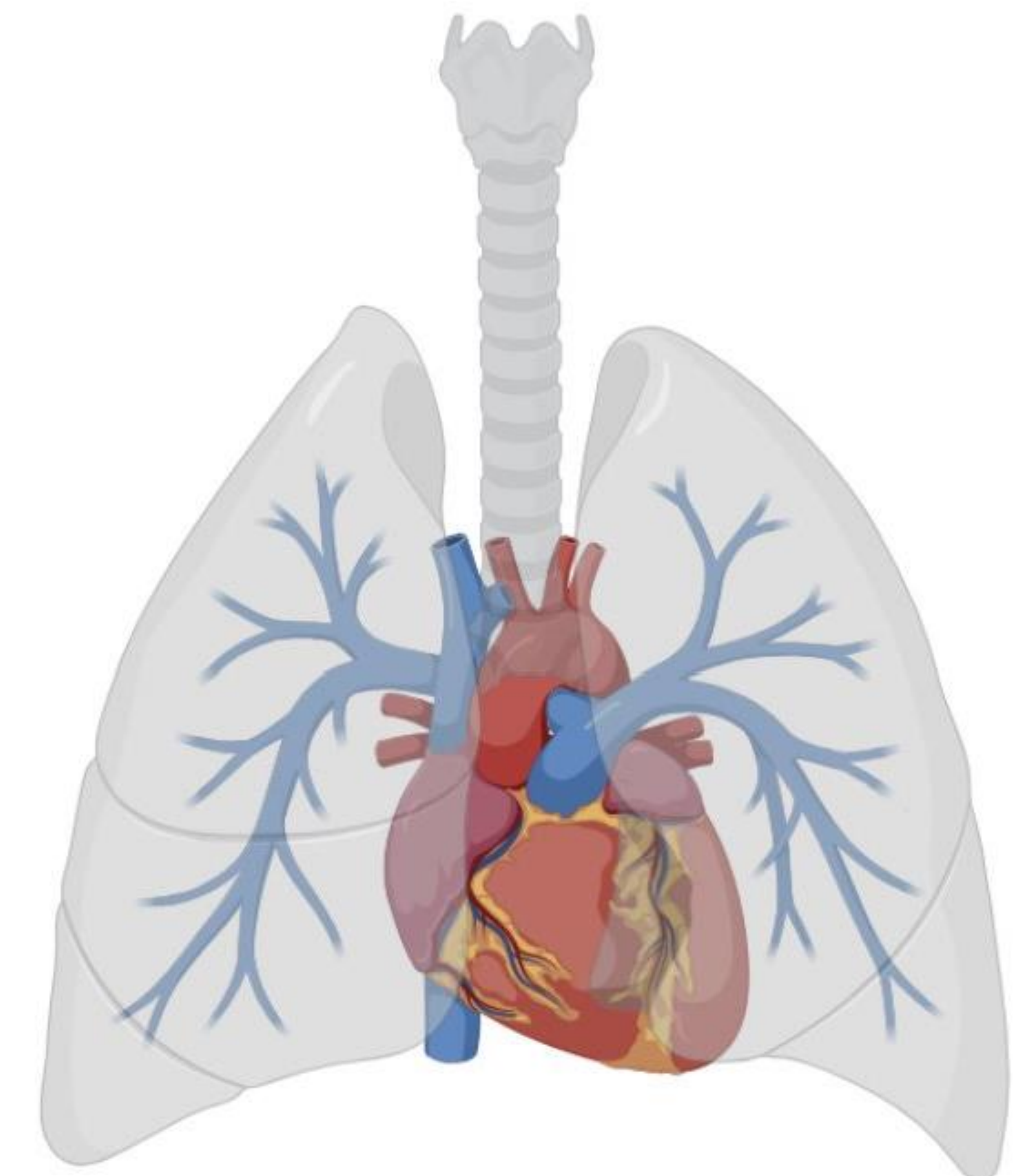


A Pivot in Plans: Preeclampsia and PPROM in a Patient with PAH

Andrea Fritz, M.D., Dillon Patel, M.D., and Ben Cobb, M.D.

Background

- Group 1 pulmonary arterial hypertension (PAH) involves a mean pulmonary artery pressure > 20 mm Hg and can be idiopathic, drug or toxin-induced, or associated with conditions like connective tissue diseases¹
- PAH is more common in females than males and is the most frequently encountered form of pulmonary hypertension in pregnancy²
- Pregnancy carries substantial risk since many of its physiologic changes, including increased blood volume and cardiac output, decreased SVR, and hypercoagulability, can exacerbate PAH and precipitate decompensation¹
- Thus, close multidisciplinary management is critical
- Frequently, these patients deliver via planned operative vaginal or cesarean delivery at 34-36w, though earlier delivery may be required²



