CONTINUOUS INTRA-THECAL CATHETER USE FOR REPEAT C-SECTION IN PREVIOUS DIFFICULT GENERAL ANESTHETIC WITH A B.M.I. GREATER THAN 100

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Clinical situation:

Previous urgent C-section with failed epidural and difficulty with awake fiberoptic intubation with recall and emotional trauma at O.S.H. Complications from previous general anesthesia and co-morbidities required a four day wean from ventilator. (aspiration and/or compliance issue). Previous B.M.I. 89 for last pregnancy.

Seen in high-risk OB. clinic for evaluation and anesthesia options:

- Agreed to regional anesthesia. Patient desires to be awake for birth with partner.
- Scheduled in main operating room.
- Airway presumed to be “intubate-able” by traditional methods.
- Clearly traumatized by last experience.
- Discussed options of regional anesthesia with patient and family.
- Accepted potential risk of possible prolonged P.D.P.H.
- Agreed to intra-thecal catheter placement with general anesthesia as an alternative.

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Procedure:

1. Ultrasound and multiple needle lengths available for procedure. Sitting.
2. Para median approach, first attempt after lamina identified. Good C.S.F. flow.17 g Tuohy with 19 g catheter placed 4 cm in the intra-thecal space.
3. C.S.F. flow confirmed in sitting and supine position with 3 cc syringe.

Discussion

1c.c. of bupivacaine 0.75% with dextrose for foley insertion (30 minutes) for modified saddle block

0.5 c.c. of bupivacaine given prior to prep(T4-6 level)

0.5 c.c. of bupivacaine given every 30-40 minutes to maintain level(total 3.5 cc). 200ug of intrathecal morphine given at conclusion

Catheter pulled at end of case with no issues

Conservative therapy for potential P.D.P.H. initiated post operatively

No P.D.P.H. Discharged home P.O.D. 2 with no complications

Follow up at one month with no concerns and very satisfied

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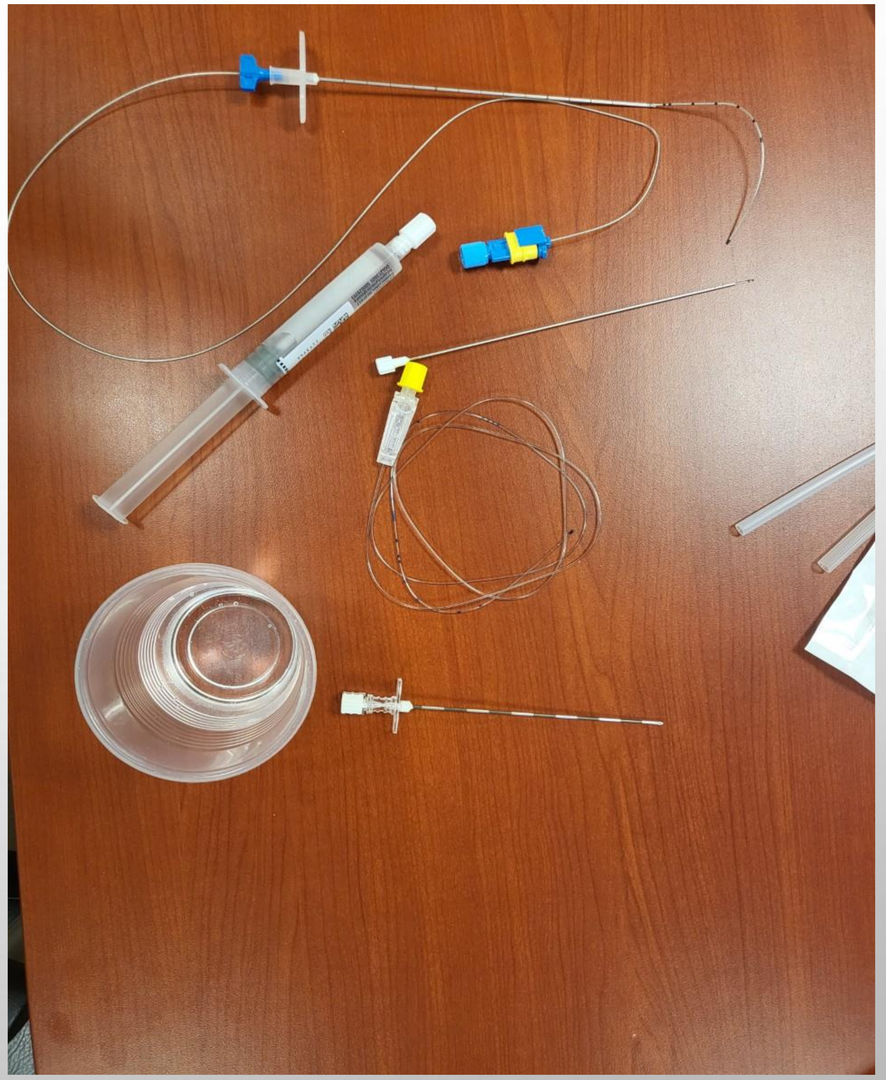
CATHETER TYPE
FENESTRATED VS NON-FENESTRATED