

Keeping it warm: Anaesthetic Management of Labour and Delivery in Paramyotonia Congenita

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INTRODUCTION	PATIENT DESCRIPTION	PLANNING & INTERVENTION	INTRAPARTUM COURSE	IMPLICATIONS
- Paramyotonia congenita (PC) is a rare autosomal dominant skeletal muscle sodium-channel disorder. - Cold exposure and repeated activity can trigger myotonia and muscle stiffness. - In pregnancy, anaesthetic care is challenging because shivering, hypothermia, electrolyte disturbance and some neuromuscular blockers may precipitate peri-partum problems. - Published obstetric guidance is limited and largely case-report based.	19-year-old primigravida with a known diagnosis of PC. - Reported cold-induced muscle stiffness. - Sodium channel-blocking medication had been stopped during pregnancy. - Referred antenatally for anaesthetic assessment. - A multidisciplinary plan was made before labour to reduce avoidable triggers and define an escalation strategy.	- Maintain normothermia using a warm labour room and warmed intravenous fluids. - Monitor electrolytes, particularly potassium. - Discuss analgesic options early and favour neuraxial techniques if escalation becomes necessary. - Avoid depolarising neuromuscular blockers and reduce the chance of general anaesthesia where possible.	- Labour occurred spontaneously at term. - Foetal compromise with failure of descent prompted transfer to theatre for operative delivery. - Spinal anaesthesia was used successfully. - Temperature control and shivering avoidance were maintained throughout. - Maternal potassium stayed within the normal range. - There were no myotonic episodes or respiratory problems; maternal and neonatal outcomes were good.	- Antenatal planning and multidisciplinary communication were central to safe care. - Hypothermia and shivering were treated as major avoidable triggers. - Neuraxial anaesthesia helped avoid depolarising neuromuscular blockade and the airway risks of general anaesthesia. - Available evidence suggests malignant hyperthermia risk is low and comparable with the general population. - A cautious, individualised obstetric anaesthetic plan remains essential.
Cold is a clinical trigger, not just a comfort issue.	Antenatal review created time for proactive planning.	The strategy was to prevent triggers and avoid avoidable GA.	Spinal anaesthesia enabled an uncomplicated operative delivery.	Temperature control should be treated as a peri-partum intervention.

KEY DELIVERY PRINCIPLES

1. IDENTIFY TRIGGERS Cold exposure, shivering and repeated activity may worsen myotonia.	2. KEEP MOTHER WARM Warm room, active warming when required and warmed IV fluids.	3. REDUCE NEED FOR GA Discuss neuraxial analgesia / anaesthesia early and plan escalation.	4. IDENTIFY TRIGGERING DRUGS Avoid depolarising neuromuscular blockers if operative delivery is needed.	5. MONITOR & COMMUNICATE Check potassium, anticipate airway issues and involve senior staff early.
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REFERENCES

1. Najid S, et al. Analgesia and anaesthesia management of labour and caesarean delivery for a parturient with PC. Turk J Anaesthesiol Reanim. 2019.
2. Girard T, et al. The myotonias and susceptibility to malignant hyperthermia. Anesth Analg. 2009.