Pregnancy Preserving Management of Uterine Artery Pseudoaneurysm

Justine Lewis MD, David Berman MD, MEd, Anna Gitterman, MD

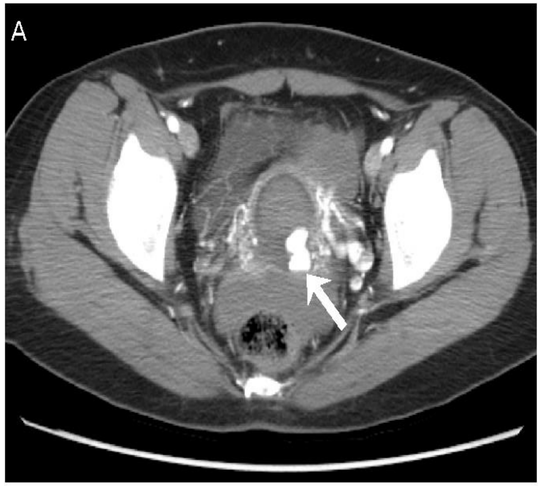
Background

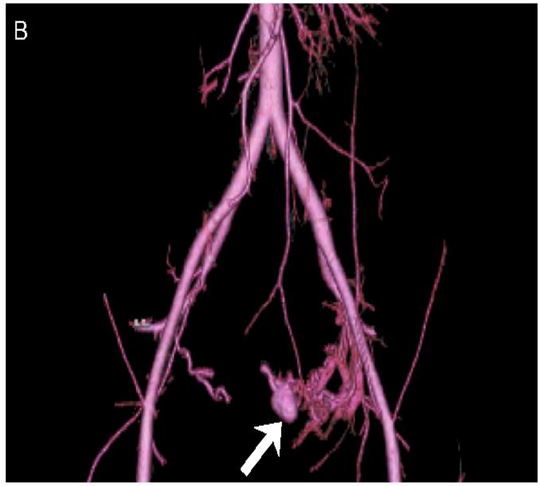
•**Uterine artery pseudoaneurysm (UAP)**: rare, life-threatening vascular lesion

Unlike true aneurysm, does not contain all three arterial wall layers

Damaged/weakened vessel resulting in collection of blood in surrounding tissue

RUPTURE------> Life threatening hemorrhage





•Requires multidisciplinary coordination (MFM, IR, OB anesthesia, NICU)

•Limited evidence base guiding care

JOHNS HOPKINS MEDICINE

Multidisciplinary planning enabled pregnancy-sparing embolization, but evolving anticoagulation needs ultimately dictated anesthetic choice at delivery.

Case Presentation

Hospital Course

G1P0, 29w1d; enlarging UAP (1.2 → 3.6 cm) + fibroids, recurrent pain and PTL

Urgent IR embolization under neuraxial. UAP excluded and uteroplacental flow preserved

DVT/PE → LMWH + IVC filter

Later: **NRFHT + preterm labor**

High hemorrhage risk + anticoagulation → **general anesthesia for classical C-section**

Viable neonate, EBL 832 mL; no transfusion/hysterectomy

JOHNS HOPKINS
MEDICINE

Anesthetic strategy in UAP is dynamic—neuraxial techniques may be safe for IR, but anticoagulation and hemorrhage risk often necessitate general anesthesia at delivery

Teaching Points

Rapidly enlarging UAP = obstetric emergency

Neuraxial anesthesia safe for IR in selected patients

Uterine artery embolization can be **pregnancy-sparing**

Thromboembolism + anticoagulation reshape anesthetic planning

General anesthesia often required at delivery due to:

- Anticoagulation status
- Hemorrhage risk
- Altered anatomy

Early anesthesiology leadership is essential

Multidisciplinary collaboration essential for successful outcomes

JOHNS HOPKINS
MEDICINE