patient at the conclusion of the surgery.

Management of a Non-Adherent Patient in Chronic 3rd Degree Heart Block Presenting for C-Section
Adam Snavely, M.D., Ken Raessler, M.D., Anesthesiology, Maine Medical Center, Portland, ME.
A 21 year-old G3P2 patient is transferred to our facility with concern for preterm labor. The patient’s past medical history is most notable for complete congenital heart block resulting in two remote episodes of syncope. The patient has not pursued pacemaker therapy as recommended by her cardiologist. In this abstract, we discuss the prevalence of third degree heart block, identify key points of perioperative management in obstetric patients with third degree heart block, and discuss our management of this patient’s c-section with spinal anesthesia.

To Do or Not To Do: Caesarean Section and Diabetic Ketoacidosis
Saravanan Solaidhanasekaran, B. Uthappa, M. Purva, Anaesthetics & ICU, Hull Royal Infirmary, Hull, United Kingdom.
A 33 year-old primigravida with type 1 diabetes mellitus who was 36 weeks pregnant was admitted overnight with DKA to A&E. She remained acidotic during the night with pH of 7.25 and base deficit of 15 with bicarbonate of 12. Her BM was 17.8, pH was 7.22 with base deficit of 20.3 and she had received 4 litres of 0.9% saline. It was decided to deliver by LSCS because of worsening general condition despite optimal management of DKA. LSCS was performed under GA after insertion of arterial and CVP lines before induction. Patient was transferred to ITU for postoperative management.

ECMO as a Rescue in Amniotic Fluid Embolism
Kim Strupp, Dawit Haile, M.D., Mayo Clinic, Rochester, MN.
A 35 year-old G1P0 parturient at 38 6/7 weeks underwent Cesarean section for rectovaginal fistula and developed the sudden onset of hypoxia, anxiety and agitation twenty-four hours later. She deteriorated clinically, requiring intubation and mechanical ventilatory support. She was persistently hypoxic despite PEEP 15 and multiple recruitment maneuvers. She was hypotensive and tachycardic, requiring multiple
inotropes. She became progressively more acidotic and difficult to ventilate. Venovenous ECMO was initiated 16 hours after the onset of symptoms. She was supported with ECMO over the next 8 days. She was discharged 20 days after admission and is doing well 6 months post-partum.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
**Anaesthetic Management of a Parturient With Newly Diagnosed and Symptomatic Wolff-Parkinson-White Syndrome for Lower Segment Cessarean Section**

EeMei Soo, M.B., B.S., Krzysztof Kurzatkowski, M.B.,B.Ch., Nazneen Sudhan, M.B.,B.S., Abhay Vaidya, M.D., F.R.C.A, Yaqub Latoo, M.D., F.R.C.A, Anaesthetic and Intensive care, Norfolk and Norwich University Hospital, Norwich, United Kingdom, Anaesthesia, Bedford Hospital, Bedford, United Kingdom.

A 25 year-old primigravida presented with history of WPW syndrome diagnosed in the first trimester. Despite initiation of beta-blocker therapy the patient continued to be symptomatic. The anaesthetic management included a CSE technique which comprised of a low dose spinal with 1.2 mls of 0.5% Heavy Bupivacaine with 20 micrograms of Fentanyl. A T4 sensory block was achieved using extradural volume expansion with 5 mls of Normal Saline. A sequential and titrated administration of a total of 0.25% Levobupivacaine was undertaken as required. As a result vasoactive drugs which could have precipitated malignant ventricular arrhythmias were avoided.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC739

**Temporary Vision Loss Secondary to Posterior Reversible Encephalopathy Syndrome (PRES) in a Preterm Parturient With Eclampsia**

Nazneen Sudhan, Senthil Thanikasalam, M.B., B.S., David Liu, M.D., F.R.C.A, Watson Gomez, M.D., F.R.C.A, Yaqub Latoo, M.D., F.R.C.A., Anaesthetic and Intensive care, Norfolk and Norwich University Hospital, Norwich, United Kingdom, Anaesthesia, Bedford Hospital, Bedford, United Kingdom.

