

Anesthetic Management of Obese Parturient Coming for Emergency C- Section

Dr. H.R.Swetha¹, Dr. Parashuram, Jajee²

¹Assistant Professor SIMS, Bangalore, India

²Professor & HOD Department of Anaesthesia. SIMS, Hesargata Main Road, Bangalore, India

Abstract: *Obesity is a risk factor for anaesthesia related maternal mortality. Here is a case where spinal anaesthesia was given to a parturient with morbid obesity, and deep transverse arrest coming for emergency C-section*

Keywords: anaesthesia, obese, parturient, emergency, c section

1. Case Report

An 30 year old Female G₂ P₂ L₁ 40 weeks previous normal delivery came with deep transverse arrest for emergency c-section, she was a morbid obese patient.

She was short statured, Ht-150 cm, Wt – 150 Kg, her PR-90/mim, BP-130/90, airway showed stork neck, TMD <6.5 cm, mouth opening adequate, mallapathi grade II. She was NPO for 4 Hours. No recent investigations done. Since no investigation available full stomach, difficult airway, spinal anaesthesia was planned 18 G cannula was put to Right hand she was preloaded with 500 ml RL BP, PULSE Oximeter, chest leads, was connected base line reading was PR 82/min, BP -120/80, SPO₂-94 UNDER Room AIR PATIENT PUT in sitting Position, Under Aseptic Precaution, Lumbar Puncture done with 22G Needle blindly at L₅ L₄ after 4 attempts there was free flow of csf 0.5% heavy bupivocain 2 ml was given after free flow of csf and patient put in supine position. After 1 min level checked and surgery started lower transverse incision was put and a live female baby of 4.25 kg delivered. Inj oxytocin 30 IU given. There was pph it was managed with inj methergin inj prostadin.

After uterine closure patient started complaining of pain inj midazolam 1.5mg inj fentanyl 50ml inj paracetamol 1 gm inj diclofenac given. For skin closure local anaesthesia was given. Duration of spinal anaesthesia was 1 Hnr. Duration of surgery was 1:45 mins.

Post operative anaesthesia managed with paracetamol infusion, anamol suppository, inj tramadol. She was mobilized within 4 Hour of surgery. She was fine and discharged on 5th pod. (post operative day)

2. Discussion

The most recent report into maternal mortality in the uk 2003-05 saving mothers lives highlights the risk associated with obesity in obstetric population. On admission to Labour ward, They should be reviewed by duty anaesthetist and anesthetic management plan should be made in case operative delivery is required.

Regional anaesthesia is preferred in obesity but requires a skilled anaesthetist and appropriate equipment. A back up plan to GA must always be considered and advanced airway skills, including awake fibroptic should be available.

Here patient presented for emergency lscs with transverse arrest in view of lack of time & obese patients have high initial rate of unsuccessful regional anaesthesia, especially epidural catheter placement, epidural was not put.

This patient presented to labour ward with fetal distress in midnight therefore before epidural could be arranged the patient was on operating table in view of difficult intubation need for fiberoptic intubation, single shot spinal anaesthesia was planned and in view of inadequate anaesthesia level supplementary opioids and analgesic given. Though epidural anaesthesia is considered ideal for obese patient coming for lscs. In case of emergency I would like to share our experience of a successful operating delivery under spinal anaesthesia. In our case there was no complication to either baby or mother.

3. Conclusion

Looking for the complication due to general anaesthesia & epidural anaesthesia, spinal anaesthesia with supplementary iv analgesics can be considered in morbid obese parturient coming for emergency lscs.

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Author Profile

Dr. Swetha H.R. (M.D) Assistant professor Saptagiri Institute of medical science & research center Bangalore India

Dr. Parashuram Jajee, MD, DA prof and hod dept of anaesthesiology, saptagiri institute of medical science & research Bangalore India