Obstetric Anesthetic Management of a Patient with Active Wegener's granulomatosis

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Wegener's granulomatosis (WG) is a systemic vasculitis distinguished by the formation of necrotizing granulomas primarily in the upper and lower respiratory tracts and kidneys (3,4). Organ involvement and disease course can be highly variable and, if left untreated, morbidity and mortality dramatically increase. WG is very rare and appears to peak in the 4th and 5th decades (3). This may explain the paucity of case reports involving WG and pregnancy in the literature (2). After extensive review of standard anesthesia texts and journals there is even less reported about obstetric anesthetic management.

A 20 year old primigravida female with WG presented with active disease in her third trimester for inpatient treatment. She was diagnosed with a flare of WG leading to a collapse of her right lung and community acquired pneumonia. A multidisciplinary approach to management was taken and aggressive treatment with steroids and Cyclophosphamide, a known teratogen, was recommended. At 31 weeks gestation she was referred for an obstetric anesthesia consult to plan for a C-section prior to starting treatment. After a thorough history and physical along with confirmation of laboratory Results the decision was made to proceed with regional anesthesia and avoid general anesthesia if possible. At 32 weeks gestation, an epidural was placed and slowly dosed to a T4 sensory level with careful consideration not to disrupt her tenuous respiratory status. A successful C-section was then performed and a continuous epidural infusion was started in recovery for post-op pain control.

Due to its variable presentation and unpredictable need for aggressive treatment, WG can be challenging to manage during pregnancy. The most common advice to women planning to get pregnant is to wait until they are in remission, but this is no guarantee they will not relapse (2). The teratogenic and immunosuppressant nature of the most effective medications for active disease leads to a therapeutic dilemma (1). General anesthesia in patients with WG can be particularly challenging due to airway narrowing and fragility along with renal, cardiac, and neurologic disorders (4). Since there is limited data to support the safety of neuraxial anesthesia in these patients it is important to evaluate laboratory studies and a complete neurologic exam. Obstetric anesthetic management necessitates an appreciation of the widespread organ involvement of this disease.

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