

Management of a Parturient with a History of Thoracic Sympathetic Ganglion Ablation

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BACKGROUND

Thoracic sympathectomy as a treatment for hyperhidrosis was developed between 1920-1940

The levels ablated are in the sympathetic trunk between the 2nd and 5th ribs, typically spanning the T2-T5 ganglia^[1].

Permanent bradycardia has been described after the procedure but there is not enough publicly available data to appreciate the incidence of this complication^[2].

References

1. Cerfolio RJ, De Campos JR, Bryant AS, et al. The Society of Thoracic Surgeons Expert Consensus for the Surgical Treatment of Hyperhidrosis. Ann Thorac Surg 2011
2. Vannucci F, Araújo JA. Thoracic sympathectomy for hyperhidrosis: from surgical indications to clinical results. J Thorac Dis. 2017

CASE

PATIENT

- G1P0 South Korean Female
- Bilateral thoracic sympathetic ganglion ablation (7 years prior)
- Healthy with good functional status

PROCEDURE

1. Standard monitors placed
2. Dural puncture epidural performed
3. Test dose omitted
4. Epidural catheter bolused with bupivacaine 0.125%
5. Catheter placed to standard programmed intermittent epidural bolus setting

VITAL SIGNS

PRE-PROCEDURE VITALS

HR 106, BP 98/58, SpO2 96%

POST-PROCEDURE VITALS

**HR 104, BP 102/63,
SpO2 96%**

DISCUSSION AND TEACHING POINTS

HEMODYNAMICS



- ❖ Thoracic sympathetic ganglion ablation may theoretically cause permanent sympathectomy
- ❖ Avoiding intrathecal local anesthetic administration and intravenous epinephrine administration can prevent hemodynamic shifts

SAFETY & RESEARCH



- ❖ Other neuraxial procedures like a spinal anesthetic may not be well-tolerated in this patient population
- ❖ Further research is warranted to explore obstetric implications of the ablation procedure