A preterm primiparous suffered six episodes of seizures with brief period of unconsciousness. Initial assessment revealed restlessness and agitation with bilateral loss of vision. Eclampsia was diagnosed on the basis of fulminant hypertension, proteinuria and pedal edema. Eclampsia protocol was instituted to stabilise blood pressure. PRES syndrome was diagnosed on urgent MRI Brain. An emergency caesarean section under general anaesthesia was undertaken. Repeat MRI of brain at eight weeks following the initial event completely reversed back to normal. Early diagnosis of PRES with timely institution of aggressive antihypertensive therapy and providing intensive care support can prevent serious irreversible neurological sequale.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC740

**Case Report: Combined Spinal Epidural (CSE) Anesthesia and Fetal Muscle Relaxation for Percutaneous Umbilical Blood Sampling (PUBS) and Fetal Intravascular Transfusion (FIT) in an Obstetric Patient**

Siam Sukumvanich, M.D., Christopher James, M.D., Anesthesiology, Mayo Clinic, Jacksonville, FL.

We report a case of Percutaneous Umbilical Blood Sampling (PUBS) and Fetal Intravascular Transfusion (FIT) that was successfully performed under CSE. Case: 28 year-old female G5P1 with antiphospholipid syndrome and illicit drug use, presented for PUBS/FIT at 26 weeks. Her pregnancy was complicated by alloimmunization with severe fetal anemia. CSE was choosen due to the following: 1) The procedure necessitates limited maternal movement for umbilical cord puncture and transfusion. 2) The ability to
extend the anesthetic due to multiple blood sampling and the need for an emergency cesarean section. The fetus and mother tolerated the procedure without complications.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC868
Anesthetic Management of a Parturient With Chronic Lyme Disease: A Case Report and Review of Literature
Howard Lee, Jessica Sumski, M.D., Marianne David, M.D., George Washington University Medical Center, Washington, DC.
The patient is a 34 year-old G1P0 parturient who presents at 39.3 weeks gestation age for primary Cesarean section. The patient reports a history of chronic Lyme disease diagnosed four years prior. Her symptoms include persistent vertigo, paresthesias, headaches, low grade fever, and fatigue. MRI examination reveals enhancement in the 7th and 8th cranial nerves. An epidural catheter is placed and Bupivacaine 0.5% is administered until an adequate level of anesthesia is achieved. She received a PCEA infusion of bupivacaine 0.0325% with fentanyl for post-operative pain control. The epidural block regressed after 3 hours with return of baseline neurologic function.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC869
Urgent Cesarean Section in a Parturient With Acute-Onset Obstructive Hydrocephalus and Elevated Intracranial Pressure Secondary to a Newly Diagnosed Acoustic Neuroma
Michael A. Tahir, M.D., Anne McConville, M.D., Jennifer Jou, M.D., Chuck Fox, M.D., Frank Rosinia, M.D., Department of Anesthesiology, Tulane University School of Medicine, New Orleans, LA.
Parturients presenting with acute-onset increased intracranial pressure represent a unique challenge. We report a case of a 40 year-old parturient with acute-onset obstructive hydrocephalus secondary to an acoustic neuroma which was not diagnosed until the third trimester of the pregnancy. Rapid-onset signs and symptoms of elevated intracranial pressure prompted further evaluation and diagnosis. Initial management was expectant, but soon shifted towards urgent cesarean section under general anesthesia utilizing strategies to lower the intracranial pressure. Ventriculoperitoneal shunt placement followed delivery. Craniotomy was performed a month later, and both the mother and fetus had good outcomes.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC870
