

**Cesarean Section in Parturient with Severe Cardiomyopathy
Requiring Mechanical Support and Utilization of
Intraoperative Transesophageal Echocardiogram**

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- 28 y.o G1P0 at 36w3d presented to an outside hospital for shortness of breath and rupture of membranes
- Presented with new and progressive lower extremity edema and dyspnea on exertion. On examination found to be hypoxic with pulmonary edema on chest X-ray.
- Lab findings included BNP of 3892 and an echocardiogram showed LVEF of 15-20%
- Decision to transfer to our institution for higher level of care

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- Multidisciplinary team formulated delivery plan of vaginal delivery with EKG and arterial line monitoring, early epidural placement, and milrinone administration if lactate >1.7
- Epidural placed without complication with initial bolus deferred. Aggressive diuresis initiated.
- Several hours later developed the inability to lie flat and decreased urine output despite aggressive diuresis. Shortly thereafter terminal fetal bradycardia and decision made to proceed with emergent cesarean section.

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- Initiation of general anesthesia with subsequent RIJ CVL placement. Fetus was successfully delivered.
- Transesophageal Echocardiogram was utilized and showed severe biventricular dysfunction with an estimated EF 15%. Cardiogenic Shock Team activated and team made decision to initiate mechanical support.
- Successful Impella placement in Cath lab. Transferred to our CVICU and required mechanical support for 7 days. Discharged home on continued inotropic support.
- Intraoperative esophageal echocardiogram can help guide not only intra-operative inotropic management but also decisions for possible mechanical support in cases of severe decompensated cardiomyopathy