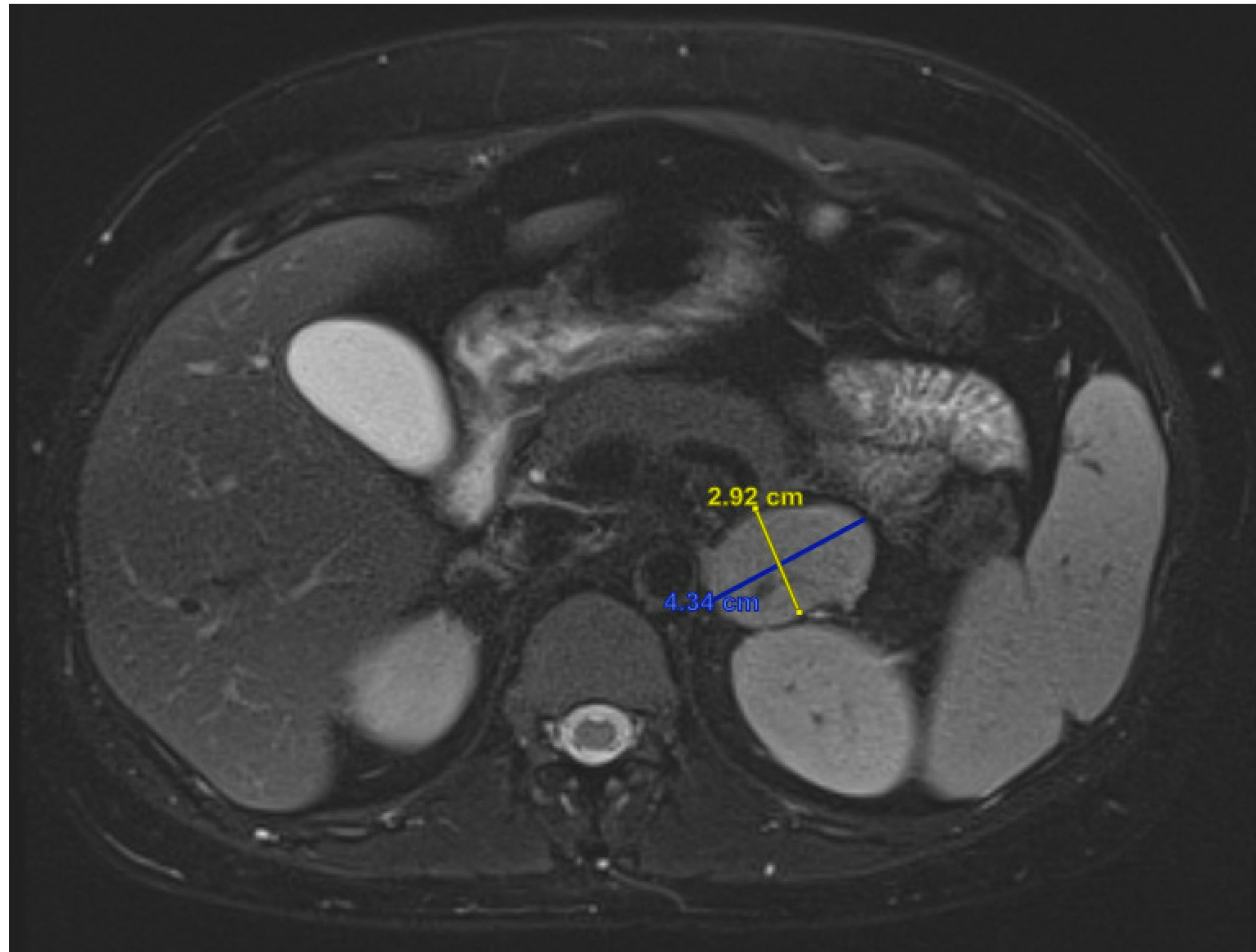


Robotic Adrenalectomy for the Treatment of Pheochromocytoma in a Parturient

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Background:

- Pheochromocytomas in the parturient are exceedingly rare (<0.007%) compared to HTN in pregnancy (5-10%)
- Current guidelines: medical management of HTN followed by surgical resection in the 2nd trimester

Multidisciplinary approach:

- MFM
- Cardiology
- Anesthesiology
- Endocrinology
- Urology

SOAP 2022
ANNUAL MEETING

29yoF G5P1213 presents for Single Port L Robotic Adrenalectomy

OB Hx:

- 3 prior CDs
- h/o Pre-E with HELLP

PMHx:

- HTN
- Nephrolithiasis

Presents @ 22wks GA

- TTE: recovered
- EF 55-60%, NLVF
- MR non-con: 4.3 x 3.8cm L adrenal mass

Medical Pretreatment x 2 wks

- Doxazosin -Selective alpha-1 blockade
- Metoprolol tartrate (reflex tachycardia)

lost to follow up

Pheochromocytoma @ 7wks

- HTN emergency
- Globally depressed LV function + septal WMAs, EF 45-50%
- Renal US: 3.6cm L suprarenal mass
- 24h urine: + nor/metanephrines

Multidisciplinary meeting prior to sx:

- Anesthesiology
- Endocrinology
- Cardiology
- Maternal Fetal Medicine
- Urology

DOS @ 24wks2d:

- Preop epidural block
- Arterial line
- Robotic approach to resection
- No extremes in HR or BP encountered
- No complications

Pheochromocytoma Management in the Parturient

- Pheochromocytoma is exceedingly rare in pregnancy, but may significantly alter maternal and fetal morbidity
- Preoperative medical management should include assessment of cardiac function
- Individualized planning with shared decision making is key (gestational age at diagnosis, clinical response to medical treatment, presence of fetal distress)
- Multidisciplinary approach to facilitate an uneventful intraoperative course and postoperative stabilization → good patient outcome
- Robotic approach to adrenalectomy may be a good alternative for second trimester resections