Anesthetic Management of Pregnancy Following Cardiac Transplant: A Case Presentation and Review of the Literature
Jonathan M. Tan, M.D., M.P.H., Meng Wang, M.D., Ph.D., Ellen Steinberg, M.D., Ramon Abola, M.D., Anesthesiology, Stony Brook University Medical Center, Stony Brook, NY.
29 year-old G1P0 with a history of heart transplant in 2007 secondary to congestive heart failure due to viral cardiomyopathy presented at term for delivery. The patient had no complications related to her cardiac transplant and was stable on her anti-rejection therapy. An interdisciplinary team was formed to manage her pregnancy and delivery. After an epidural placement and a planned induction, the patient had an uneventful vaginal delivery in the labor and delivery suite. We discuss the obstetric, anesthetic, and cardiac considerations related to this case and review the most recent literature on pregnancy following heart transplant.
Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC871
**Peripartum Cardiomyopathy: General versus Neuraxial Anesthesia for Cesarean Delivery**
*Miguel A. Telleria, M.D., M.B.A., Daria Moaveni, M.D., J. Sudharna Ranasinghe, M.D., Anesthesiology, University of Miami, Miami, FL.*
A 25 year-old G3P0111 woman at 27 weeks gestation presented to the labor floor following multiple shocks from her life vest. The patient had a history of peripartum cardiomyopathy with an EF of 15%. She was admitted to the cardiac intensive care unit for medical optimization. Following a multidisciplinary meeting, it was decided to minimize the risk of cardiac decompensation and electively deliver the patient at 29 weeks gestation. The anesthetic plan included a pre-induction arterial line, awake fiberoptic inubation, and general anesthesia with TEE available. Cesarean delivery was done without surgical or anesthetic complications.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC872
**Incarcerated Uterus: Therapeutic Spinal?: A Case Report**
*Eric Ursprung, M.D., Laura Baecher-Lind, M.D., Roman Schumann, M.D., Anesthesiology, Tufts Medical Center, Boston, MA.*
An incarcerated uterus is a rare complication of pregnancy in which the fundus of a gravid, retroflexed uterus becomes trapped beneath the sacral promontory. Anesthetic techniques may be required during treatment but have not been studied systematically. We describe a case in which the anesthetic itself may have been therapeutic.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC873
**Persistent Paraparesis After Spinal Anesthesia in a Parturient: A Practitioner's Nightmare!**
*Fred Usoh, Kalpana Tyagaraj, M.D., Oksana Bogatyryova, M.D., Anesthesiology, Maimonides Medical Center, Brooklyn, NY.*
37 year-old parturient underwent C-Section under spinal anesthesia. She had history of FMD, bilateral carotid artery dissection and on full dose aspirin. During spinal insertion, a brief episode of paresthesia was noted. Postoperatively, patient was unable to move her legs. Neurological examination revealed lower extremity paraparesis, hypertonia, positive Babinski and T11 sensory loss. Imaging studies were normal. High dose steroid was initiated for suspected transverse myelitis. She was evaluated by three neurologists; one suspected conversion disorder. Patient had gradual motor function improvement with physiotherapy and transferred to rehabilitation center ambulating with assistance.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC874
**Persistent Epidural Fluid at the Cervical Spine Level**
*Madhumani Rupasinghe, Naveen Vanga, M.D., Anesthesiology, UTHSC Houston, Houston, TX.*
A 28 year-old female, admitted for induction of labor. Patient requested an epidural and the space was found after three attempts. Twelve hours later, patient complained of an occipital headache and neck pain. Initial course of action was observation with bed rest and hydration. Six hours later, headache had

