

Gestational Gigantomastia and Anesthesia

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A 37-YR-OLD parturient with a history of previous ectopic gestation and subacute cutaneous lupus developed massive bilateral breast enlargement causing ulceration and difficulty in breathing and standing up. The added weight gain was 30 kg. Elective cesarean section was performed during uneventful spinal anesthesia at 34 weeks of gestation. Spinal block was placed in the lateral decubitus position to avoid back pain and mastalgia. Six months later, a bilateral mammoplasty was performed during general anesthesia. Gigantomastia or excessive breast growth complicates between 1:28,000 and 1:118,000 deliveries. Its etiology is unknown, although hormonal and/or autoimmune mechanisms may be responsible. Breathing problems, immobility, ulcerations, bleeding, or infection may arise. Elective

termination of pregnancy is recommended. In most cases, cesarean delivery is indicated.¹ Although there is no reference in the literature regarding the anesthetic considerations in gigantomastia, several implications must be considered, including the reduced chest wall compliance and reduced lung volumes, the increase in work of breathing, minute ventilation, and oxygen consumption. These changes can lead to hypoxemia and rapid desaturation.² The increase in intrathoracic pressure caused by higher inspiratory pressure can impair ventricular filling and cardiac output. Moreover, breast enlargement predisposes the obstetric patient to a difficult airway during laryngoscopy.³ Regional anesthesia is a desirable technique for cesarean section. During general anesthesia, adequate preoxygenation, ramped head position, the use of a short-handled laryngoscope, and acid aspiration prophylaxis are mandatory.³ The operating table should be appropriately sized. We recommend wide arm boards placed parallel to the operating table and a semi-Fowler's position to improve respiratory comfort for the patient.

References

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