Abstract # 139

**Anesthetic Management of a Parturient with Hereditary Hemorrhagic Telangiectasia for Labor and Subsequent Cesarean Delivery**

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The management of pregnant women with Hereditary Hemorrhagic Telangiectasia (HHT, or Osler-Weber-Rendu Syndrome) can be challenging for the obstetric anesthesiologist due to the pathophysiologic changes associated with the disease. Although its prevalence is rare, reports of significant morbidity and mortality exist(1), most related to the presence of arteriovenous malformations (AVMs) in the circulation. Few case reports exist in the literature describing anesthetic management of parturients with HHT for either vaginal or cesarean delivery.(2,3,4)

A 30-year-old woman with HHT presented to our Labor and Delivery suite at 41 weeks gestation. An echocardiogram with bubble study confirmed the presence of a shunt and probable pulmonary AVM. MRI was negative for spinal AVMs. After induction of labor and early dilation of the cervical os, a lumbar epidural was placed. Following an uneventful first stage of labor, multiple fetal decelerations forced expeditious delivery. Vacuum assistance failed and the patient was taken for cesarean delivery. The patient was given supplemental oxygen and her epidural was bolused incrementally to achieve a T5 anesthetic level. Blood pressure was maintained with phenylephrine. There were no episodes of oxygen desaturation or hypotension. Eight minutes after incision, a 3.9 kg boy was delivered with normal Apgar scores. The patient was kept on the Mother and Infant Unit for post-partum monitoring. No complications were reported, and the patient was eventually discharged without incident.

Most women with HHT will have uneventful pregnancies and deliveries; however, there have been case reports of serious morbidity and even mortality in parturients with this disease. The physiologic changes associated with pregnancy can make women with HHT and AVMs more susceptible to untoward effects. Neuraxial blockade has been proposed as a particularly beneficial option for parturients with HHT due to properties that may attenuate shunt through AVMs. Given our success with management of our patient, we support the suggestions described in the case reports referenced, including early institution of epidural analgesia, shortened second stage of labor, maintenance of hemodynamics during labor or cesarean delivery, and appropriate post-partum surveillance.