Tethered Spinal Cord in a Parturient with ccTGA Requiring General Anesthesia

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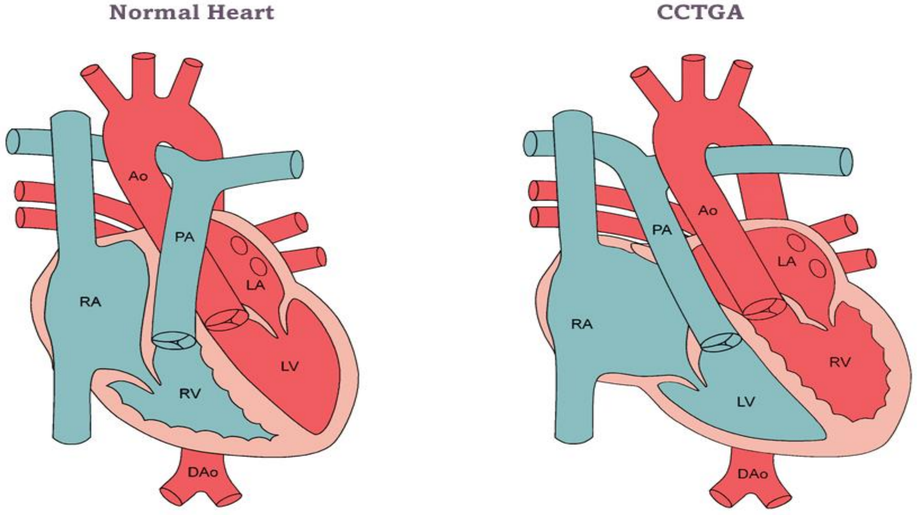

26F G1P0 37w3d, BMI 21.84, 49.9kg 132 cm (4'4)

- Congenitally corrected Transposition of Great Arteries
- complete situs inversus totalis with dextrocardia
- Complete heart block w single chamber pacemaker – 100% V-paced
- Residual VSD
- Tethered spinal cord with Neurogenic bladder
- Hip dysplasia w limited mobility
- CARPREG II Score 5 (arrythmia, LVEF < 55%)
  - 41% probability peripartum cardiac event
- **Planned primary C-section under GA**

PERIOPERATIVE

PREOP

- Neuraxial contraindicated (tethered cord)
- Multidisciplinary planning: anesthesia, maternal-fetal medicine, cardiology, electrophysiology
- No O2 requirements, mild peripheral edema (nml preg). No new changes to activity tolerance
- Pacemaker asynchronous mode, VOO

Labs/Imaging

- Echo: Mildly enlarged morphologic right ventricular size (systemic ventricle), EF 43%, mod AV reg (morphological TR). Unable to est LVSP.
- Cardiac Index 3.25
- H/H 12.4/37.5 Plt 129. Cr. 0.64

OR

- Standard monitors, PIV x2
- Induction: RSI with 100mg propofol and 100mg succinylcholine.
- Atraumatic 5.5 ETT, Glidescope (one attempt)
- EBL ~760 mL, stable vital signs throughout
- TAP blocks for postop analgesia

POST OP

- PACU recovery uncomplicated
- Pacemaker returned to baseline
- Tele x 48h without events
- DC home on POD 3

DISCUSSION

- Tethered cord may preclude neuraxial even in high risk cardiac disease
- Systemic RV physiology increases anesthetic risk
    - High maternal mortality, hospitalizations, heart failure, arrhythmias
- General anesthesia is viable
- Importance of multidisciplinary planning