VOLUME - 13, ISSUE - 07, JULY - 2024 • PRINT ISSN No. 2277 - 8160 • DOI : 10.36106/gjra

Original Research Paper

Anaesthesiology

ANAESTHETIC MANAGEMENT OF PREGNANT PATIENT WITH OVARIAN MUCINOUS CYSTADENOMA POSTED FOR LAPAROTOMY WITH SALPHINGOOPHORECTOMY

Dr Arun Kumar L Department Of Anaesthesia, Kvg Medical College, Sullia

Dr Anish Sharma Department Of Anaesthesia, Kvg Medical College, Sullia

Dr Manisha J Department Of Anaesthesia, Aj Shetty Medical College, Mangalore

ABSTRACT

Introduction: Incidence of nonobstetric surgery during pregnancy ranges between 0.75-2%. Anesthetists need to modify standard anesthetic protocols to accommodate pregnancy induced physiological changes and the fetus. Presenting a case of primigravida posted for ovarian mucinous cystadenoma. **Case Report:** A 24year old primigravida at 13+4days of gestation with no comorbidities came with complains of pain abdomen since 5days.On examination, vitals were stable. Abdominal examination revealed tenderness in right iliac fossa. Blood investigations were normal. Transabdominal sonography showed right adnexal cyst of 24x9x4 with internal echoes. Doppler showed no vascularity. Preoperatively optimization was done by advising NPO, antiaspiration prophylaxis. In OT, all standard monitors were attached. Adequate preloading done. Under sterile aseptic precautions, subarachnoid blockade was achieved at L3-L4 interspace with 2.8ml of 0.5%bupivacaine and 20mcg fentanyl in lateral position achieving blockade till T6. Oxygen supplemented via facemask. Hypotension was treated with vasopressors. Hypothermia prevented with forced air warming. 1750 ml of cystic fluid was aspirated. Postoperatively shifted to ICU and USG abdomen revealed SLIUF-13 weeks GA. **Conclusion:** Any emergency surgery can be performed in any trimester depending on urgency. Whenever possible, surgeries are considered in second trimester as spontaneous abortion is less likely. Regional anesthesia is preferred choice whenever possible to avoid fetal exposure to drug and protection of maternal airway.

KEYWORDS : nonobstetric surgery, antiaspiration, subarachnoid blockade

INTRODUCTION

Incidence of non obstetric surgery during pregnancy ranges between 0.75-2%. Anaesthetists need to modify standard anaesthetic protocols to accommodate pregnancy induced physiological changes and the fetus. Presenting a case of primigravida posted for ovarian mucinous cystadenoma.

The anaesthetist has the following goals:

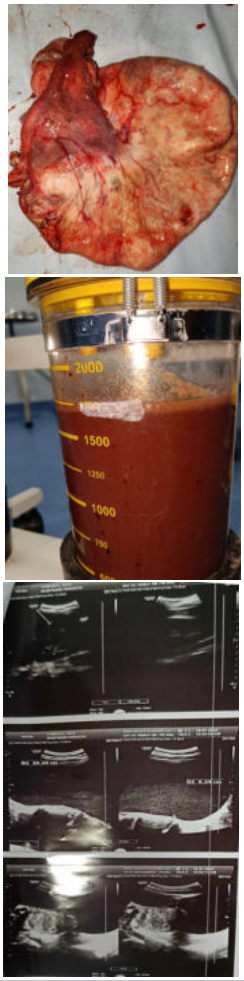
(i) Optimize and maintain normal maternal physiological function;
(ii) Optimize and maintain utero-placental blood flow and oxygen delivery;
(iii) Avoid unwanted drug effects on the fetus;
(iv) Avoid stimulating the myometrium (oxytocic effects);
(v) Avoid awareness during general anaesthesia;
(vi) Use regional anaesthesia, if possible

Case Report

A 24year old primigravida at 13+4days of gestation with no comorbidities came with complains of pain abdomen since 5days.On examination, vitals were stable. Abdominal examination revealed tenderness in right iliac fossa. Blood investigations were normal. Transabdominal sonography showed right adnexal cyst of 24x9x4 with internal echoes. Doppler showed no vascularity. Preoperatively optimization was done by advising NPO, antiaspiration prophylaxis. In OT, all standard monitors were attached. Adequate preloading done. Under sterile aseptic precautions, subarachnoid blockade was achieved at L3-L4 interspace with 2.8ml of 0.5%bupivacaine and 20mcg fentanyl in lateral position achieving blockade till T6. Oxygen supplemented via facemask. Hypotension was treated with vasopressors. Hypothermia prevented with forced air warming. 1750 ml of cystic fluid was aspirated. Postoperatively shifted to ICU and USG abdomen revealed SLIUF-13 weeks GA.

Anaesthetic Management

Preoperatively optimization was done by advising NPO, antiaspiration prophylaxis. In OT, all standard monitors were attached. Adequate preloading done. Under sterile aseptic precautions, subarachnoid blockade was achieved at L3-L4 interspace with 2.8ml of 0.5%bupivacaine and 20mcg fentanyl in lateral position achieving blockade till T6. Oxygen supplemented via facemask. Hypotension was treated with vasopressors. Hypothermia prevented with forced air warming. 1750ml of cystic fluid was aspirated. Postoperatively shifted to ICU and USG abdomen revealed SLIUF-13 weeks of gestational age.



DISCUSSSION

Non obstetric surgery during pregnancy is not uncommon and can have excellent outcomes with proper planning. Pregnancy is considered full stomach and antiaspiration prophylaxis is must. Anesthetic management focus on avoiding hypoxemia, hypotension, acidosis as maternal catastrophe can pose risk to fetus.

Conflicts of interest:
The authors declare that they have no conflicts of interest.

Acknowledgements:
The authors declare that they have no competing interest.

CONCLUSIONS:

Any emergency surgery can be performed in any trimester depending on urgency. Whenever possible, surgeries are considered in second trimester as spontaneous abortion is less likely. Regional anaesthesia is preferred choice whenever possible to avoid fetal exposure to drug and protection of maternal airway.

REFERENCES:

1. Reitman E, Flood P. Anaesthetic considerations for non-obstetric surgery during pregnancy. Br J Anaesth 2011;107(S1):i72–i78
2. Walton NKD, Melachuri VK. Anaesthesia for non-obstetric surgery during pregnancy: continuing education in anaesthesia.Crit Care Pain 2006;6(2):83–5.
3. Bajwa SJS, Bajwa SK. Anaesthetic challenges and management during pregnancy: strategies revisited. Anesth Essays Res 2013;7(2):160–7.