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still not resolved and patient reported worsening with ambulation. Due to slightly unusual presentation of symptoms and elevated patient concern an MRI of the brain and neck was obtained. MRI: Epidural collection throughout the cervical spine, as high as C2-3. Epidural fluid is possible, blood products may be less likely.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC875
Subdural Hematoma After an Epidural Blood Patch
We report the case of a 37-year-old postpartum patient who developed a contained subacute spinal subdural hematoma causing mass effect on the cauda equina and severe spinal stenosis after undergoing an epidural blood patch for postdural puncture headache. Although epidural blood patches are effective treatments for puncture headaches and are often performed without problems, clinicians should be aware of rare complications and perform appropriate history-taking and physical examination if patients report discomfort. Early imaging when compressive symptoms are present is mandatory.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC876
Parturient With Metastatic Laryngeal Cancer Presenting for Urgent Cesarean Section
Gabriel C. Wade, Tilak D. Raj, M.D., Anesthesiology, University of Oklahoma College of Medicine, Oklahoma City, OK.
We present a 41-year-old at 28 week gestation G1P0 with coronary artery disease, diabetes, hypertension, GERD, and primary laryngeal cancer with metastases to the base of skull and cervical lymph nodes. The patient was aware of her terminal condition early in pregnancy but chose to forgo chemotherapy to be able to have her only child. She was admitted for better pain management of her headache due to metastasis. She became unresponsive on the floor from her pain medications and taken for an urgent C-section. We discuss the many issues presented to us in an urgent manner.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC877
Classic LMA as a Bridge to Tracheal Extubation in a Parturient With a Difficult Airway
Khodadad Namiranian, M.D., Ashutosh Wali, M.D., Baylor College of Medicine, Houston, TX.
A 35-year-old African-American woman, G4P3003, twin pregnancy at 30 weeks, uncontrolled chronic hypertension, severe pre-eclampsia, morbid obesity, coronary artery disease, two coronary stents, diabetes mellitus, and pulmonary hypertension was admitted. Airway examination revealed Mallampati class IV, oral opening >3cm, TMD>6.5, and full range of neck motion. General anesthesia was induced with etomidate/propofol, fentanyl, and succinylcholine. First attempt with Glidescope was unsuccessful, followed by successful intubation with WuScope. Due to difficult tracheal intubation, morbid obesity, cardiopulmonary limitations, and anesthesia related maternal mortality occurring due to failed extubation postoperatively, staged extubation was performed using laryngeal mask airway as a bridge to extubation.
Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC878
Coagulation Conundrum
Jesse Weir, M.D., Anesthesiology, University Of Kansas Medical Center, Kansas City, KS.
29 year-old G1P0 with PMH of SLE (+ lupus anticoagulant), antiphospholipid antibody syndrome and h/o DVT presented for ECV which failed. Pt diagnosed with preeclampsia. Repeat c/s planned. Patient on heparin. Last dose given 30 hours prior. Labs were significant for plts 120 K/UL and a PTT of 69.7 sec. Repeat PTT 4.5 hours later remain elevated (62.3). Heparin assay was less than normal. Can we proceed with regional as lupus anticoagulant can falsely elevate PTT? TEG performed and was mildly elevated. Fetal bradycardia ensued requiring stat c/s under GETA. Placenta accrete diagnosed. Hysterectomy performed.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC879
Factor V Deficiency in Pregnancy: Anesthetic Implications
Lauren Welsh, M.D., Sonia Vaida, M.D., Dmitri Bezinover, M.D., Piotr Janicki, Anesthesiology, Penn State Milton S. Hershey Medical Center, Hershey, PA.
We describe the anesthetic management of a pregnant patient with severe, symptomatic congenital factor V (FV) deficiency presenting for spontaneous labor. Congenital FV deficiency is a very rare bleeding disorder, with a prevalence of 1:1,000,000, inherited as an autosomal recessive trait. Patients with severe FV deficiency (FV<10-15%) present a significantly increased risk for postpartum hemorrhage. FV concentrate is currently not available; therefore, fresh frozen plasma administration (FFP) is required to increase the FV level. We administered 10 mg/kg of FFP beginning with the 2 stage of labor. The patient’s coagulation profile improved significantly and she delivered uneventfully by vaginal route.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC880
We Got Lucky: Neuraxial Anesthesia in a Parturient With Placental Abruption and Unrecognized Disseminated Intravascular Coagulation
A grand multiparous patient was admitted with premature preterm rupture of membranes. She had 4 prior cesarean deliveries. On hospital day 3, she developed vaginal bleeding and a presumptive diagnosis of placental abruption was made and coagulation studies were drawn. Due to the likelihood of difficult cesarean delivery, urgent repeat cesarean delivery was elected. Since both mother and fetus were deemed stable, a neuraxial anesthetic was employed. Postoperatively, she had extensive vaginal bleeding. We discovered her preoperative coagulation studies reflected severe disseminated intravascular coagulation (fibrinogen 35mg/dL and international normalized ratio 2.1). She went on to have an otherwise uneventful recovery.
Pneumomediastinum With Subcutaneous Emphysema Following Cesarean Delivery Under Neuraxial Anesthesia

