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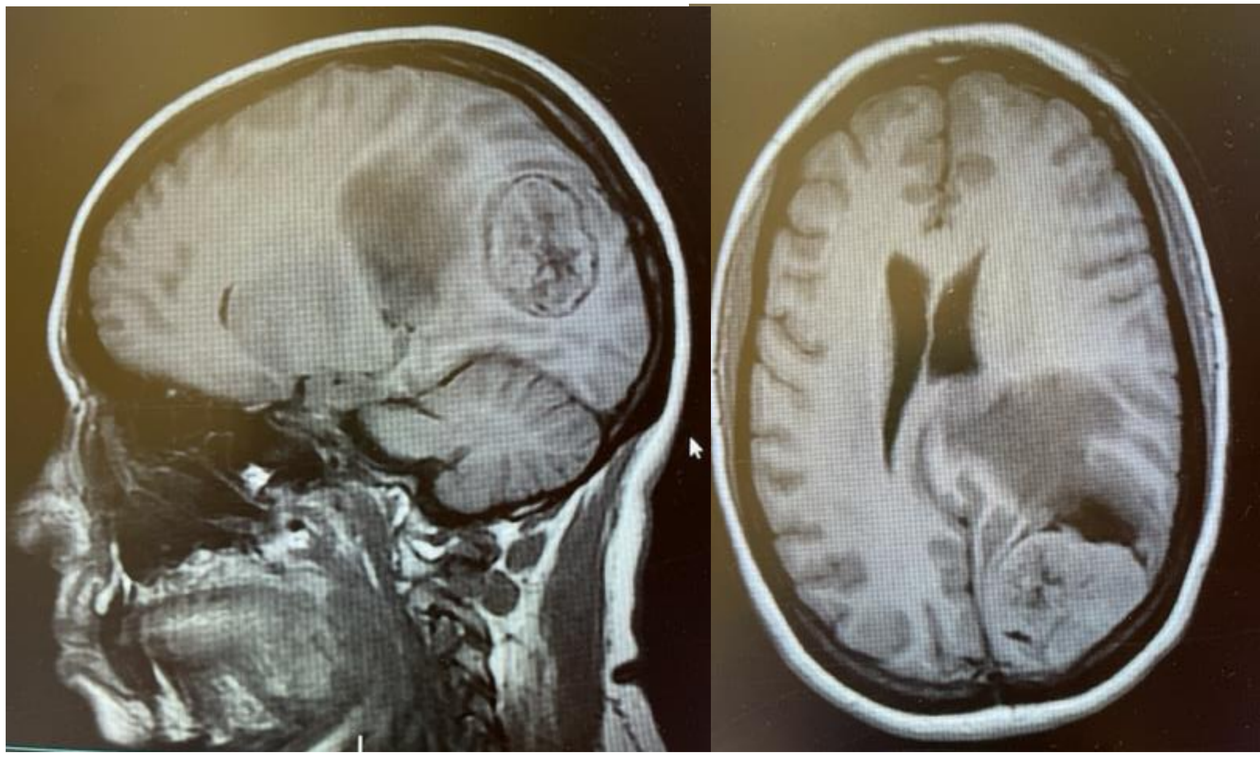
Anesthetic management of obstetric patient with large parieto-occipital meningioma: a case report

Rebecca Thompson, MD; Kristin Falce, MD; Barbara Orlando, MD, Ana Lisa Ramirez-Chapman, MD

- Incidence of brain tumors in pregnancy is similar to nonpregnant women of the same age

- Previously asymptomatic neoplasms may enlarge during pregnancy and become symptomatic with multiple potential implications for the anesthesiologist

Case: 40-year-old parturient presented in her third trimester with 10-day history of worsening headache, visual changes, memory dysfunction, gait disturbance



