

A Cervical Conundrum: New diagnosis of thyroid goiter and dural venous fistula in pregnancy

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Background

- Spinal dural venous fistula presents a challenging clinical scenario
- Often diagnosed incidentally or 3rd trimester:
 - hematomyelia
 - neurologic dysfunction
 - leg spasticity/pain
 - most often cervical

Contraindication to Neuraxial?

High Cardiac Output

Shear force on dural fistula

Increased risk of hemorrhage/spinal cord dysfunction



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Case Presentation

History

- 23yo G1P0, 28w1d
- Dysphagia and new orthopnea-> admission for expedited workup

Imaging

- CT Scan: Tracheal deviation from enlarged thyroid gland
- MRI: Vascular lesion from IJ -> cervical spinal canal

Intrapartum Management

- Avoidance of Valsalva + intubation
- Uncomplicated spinal (27G) anesthesia for cesarean
- Normotension

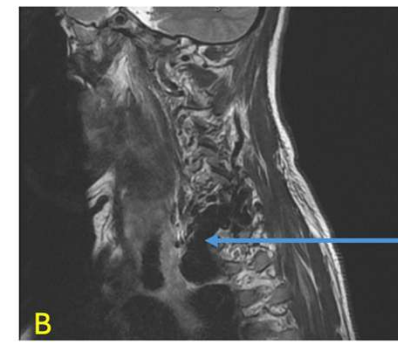
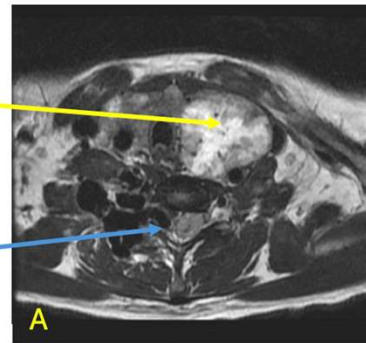
Postpartum

- Discharged POD 4
- Plan for postpartum embolization

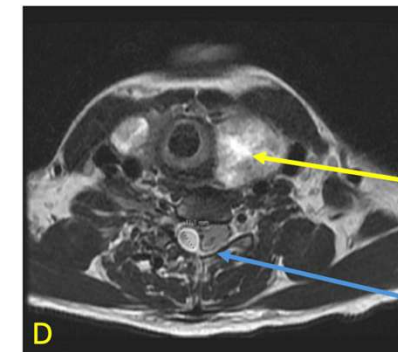
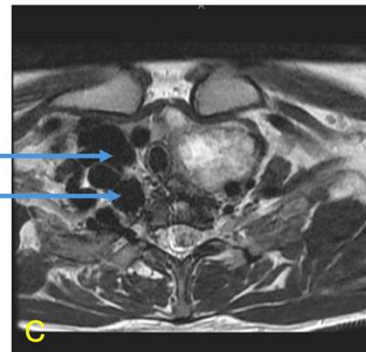
Thyroid goiter with tracheal deviation

Dural venous fistula with spinal cord compression

Venous malformation extending from the internal jugular vein



Sagittal view of dural venous fistula

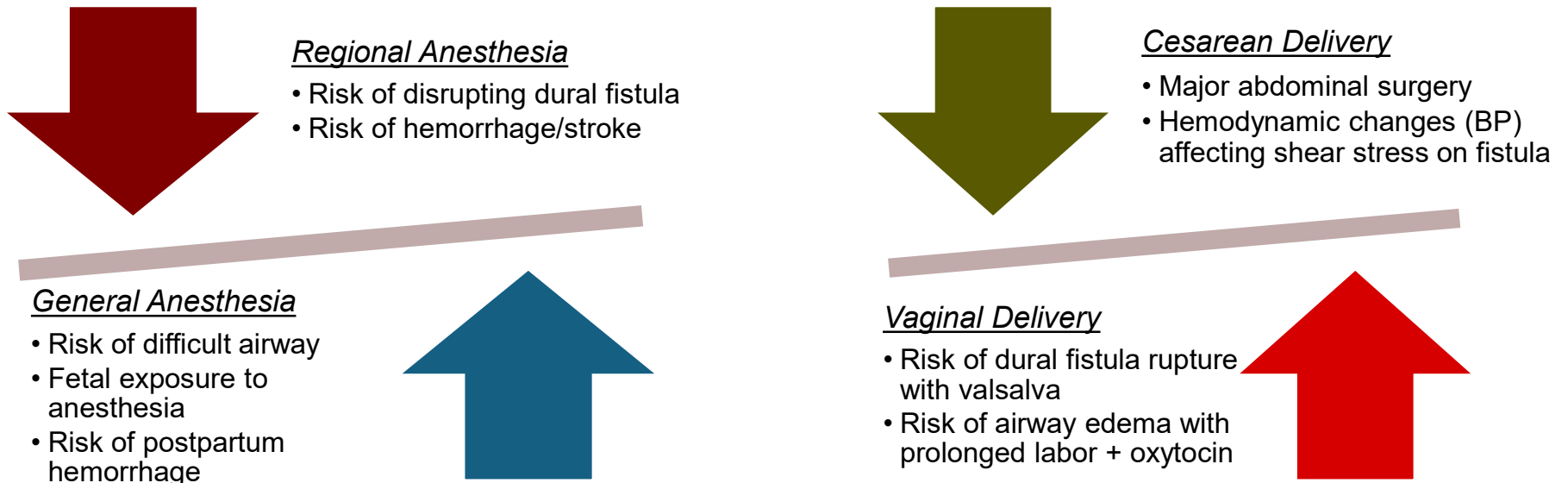


Thyroid goiter
Spinal cord with indentation and deviation

Key Points

Collaborative Risk versus Benefit discussion

OB Anesthesia, Neurosurgery, Neuroradiology, and Maternal Fetal Medicine



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