Background and Aims Pregnant women with hypertrophic cardiomyopathy (HCM) have an increased risk of cardiovascular complications during labor. Particularly when a high outflow gradient is present, tachycardia and systemic vasodilatation are not well tolerated and may lead to cardiac arrest.1

Methods A 39-years-old, ASA III, 39-week pregnant woman with HMC was admitted in a tertiary obstetric center for labor induction. HCM was diagnosed two years before following routine electrocardiogram (EKG). At time of delivery patient presented with dyspnea for medium efforts and was taking bisoprolol 2.5mg id. Holter identified occasional polymorphic ventricular extrasystoles. Transthoracic echocardiography revealed asymmetric hypertrophy of ventricular walls with anterior-inferior septal predominance producing high outflow gradient. Global systolic function was preserved.

Results After hemodynamic monitoring including continuous EKG and invasive blood pressure, labor was induced with vaginal misoprostol and continuous spinal analgesia was early performed. A total of Sufentanil 2.5mcg and Ropivacaine 0.2% 5mg were titrated without hemodynamic repercussion and good pain relieve. Vacuum delivery was uneventful. The newborn had an Apgar score of 9/10.

Mother surveillance and hemodynamic monitoring was maintained during the first 12h of puerperium in an intermediate care unit.

Conclusions To address this case, a multidisciplinary team composed by cardiologists, obstetricians and anesthesiologists was assembled. It was decided to perform a vaginal delivery induction with misoprostol avoiding oxytocin. Vacuum delivery was a strategy to shorten expulsive period. Early and effective labor analgesia with minimal hemodynamic repercussion was key to maintain cardiovascular homeostasis during labor in a patient with symptomatic HCM. Continuous spinal technique was definitely the best option.

Background and Aims Morbid obesity is associated with a significantly higher risk of pre-existing medical conditions, developing antenatal complications, induction of labour, caesarean section. We report the anesthetic management of a multigravida woman with morbid obesity.

Methods A 36 years old, multigravida with 41 weeks’ gestation, 198 kg, BMI 67, with massive swelling of lower limbs and body presented for the procedure of delivery. There was no history of any significant co-morbidity. The surgical history included appendectomy, tonsillectomy and inguinal hernia repair. She was a medium smoker and she was 110 kg in her first gestation. The baseline vital parameters including heart rate (HR), non-invasive blood pressure (NIBP), electrocardiogram (ECG) and oxygen saturation (SpO2) were attached and noted. The patient was planned to give epidural anesthesia for vaginal delivery in sitting position. An informed consent was obtained from the patient for publication of the report without disclosing his/her identity. The lumbar puncture was done at L2-L3 interspace. The epidural space was found in 7 cm and the catheter was inserted plus 7 cm.

Background and Aims Women with spina bifida present both obstetrical and anaesthesia challenges. They are more likely to require a caesarian delivery and traditionally neuraxial anesthesia has been avoided due to concerns of worsening neurologic disability.

Methods A 35-year-old G1P0, at 37 weeks’ gestation, was proposed to an elective caesarean section because of her spinal bifida occulta medical history. An MRI scan could not be performed before hospital admission. She reported no motor or sensory deficits. At physical exam, we could see a skin dimpling, 3,5 cm away from the anal margin. Despite we don’t have a spinal image, we decided to perform a combined spinal and epidural anaesthesia. With the patient in sitting position, the puncture in L3-L4 epidural level was performed with a Tuohy 18 G needle. The epidural space was located 5 cm deep from the skin. The spinal block was performed with the “needle-through-needle” technique. After clear cerebrospinal fluid flowed, it was administered 8,5 mg of 0,5% hyperbaric bupivacaine and 2,5 µg of sufentanil in the subarachnoid space. After the injection, an epidural catheter was introduced 9 cm cephalic.

Results The block reached approximately T4 level in about ten minutes after injection, at which point surgery was begun. The surgery lasted about 60 minutes and there was no need to epidural top-up.

Conclusions Administration of epidural or combined spinal and epidural anaesthesia may be considered in women with various forms of spinal dysraphism and stable neurologic function. The complications encountered are related to the altered anatomy.

Background and Aims Women with spina bifida present both obstetrical and anaesthesia challenges. They are more likely to require a caesarian delivery and traditionally neuraxial anesthesia has been avoided due to concerns of worsening neurologic disability.

Methods A 35-year-old G1P0, at 37 weeks’ gestation, was proposed to an elective caesarean section because of her spinal bifida occulta medical history. An MRI scan could not be performed before hospital admission. She reported no motor or sensory deficits. At physical exam, we could see a skin dimpling, 3,5 cm away from the anal margin. Despite we don’t have a spinal image, we decided to perform a combined spinal and epidural anaesthesia. With the patient in sitting position, the puncture in L3-L4 epidural level was performed with a Tuohy 18 G needle. The epidural space was located 5 cm deep from the skin. The spinal block was performed with the “needle-through-needle” technique. After clear cerebrospinal fluid flowed, it was administered 8,5 mg of 0,5% hyperbaric bupivacaine and 2,5 µg of sufentanil in the subarachnoid space. After the injection, an epidural catheter was introduced 9 cm cephalic.

Results The block reached approximately T4 level in about ten minutes after injection, at which point surgery was begun. The surgery lasted about 60 minutes and there was no need to epidural top-up.

Conclusions Administration of epidural or combined spinal and epidural anaesthesia may be considered in women with various forms of spinal dysraphism and stable neurologic function. The complications encountered are related to the altered anatomy.

Background and Aims Women with spina bifida present both obstetrical and anaesthesia challenges. They are more likely to require a caesarian delivery and traditionally neuraxial anesthesia has been avoided due to concerns of worsening neurologic disability.

Methods A 35-year-old G1P0, at 37 weeks’ gestation, was proposed to an elective caesarean section because of her spinal bifida occulta medical history. An MRI scan could not be performed before hospital admission. She reported no motor or sensory deficits. At physical exam, we could see a skin dimpling, 3,5 cm away from the anal margin. Despite we don’t have a spinal image, we decided to perform a combined spinal and epidural anaesthesia. With the patient in sitting position, the puncture in L3-L4 epidural level was performed with a Tuohy 18 G needle. The epidural space was located 5 cm deep from the skin. The spinal block was performed with the “needle-through-needle” technique. After clear cerebrospinal fluid flowed, it was administered 8,5 mg of 0,5% hyperbaric bupivacaine and 2,5 µg of sufentanil in the subarachnoid space. After the injection, an epidural catheter was introduced 9 cm cephalic.

Results The block reached approximately T4 level in about ten minutes after injection, at which point surgery was begun. The surgery lasted about 60 minutes and there was no need to epidural top-up.

Conclusions Administration of epidural or combined spinal and epidural anaesthesia may be considered in women with various forms of spinal dysraphism and stable neurologic function. The complications encountered are related to the altered anatomy.