General Anesthesia for Vaginal Delivery of twins in an Anticoagulated Obese Laboring Woman with Severe Reflux

Abstract Type: Case Report/Case Series
Vilma E. Ortiz, M.D.; Jason M. Lewis, M.D.
Massachusetts General Hospital

We report on a patient in whom full anticoagulation for a pulmonary embolus (PE) challenged the obstetric and anesthetic plan for delivery of her vertex/transverse (back up) twins.

Case Report: A 32-year-old, G2P0 woman at 35 weeks gestation with dichorionic twins was transferred to our hospital in active labor. She was anticoagulated with enoxaparin for a recent PE, and was recently treated with antibiotics for suspected pneumonia. Her history was complicated by severe acid reflux on pantoprazole, ranitidine, sucralfate and metoclopramide. Her BMI was 34 kg/m2. Her airway and lung exams were unremarkable.

Because of her significant risk of bleeding, the obstetrician was reluctant to perform a C-section. The obstetric plan was for vaginal delivery of both twins, with a strong likelihood of an extremely painful intra–utero manipulation of the second twin to achieve a vertex presentation. As regional anesthesia was contraindicated, the patient requested a general anesthetic (GA). The anesthesiologist and obstetrician discussed the optimum timing for the induction of anesthesia. The desire to minimize the exposure of the unborn babies to anesthetic agents was weighed against the desire to avoid a rushed induction in an obese laboring patient with reflux after delivery of the first of the twins. The decision was made to provide GA for the delivery of both babies rather than repositioning, preoxygenating, inducing and intubating her between deliveries.

The patient received intravenous nalbuphine for labor pain and was transferred to the operating room when the presenting baby’s head was visible at the introitus. The patient was placed in the reverse-Trendelenburg position with a left-lateral tilt and was thoroughly preoxygenated. A rapid sequence induction with propofol and succinylcholine was executed and the intubation was uneventful. The patient was subsequently placed in the lithotomy position for forceps-assisted vaginal delivery of a baby girl, sixteen minutes after induction of general anesthesia; her Apgar scores were 1 and 7. One minute later, a second girl followed by total breech extraction; her Apgars were 2 and 7. The patient was extubated at the end of the procedure and was discharged home two days later with her enoxaparin continued.

Discussion: This case demonstrates the use of GA for the vaginal delivery of twins in an anticoagulated patient. We had to balance the likelihood of an intra–utero version with the risks of a GA. The timing of the induction of anesthesia also had to be considered as converting to a GA after the first twin was born would have entailed a delay due to repositioning and preoxygenating the patient (made necessary by her size and history of reflux). This case illustrates the importance of communication among all team members, particularly when an unexpected condition such as full anticoagulation mandates a departure from standard practice.

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