MRI brain, sagittal and axial images of 5cm intracranial mass

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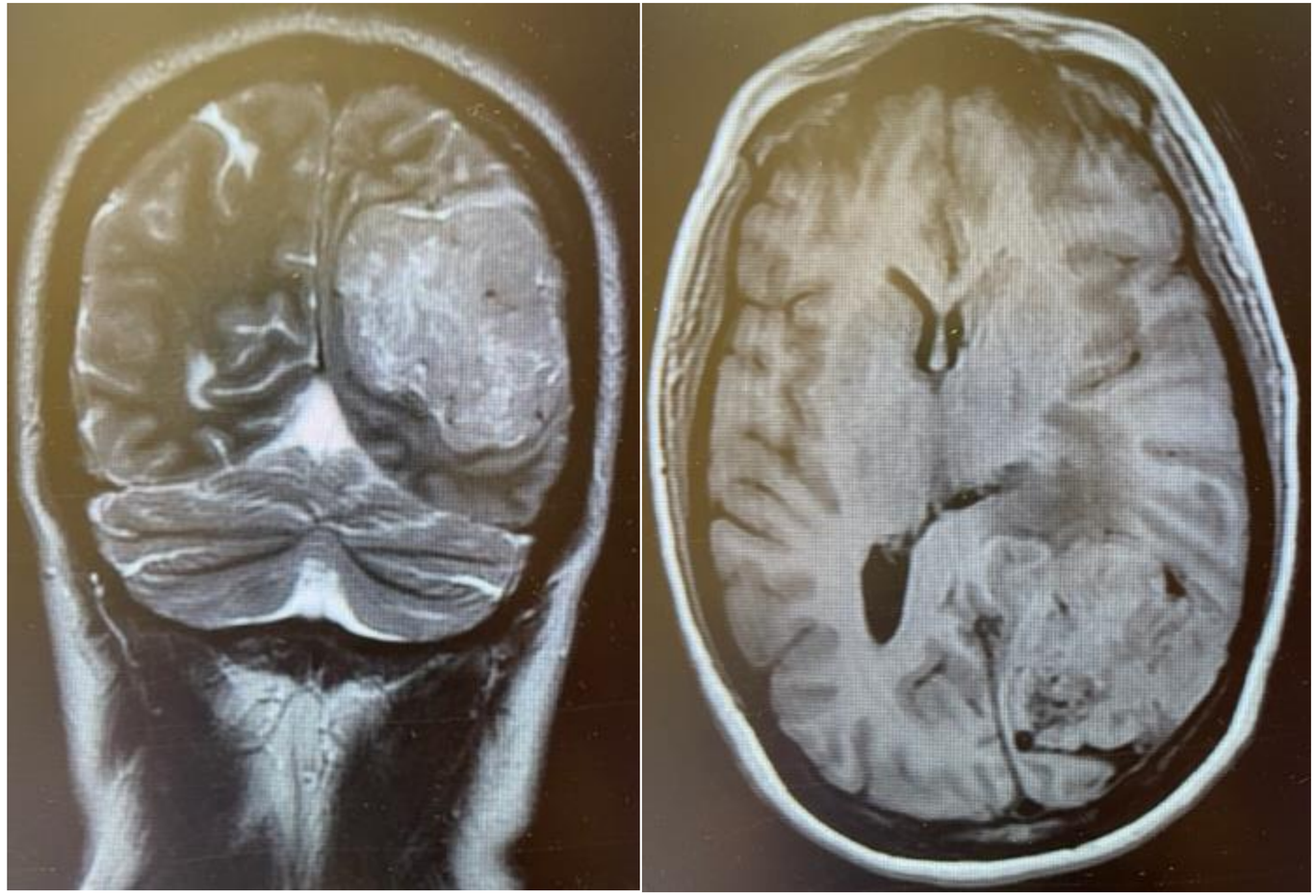
- Cesarean section under general anesthesia
  - 2/2 elevated ICP
  - Pre-induction radial arterial line
  - Titrated phenylephrine and nicardipine PRN for MAP goals > 70
  - 2 large bore PIVs
  - Induction meds: propofol 200mg, rocuronium 100mg, remifentanil gtt 0.2 mcg/kg/min
  - Post-op bilateral quadratus lumborum blocks w/ 0.25% bupivacaine prior to extubation
- Delivery of healthy baby w/o complications: APGARs 1, 6, 8
- 24 hours post cesarean → Craniotomy for mass resection
- Mom and baby doing well to date; mom 90% back to baseline



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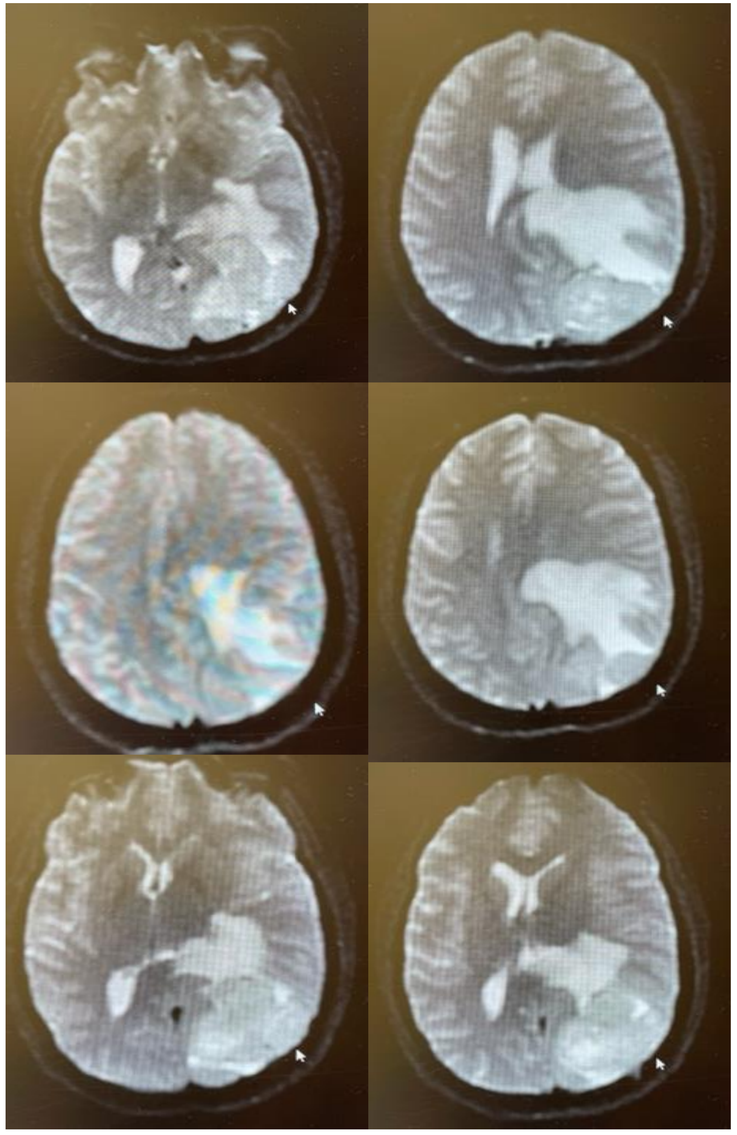
CONCLUSION

- Space-occupying intracranial lesions in pregnant women; implications for delivery:
  - Higher likelihood of cesarean delivery with general anesthesia
    - Decrease risk of increased ICP during labor
    - Risk of herniation from neuraxial anesthesia

- These cases require more communication, consideration, and planning on the part of the obstetric anesthesiologist

- Imperative to seek advice from neurologists and neurosurgeons in each case, as there is insufficient data to make general recommendations regarding delivery and anesthesia plans