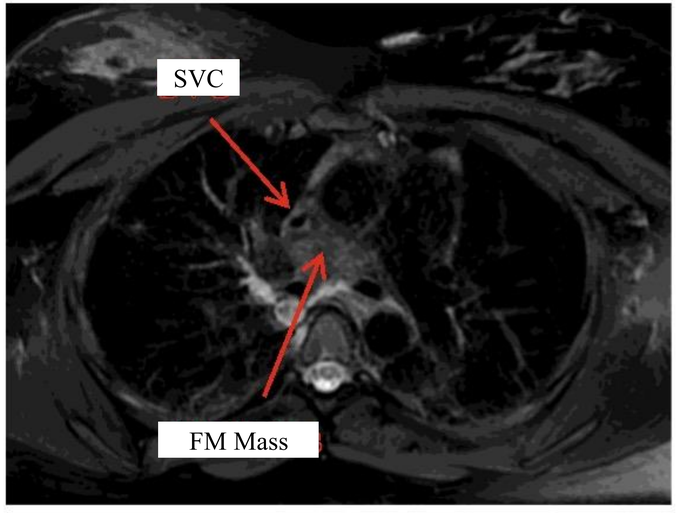
Background

- Mediastinal masses in pregnancy pose high anesthetic risk.
- **Fibrosing mediastinitis (FM)** is a rare fibroinflammatory disorder characterized by progressive **encasement of mediastinal structures** including the following: superior vena cava (SVC), pulmonary vasculature, and airway.
- **Histoplasmosis** is the most common cause in the United States; although many are **idiopathic**.
- There is **limited guidance** for obstetric anesthesia in patients with FM.
- Cesarean delivery is favored; however, trial of labor is not contraindicated. Avoidance of general anesthesia is encouraged.

Case Presentation

- 27-year-old G7P2133 at 35 weeks, 3 days with FM and SVC Syndrome
- 4cm mediastinal mass encasing pulmonary artery + SVC narrowing
- Symptoms: dyspnea, chest pain, facial fullness
- Normal cardiac function; mild LFT abnormalities
- Multidisciplinary planning – no pre-delivery intervention
- Planned TOL after prior VBAC
- Management: early, titrated epidural, continuous monitoring, strict euvolemia
- Outcomes: successful vaginal delivery, PPH managed medically + transfusion, stable post-partum course



T2-weighted MRI showing FM mass with SVC compression

Discussion

- Trial of labor (TOL) can be considered in FM with SVC syndrome.
- Individualize delivery based on cardiopulmonary status.
- Early neuraxial anesthesia is critical for stability.
- General anesthesia poses substantial risk and should be avoided.
- Maintain strict volume control.
- Continuous cardiopulmonary monitoring is essential.
- Multidisciplinary coordination improves outcomes.
- Prepare for obstetric complications (PPH).