THE UNIVERSITY OF ALABAMA AT BIRMINGHAM.

Intraoperative Pulmonary Embolus During Cesarean Delivery

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Disclosures

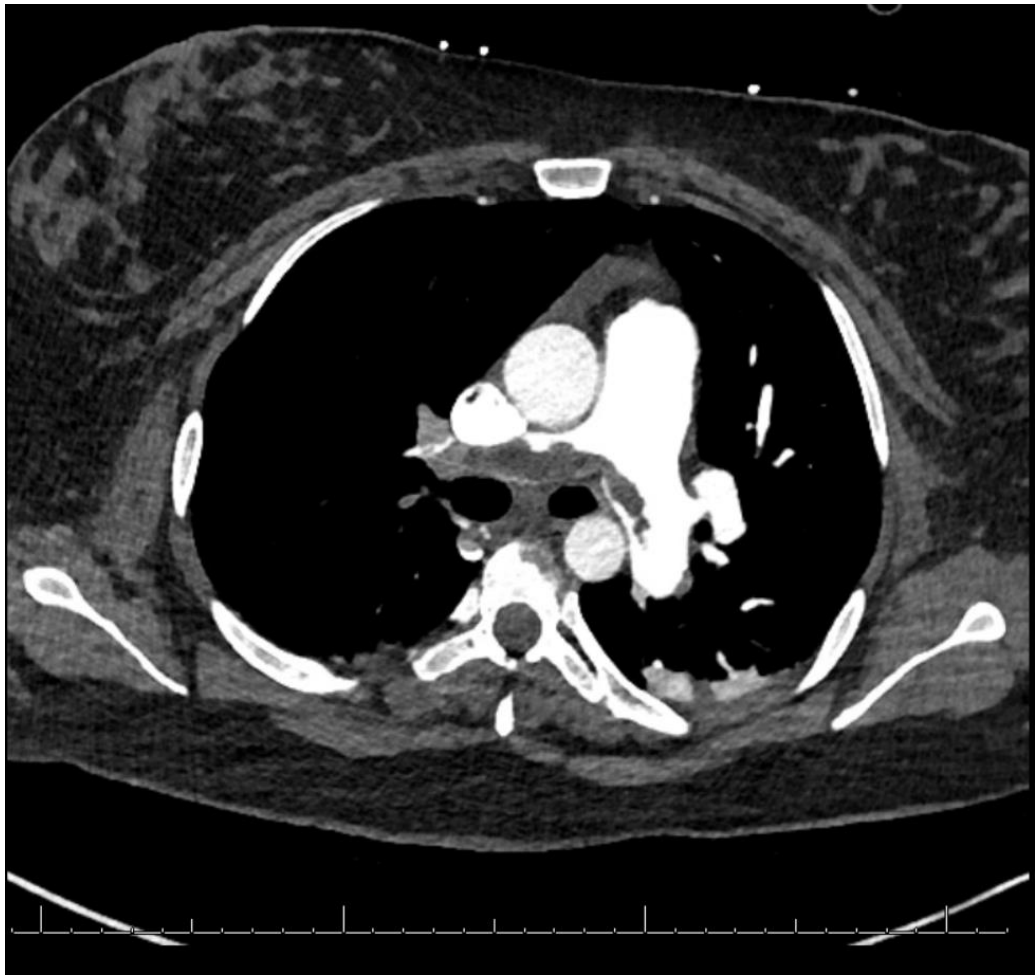
- Authors have no disclosures

Background

- Pulmonary Embolus (PE) occurs in 1/2000 pregnancies
- Intraoperative PE can be difficult to diagnose
  - Hemodynamic changes, lab values, end tidal CO2, EKG changes, TTE
- Initial care is supportive, however, rapid treatment with appropriate modality is instrumental in reducing mortality
  - Anticoagulation
  - Systemic thrombolytics
  - Catheter directed embolectomy
- Communication with surgical team is vital in choosing the appropriate therapy

Case Report

- 31yo P1001 at 27 weeks gestational age presented as a transfer for right lower extremity acute limb ischemia
- Scheduled for Cesarean Section for worsening pre-eclampsia after 4 week course and multiple vascular operations
- Shortly after induction patient became hypotensive and hypoxic
- In the ICU she was found to have a saddle PE, PE response team was consulted, no procedural intervention recommended
- Therapeutic anticoagulation initiated upon case completion
- Extubated on post op day 4, discharged on Apixaban



Learning Points

- Prompt recognition of PE is vital
- TEE can be a helpful adjunct, high sensitivity and specificity for rapid confirmation of PE (2)
  - RV dilatation, ventricular hypokinesis, septal bowing, McConnell's sign, tricuspid regurgitation
- Treatment options in surgical patients are not well studied
  - Systemic thrombolytics – high risk of hemorrhage, contraindication in obstetric patients
  - Catheter directed embolectomy – high success rate (86.5%) in surgical patients
  - Consideration for VV ECMO
- Prompt recognition and early communication are key

References

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