Casey M. Windrix, M.D., Stephen W. Heimbach, M.D., Nathan G. Putnam, M.D., Department of Anesthesiology, University of Oklahoma College of Medicine, Oklahoma City, OK.

A 22 year-old term parturient received a Cesarean section under neuraxial anesthesia. Following delivery of the placenta the patient developed acute substernal chest pain and dyspnea. The patient was stable and did well with supportive treatment with oxygen via face mask. Follow up cardiac studies were normal, and chest CT angiography ruled out the presence of pulmonary embolism, but did confirm subcutaneous emphysema with pneumomediastinum. Based on this finding the patient was diagnosed with spontaneous postpartum pneumomediastinum, or Hamman’s syndrome, despite a typical occurrence with vaginal deliveries.

Difficult Removal of Functioning Epidural Catheter

Nic Winters, Aurel Neamtu, M.D., Anesthesia, University of Louisville, Louisville, KY.

There are numerous complications associated with epidural placement, some of which include infection, headache, hematoma, chronic low back pain, and more. There is also a good possibility an epidural will not function like one would expect. We present a case of a 28 year-old G1P0 who underwent IOL and vaginal delivery. She had a fully functional epidural placed with no issues. At withdraw of the catheter we met resistance and were unsure of the proper stepwise approach for safe removal. On removal it was found to have a knot tied in the end of the catheter.

Cesarean Delivery of an Anticoagulated Parturient With High Pressure Gradients Across Bi-Leaflet St. Jude Mitral and Tricuspid Mechanical Valves: A Case Report

Cristina Wood, M.D., Tamas Seres, M.D., Joy Hawkins, M.D., Anesthesiology, University of Colorado School of Medicine, Aurora, CO.

A 24 year-old multiparous parturient was admitted for preterm labor at 32 weeks gestation. She had St. Jude mechanical valves at the tricuspid and mitral positions with moderate to severe range of pressure gradients as well as multiple episodes of stroke and pulmonary embolism prior the admission. Given the patient’s propensity for thrombus formation, a cesarean delivery was performed while the patient was anticoagulated on a heparin infusion. An intraoperative 3D transesophageal echocardiography was performed showing immobilization of one of the tricuspid valve leaflets, likely due to thrombus. A healthy infant was delivered with less than one liter of blood loss.
Acute Normovolemic Hemodilution: The Role in a High Risk Obstetric Patient

Relin Yang, M.D., Todd Smaka, M.D., Yehuda Raveh, M.D., Jared Boyd, M.D., Jayanthie Ranasinghe, M.D., University of Miami, Miami, FL.

40 year-old G5P4 black female presented in early labor at 36 weeks gestation for emergent cesarean section. Past medical and surgical history was significant for four previous cesarean sections. Upon type and screen, the patient was noted to have a positive anti U antibody, a rare antibody associated with hemolytic transfusion reactions. Anesthetic plan consisted of acute normovolemic hemodilution, cell salvage, and general anesthesia. The patient underwent a cesarean delivery of a healthy baby boy, and at completion of the operation, 800ml of whole blood removed during hemodilution was transfused back to the patient. She recovered without further incident.

Epidural Placement in a Patient With Undiagnosed HELLP Syndrome

Diana Zentko, M.D., Christopher Jackson, M.D., Tagreed Alshaeri, M.D., Anesthesiology & Critical Care Medicine, George Washington University Hospital, Washington, DC.

A 30 year-old G2P1 female presented to labor and delivery in active labor, requesting an epidural. She had no complications throughout the pregnancy and had no signs or symptoms of preeclampsia. After a difficult epidural placement, with initial intravascular catheter placement, her labs returned showing a platelet count of 23,000. Further labs showed her to be in HELLP syndrome and DIC. She delivered the baby without complication and was transferred to the ICU for further management and concern for epidural hematoma formation.

Postpartum HELLP Syndrome and Multisystem Organ Failure in a Previously Healthy Non-Preeclamptic Patient

Darin Zimmerman, M.D., Cameron Nelson, M.P.H., Karen Slocum, M.D., M.P.H., Timothy Ebbert, M.D., Anesthesiology and Critical Care Medicine, George Washington University Hospital, Washington, DC, George Washington University School of Medicine and Health Sciences, Washington, DC.

A 28 year-old healthy patient undergoes cesarean section under combined spinal-epidural for delivery of twins. Her blood pressure is elevated throughout the case but she has no history of hypertension during the pregnancy. After delivery, she is given a dose of methergine by the OB team for continued bleeding. She complains of RUQ pain and becomes agitated followed by immediate onset of seizures; she is intubated and brought to the ICU. She progresses to HELLP syndrome, TTP-HUS, renal failure requiring dialysis, cardiomyopathy, pulmonary edema and ARDS. After 3 weeks in the hospital she is discharged home in stable condition.