Abstract # 210

The Pregnant Patient with an Abnormal Airway: An Interdisciplinary Management Plan Initiated and Coordinated by the Obstetric Anesthesiologist

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Pregnant patients can present with all types of medical and/or surgical problems. In general, surgical patients with potentially difficult airways require careful planning but providing safe obstetric care for this type of patient is particularly challenging. We present two patients with significant airway issues who were referred for OB Anesthesia consult. They were successfully managed with a multi-disciplinary team approach coordinated by the anesthesia team.

Case #1
The patient was a 31 year old G1P0 at 28 weeks EGA. PMH was significant for extensive arteriovenous malformations (AVMs) of the head, neck and airway requiring multiple sclerosing procedures and a tracheostomy for one year. Other pertinent PMH included scoliosis with Harrington rod placement and uterine myomas. The patient’s pregnancy made it difficult for her to lie flat secondary to engorgement and pulsation of the AVMs. At the request of the anesthesiologist, an otolaryngology consult was obtained and fiberoptic examination revealed multiple engorged AVMs of the upper airway partially obscuring the epiglottis.

The anesthesiologist contacted both the OB Maternal Fetal Medicine specialist and the otolaryngologist and a plan was developed to perform a primary c/section in the main Operating Room under regional anesthesia with the otolaryngologist standing by. Attempted vaginal birth was considered, but we were concerned about the effects of Valsalva maneuvers on the AVMs as the patient told us that the throbbing worsened with bowel movements. The patient was successfully managed with a continuous spinal technique in the semi-recumbent position using incremental doses of 0.5% isobaric bupivacaine. She had an uneventful c/section and recovery.

Case #2
The patient was a 31 year old G1P0 at 24 weeks EGA. She was a former preemie who required trachesotomy until age 2 resulting in severe tracheal stenosis. Audible stridor was apparent when speaking to the patient. Fiberoptic evaluation by our otolaryngologist revealed vocal cord paralysis on the right and significant vocal cord paresis on the left. A CT scan revealed thin web-like indentations into the tracheal lumen and an airway diameter of 0.6 cm at the most narrow point compatible with a subglottic stenosis.

A multidisciplinary management plan included a scheduled c/section in the main Operating Room under regional anesthesia with otolaryngology standing by. She was successfully managed with epidural anesthesia and had an uneventful c/section and recovery.

Timing and location of delivery, availability of necessary personnel and equipment for delivery and perioperative anesthesia management, including anesthetic choice, post-operative care and pain management must be carefully planned in these types of patients.