

Gravid Hysterectomy Treatment for Bleeding Placenta Accreta with Concomitant Factor V Leiden-Associated Pulmonary Embolism

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Background:

- Factor V Leiden mutations can be heterozygous or homozygous mutations with variable risk for thromboembolic complications
- Factor V Leiden has an incidence of 1-15%¹
- Responsible for 40% of venous thromboembolisms in pregnancy¹
- Anticoagulation recommendations are based on patient history, concomitant disorders, and genotype

1. Mets, TD. Silverman, NS. ACOG Practice Bulletin No. 197: Inherited Thrombophilias in Pregnancy. Obstetrics and Gynecology. 2018;132(1):e18-e34.

Patient History:

- 40yo G7P5015 woman presenting in pre-viable second trimester with vaginal bleeding
- Heterozygous Factor V Leiden (no anticoagulation)
- FIGO Grade II PAS and placenta previa
- Chest pain during hospitalization with CT showing unilateral lobar PE without RV strain on TTE necessitating therapeutic anticoagulation

Case Progression:

- Multidisciplinary discussion involving OB, anesthesiology, cardiology, and radiology
- Elected for gravid hysterectomy under general anesthesia with arterial line, central and pulmonary artery catheters, and TEE monitoring
- Uneventful case with postoperative initiation of therapeutic anticoagulation

Teaching Points

- Obstetric patients can have a complex coagulation profile despite generally experiencing a physiologic hypercoagulable state
- Consideration of POCUS or advanced TEE imaging for improved patient care
- Thorough multidisciplinary discussions are needed to weigh risks and benefits of obstetric and anesthetic management as they relate to the mother and the fetus

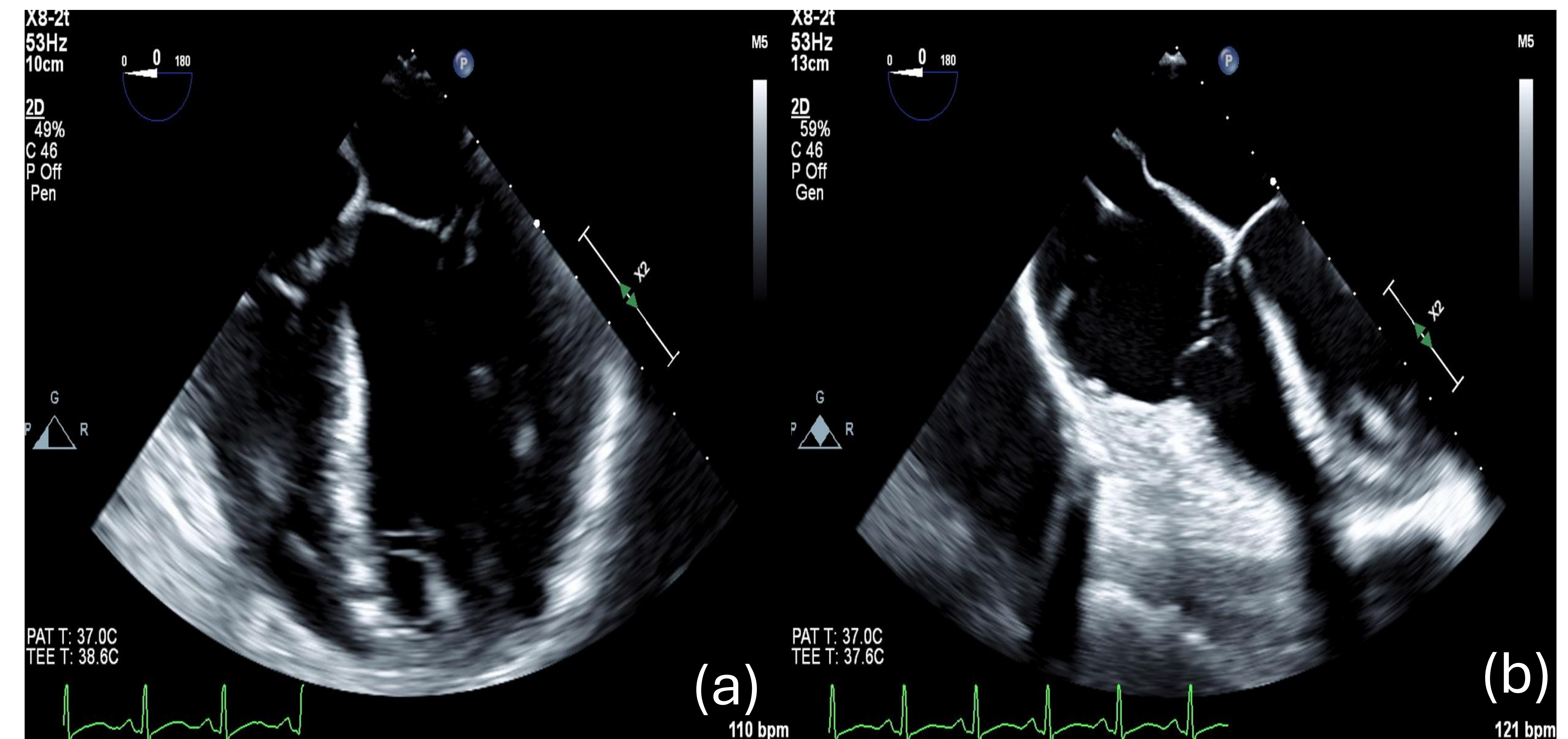


Image 1. Representative end-diastole mid-esophageal 4-chamber TEE image (a) and end-systole mid-esophageal 4-chamber TEE image (b) demonstrating lack of right heart strain in the setting of active pulmonary embolism.