

Anesthetic Considerations in a Parturient with Caudal Regression Syndrome

Drs. Zachary Ligus, Richard Wissler, Marjorie Gloff, Matthew Crane,

Loralei Thornburg, Melissa Kreso

University of Rochester Medical Center, Rochester, New York

Medical History:

- 32-year-old G3P0, 52kg, 140cm
- Caudal regression syndrome
 - Sacral 'agenesis,' spina bifida occulta, neurogenic bladder, unicornuate uterus, bilateral talipes equinovarus
- Colloid cyst 3rd ventricle (chronic, no obstructive emergencies)
- Remote history of C1-C2 fusion

Preoperative Concerns:

- Spinal contraindicated (strong neurosurgical recommendation)
- Relative contraindication to succinylcholine (denervation)
- One prior challenging intubation, but with easy mask ventilation

Operative Course:

- Scheduled primary cesarean at term, 12-hour NPO for solids
- Patient declined awake intubation on day of surgery
- After GA induction, required two-provider mask with OPA
- GlideScope[®]: esophageal; GlideScope[®] + fiberoptic "stent" = success
- Uterus manually rotated 90°, delivered infant with APGAR scores 7 & 9

Discussion:

- Ideal plan would favor continuous spinal using epidural catheter
 - Optimization required elective colloid cyst resection plus V-P shunt
 - Preferred airway management plan: awake fiberoptic intubation
 - Preop clinic discussed awake fiberoptic, video laryngoscopy
- Consider adjunct equipment
 - Guided ETT via "maneuverable" fiberoptic bronchoscope, using the panoramic glottic view from a video-laryngoscope

Summary:

- This is the third reported case of a successful delivery in a parturient with Caudal Regression Syndrome
- Flexible, multidisciplinary, patient-centered planning = safe outcomes