Needles, Numbers, and Nuance: Two Cases of Neuraxial Anesthesia in FXI Deficiency

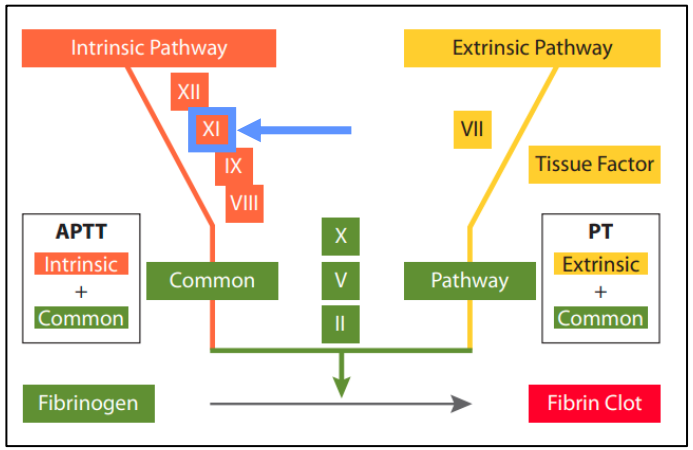
Fatine Karkri, MD Kimberly Mendoza, MD, PhD, MPH Holgar Mua Fang, MD, MPH, DESAIC Caroline Berube, MD, FRCPC

↑ Carrier screening = ↑ **Incidental FXI deficiency**

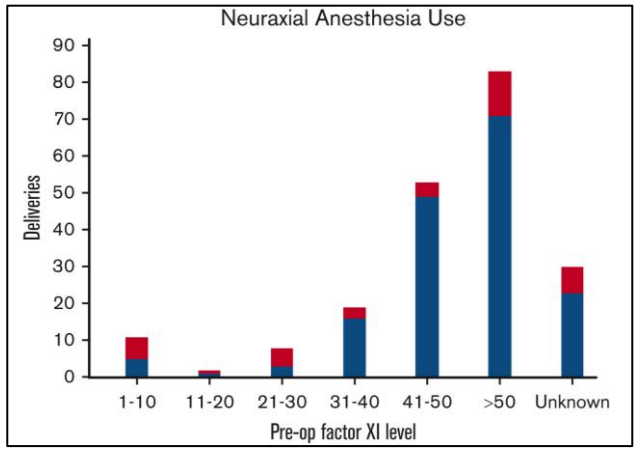
Bleeding phenotype correlates poorly with FXI activity → Bleeding history best guides neuraxial anesthesia (NA) risk

FXI 50% - Delphi consensus
Conservative threshold for NA

FXI 30% - Observational series
Safe NA reported in
select asymptomatic patients



Case-by-case multidisciplinary pathway



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Patient 1

♀ 43 y/o G1P0

F11 variant by genetics
Ø Bleeding history, prior myomectomy

FXI 42% (35+0 weeks)

Elective cesarean at 37+3 weeks
Single-shot spinal (uncomplicated)

QBL 1,233 mL

Discharged POD4

Patient 2

♀ 31 y/o G1P0

Heterozygous carrier
Minor prior bleeding

FXI 60% → 36% → **42%** (35+2 weeks)

Vaginal delivery at 39+5 weeks
Labor epidural (uncomplicated)

QBL 808 mL

Discharged PPD2

TXA
Factor replacement
Neurologic complication
Hemorrhagic complication

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- Use **bleeding history** + targeted 3rd trimester FXI testing to guide NA decisions
- Routine prophylactic TXA or factor replacement was not used in these select cases
- Consider point-of-care viscoelastic testing (ROTEM/TEG) to complement FXI activity, although not yet validated
- Interpret single intermediate FXI values in clinical context
  → FXI is usually stable in pregnancy, consider lab variability

Multidisciplinary team
Hematology-Obstetrics-Anesthesiology
→ Individualize NA decisions for FXI 30–50%

Multidisciplinary planning enabled safe NA in two **asymptomatic** patients with **third-trimester FXI ≈30-50%**

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