

Background

- Morbidly adherent placenta is associated with a high risk of severe maternal hemorrhage, especially in patients with multiple prior cesarean deliveries.
- Although neuraxial anesthesia is often preferred, general anesthesia may be indicated when significant bleeding, extensive uterine manipulation, or controlled delivery is anticipated.
- A giant fetal omphalocele adds complexity by requiring careful delivery and immediate neonatal management to prevent sac rupture.
- Anesthetic management must prioritize maternal hemodynamic stability, readiness for massive transfusion, and effective multidisciplinary coordination.

Case

- A 33-year-old G6P4014 at 36 weeks and 4 days' gestation presented for a scheduled fourth repeat cesarean delivery due to suspected focal placenta accreta identified on prenatal imaging.
- The fetus was diagnosed with a giant omphalocele containing abdominal organs and associated vascular anomalies
- Preoperative laboratory studies were within normal limits, and given the anticipated hemorrhage and need for controlled neonatal delivery, general anesthesia was selected.
- Anesthesia was induced with propofol and succinylcholine, followed by maintenance with sevoflurane, low-dose propofol infusion, and phenylephrine for hemodynamic support.
- The neonate was delivered five minutes after induction.
- After delivery, anesthesia was transitioned to propofol infusion, and uterotonics were administered; however, significant hemorrhage developed, requiring activation of a massive transfusion protocol.
- The patient received 800ml PRBC, 400ml FFP and Cryo, 200ml Platelet, 8000ml LR for an estimated blood loss of 3,500 mL, but remained hemodynamically stable with appropriate resuscitation and monitoring.
- Surgery concluded without further complications, and the patient had stable postoperative laboratory values and clinical status.

Key Points

- General anesthesia is preferred in suspected placenta accreta with anticipated hemorrhage, as it allows rapid airway control and uterine relaxation.
- High-dose volatile anesthetics aid placental management but should be reduced after delivery to limit uterine atony.
- Transitioning to total intravenous anesthesia after delivery helps maintain anesthesia while improving uterine tone.
- Early recognition of hemorrhage and prompt activation of massive transfusion are critical for hemodynamic stability.
- Multimodal uterotonic therapy is essential to control uterine atony and reduce blood loss.