Anesthetic Management for the Pregnant Patient with a Moderate-sized Right Ventricle Pericardial Effusion

Lucas Steele, MD; Becky Mirsky, MD; Johan Yusof, MD
Department of Anesthesiology, The Ohio State University Wexner Medical Center, Columbus, Ohio

BACKGROUND

- Pericardial effusions complicate up to 40% of healthy pregnancies in the United States.
- Typical causes include infection, rheumatological disease, and vascular conditions. Fortunately, most self-resolve with delivery.
- Shortness of breath is often the key presenting symptom and worsens as the pregnancy progresses.
- Effusions overlying the RV require maintenance of preload, avoidance of bradycardia, and a maintained SVR.

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FROM DISCOVERY TO DELIVERY: BRIDGING RESEARCH AND CLINICAL CARE IN OBSTETRIC ANESTHESIA

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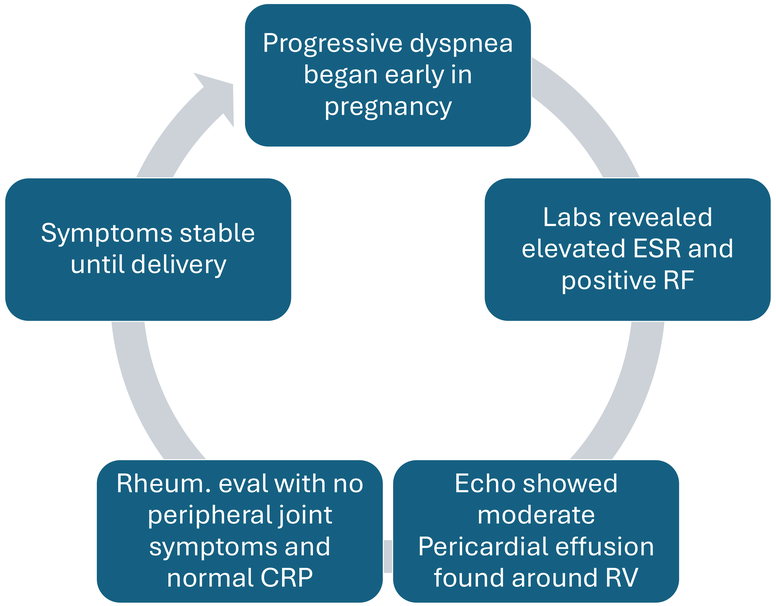
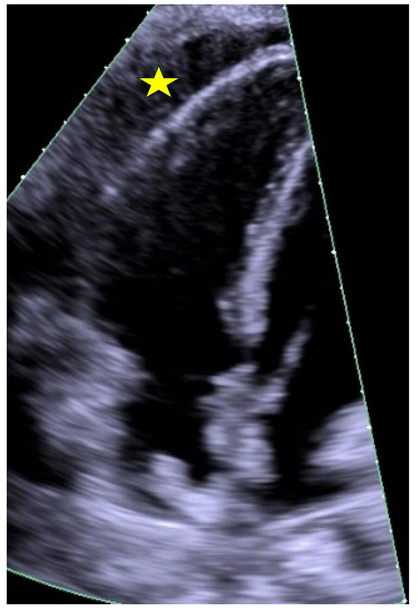
Patient: 23-year-old G2P1 at 39 weeks gestation.



Case Management

- Successful, reduced-dose CSE with 1 mL of 0.75% in 8.25% hyperbaric bupivacaine, 100 mcg PF morphine, and 15 mcg of fentanyl.
- Standard + Non-invasive hemodynamic monitoring used throughout case
- Preload, Heart Rate, and SVR maintained throughout case.
- Uncomplicated delivery (APGARs of 8 & 9) with a stable effusion on echocardiogram at 3 months post-delivery.



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KEY TAKEAWAYS

- Pregnant patients presenting with worsening shortness of breath should be evaluated for possible cardiac causes and not just assumed to be normal.
- Most pericardial effusions self-resolve with time.
- Spinal anesthesia should be implemented with caution and potentially at a reduced dose.
- Consider advanced hemodynamic monitoring, depending on the degree of effusion and symptom burden.
- Maintain SVR, HR, and Preload throughout the case.

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