1. Ballard W, Dixon B, McEvoy CA, Verma AK. Pulmonary arterial hypertension in pregnancy. *Cardiol Clin.* 2021;39(1):109-118. doi:10.1016/j.ccl.2020.09.007

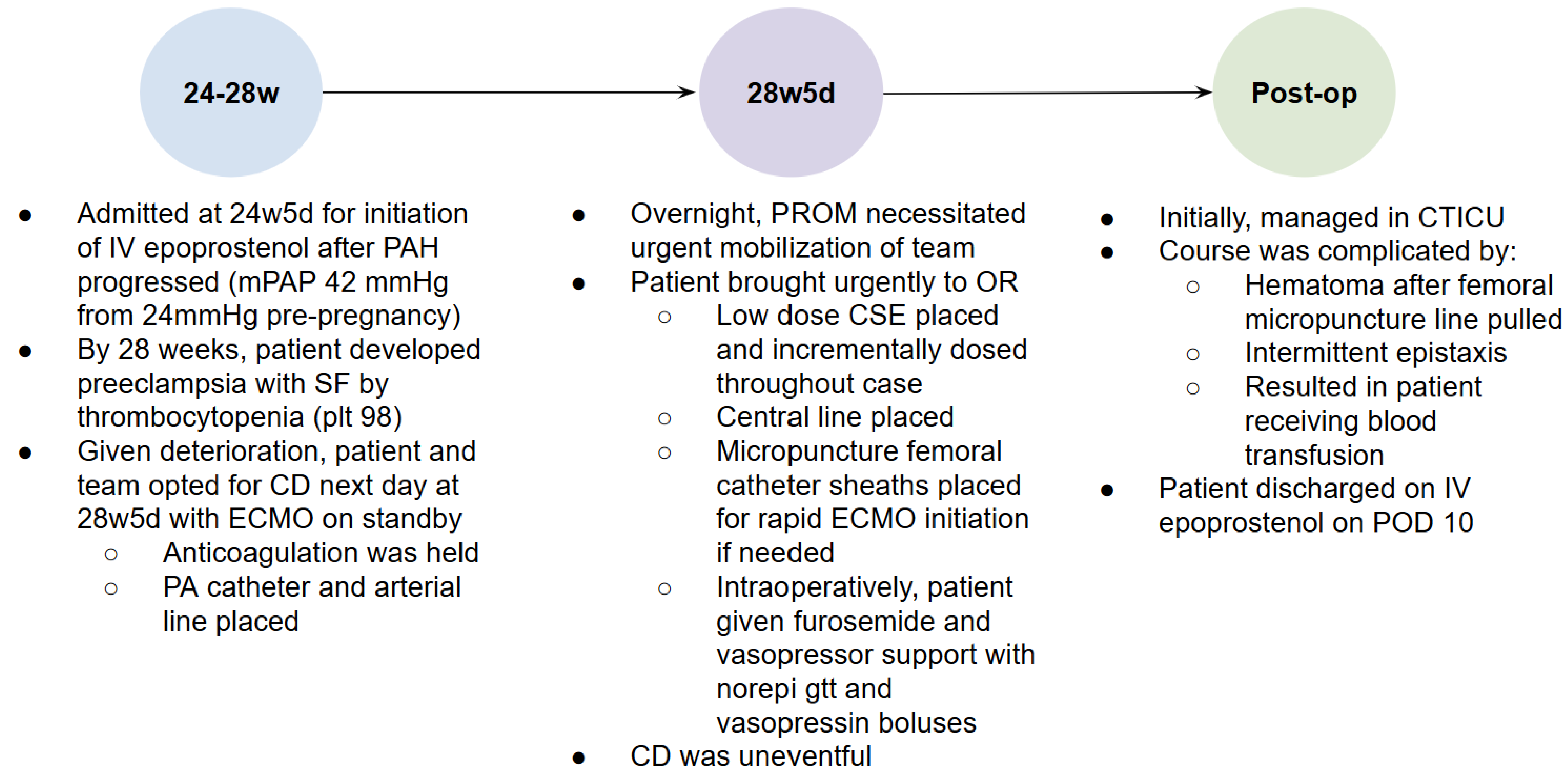
2. Martin SR, Edwards A. Pulmonary hypertension and pregnancy. *Obstet Gynecol.* 2019;134(5):974-987. doi:10.1097/AOG.0000000000003549

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Case Overview

Patient was a 32yo G3P2002 with history of mixed connective tissue disease/SLE, Raynaud's, pulmonary embolism, psoriasis, and PAH



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Learning Points

- Our case highlights importance of close monitoring, multidisciplinary coordination, and adaptability in delivery planning for patient with PAH
- Even well-controlled disease can worsen, and complications can arise throughout pregnancy, delivery, and recovery
- Anesthetic management should focus on preserving RV function by maintaining:
 - Perfusion
 - Euvolemia
 - Normothermia
 - Oxygenation and ventilation
 - Regular heart rate and rhythm
 - Adequate analgesia

