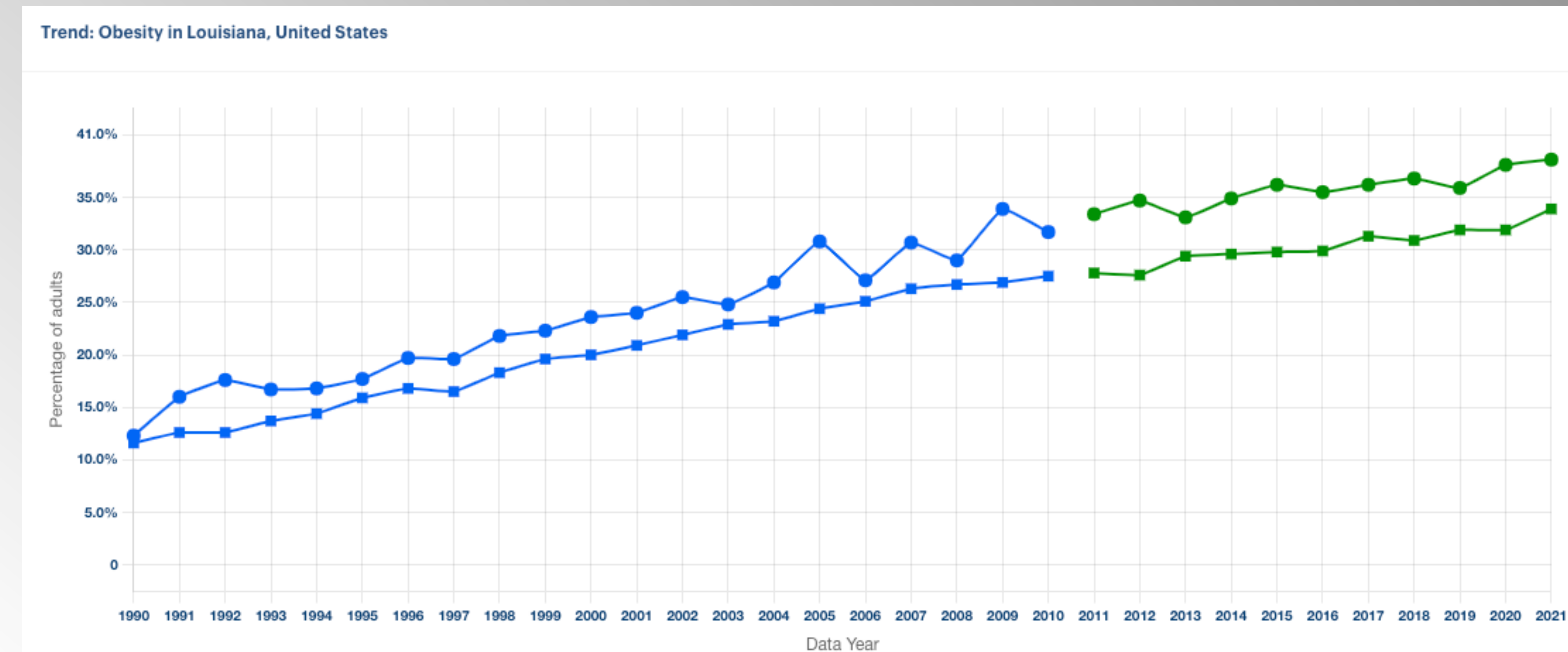


A CASE REPORT OF A SUPER-SUPER OBESE PATIENT WITH SUSPECTED PULMONARY EMBOLISM REQUIRING NEURAXIAL ANESTHESIA FOR HIGH-RISK C-SECTION

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- Super-super obesity is BMI >60
- Body Habitus and co-morbidities a unique challenge to anesthesiologists
- As intubation can be difficult or impossible, neuraxial anesthesia is often the safest choice but still not without positioning and anatomical challenges
- Creating a safe anesthetic plan in a super-superobese patient with multiple co-morbidities requires a multidisciplinary approach of all caregivers involved

Obesity in Louisiana



* Percentage of adults with a BMI >30 per CDC

<https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/LA>

Case Presentation

- 32-year-old 33wk G1P0 Female with a BMI 91
- Presentation: LE swelling, pain, and worsening SOB, fever, and chills
- Vitals: HR 120, SPO2 84% on RA, 98% on NRB
- Pertinent Findings: RLE DVT, influenza A+, leukocytosis, oliguric AKI
- Mallampati score of IV, short TM distance (<6cm), wide neck circumference (>40cm), and total body edema
- Treatment: Patient was started on heparin drip for suspected PE, as well as given Tamiflu
- Bio Physical Profile: 2/8 with inability to adequately monitor fetus
- Urgent C/s Planned
- Decision was made to halt heparin drip for 6 hours and attempt neuraxial anesthesia with ENT at bedside
- CSE was placed without complications, and patient underwent classical c/s
- Postop: Epidural catheter was removed immediately after surgery and patient returned to ICU
- Heparin drip re-started 1 hour after catheter removal
- Patient was stepped down from ICU on POD#1 and was discharged from the hospital on POD#5 with home health and Eliquis for 3-6months for provoked Pulmonary Embolism

Discussion

- Super-super obesity create a unique challenge to the anesthesiologist as both general and neuraxial anesthesia carry significant risk
- Obese patients on anticoagulation increases case complexity
- Understanding the the timeline for neuraxial procedures and anticoagulation is important to mitigate the risk for complications such as epidural hematomas
- As the growing number of super-super obese patients in America increases, it remains important to be familiar with the anatomical and physiological consequences of morbid obesity in parturients to create a safe anesthetic plan
- Multidisciplinary meetings can aid in coordination and improve outcomes in this population

ASRA Guidelines

	Time between the last dose and before catheter placement (hr.)	Time after catheter placement to drug start (hr.)	Time between the last dose and before catheter removal (hr.)	Time after catheter removal to drug start (hr.)
UFH (prophylaxis $\leq 15,000$ IU/d)	4-6	Immediately	4-6	Immediately
High dose UFH (prophylaxis $>15,000$ but $< 20,000$ IU/d)	12	1	12	1
UFH (therapeutic)	IV: 4-6 SC: 24	IV: 1 SC: 1	IV: 4-6 SC: 8-12	IV: 1 SC: 1
LMWH (prophylaxis)	12	12	12	4
LMWH (therapeutic)	24	24	Should remove catheter 4hr prior to therapeutic LMWH	4

UFH: Unrationed Heparin. LMWH: Low Molecular Weight Heparin. SC: Subcutaneous

Note: From ASRA2018 guidelines 4th edition