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CASE REPORT – SOLE COMBINED SPINAL EPIDURAL FOR CESAREAN SECTION AND HEMICOLECTOMY *Dadarkar, P. Vasdev, G.M. Anesthesiology, Mayo Clinic, Rochester, MN* The immuno-suppressed state of pregnancy may unmask a predisposition to malignancy. Our case highlights the fortuitous diagnosis of a colonic cancer, the feasibility of undertaking cesarean section(c/s) and right hemicolectomy using a sole combined spinal/epidural(cse) technique, and the management of colorectal cancer in pregnancy. A 30 year old G4P1 36 weeks gestation parturient was referred to our institution after histology post-appendectomy (at 30 weeks) revealed adenocarcinoma of the colon. History included c/s under epidural anesthesia for a non reassuring fetal heart rate. As the patient requested to be awake for the delivery and desired to breast feed afterwards, a cse technique was selected for the procedure. 1.2 mg 'heavy' bupivacaine with 20 mcg fentanyl was injected intrathecally and the epidural catheter inserted. The hemicolectomy proceeded through the midline incision after delivery of a healthy infant. The epidural catheter was bolused with 0.5% bupivacaine to maintain a T4 level. Postoperative analgesia was achieved with hydromorphone patient controlled epidural analgesia. She reported excellent analgesia for the procedure and post-operatively. The incidence of cancer complicating pregnancy approaches 0.1%. Fewer than 10% of colorectal cancers occur before 40 years and colorectal carcinoma complicating pregnancy is rare (~1:100,000). 86% occur rectally - the uncommon location of this iliocecal carcinoma is only the third such case reported in pregnancy. Gestational age plays a large role in determining the timing and nature of surgery and chemotherapy. Early detection should lead to prompt resection, followed by chemotherapy as indicated. Detection after 26 weeks may involve delaying surgery to allow the fetus to mature. C/s with laparotomy may be preferred to awaiting uterine involution after vaginal delivery. In summary, the benefits of regional anesthesia include decreased surgical stress response, improved post-operative pain management, earlier return of bowel function, improved natural killer cell cytotoxicity, and reduced risk of thromboembolic complications. We believe the euphoria associated with experiencing delivery/holding the infant, together with appropriate preparation, and gentle surgical manipulation of the liver were important factors in the success of this technique. 1. *Am J of Perinat.*9:102-10,1992 2. *Euro J of Obs and Gyn and Repro Bio.*88:71-4,2000 3. *J of Repro Med.*46:75-8,2001 4. *Mayo Clin Proc.*67:1180-04,1992 5. *Am J of Surgery.*171:68-73,1996 6. *Dis of Colon & Rectum.*40:339-43,1997 7. *Dis of Colon & Rectum.*37:1236-41,1994

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ANESTHETIC MANAGEMENT OF A VENTILATOR-DEPENDENT PARTURIENT WITH THE KING-DENBOROUGH SYNDROME *Habib, A.S. Millar, S.; Muir, H.A. Anesthesiology, Duke University Medical Center, Durham, NC* Introduction: King-Denborough syndrome (KDS) is a rare disorder of multiple facial and skeletal deformities, progressive myopathy and susceptibility to malignant hyperthermia (MH). We report the anesthetic management of labor in a parturient with KDS. Case report: A 24 year old primiparous woman was admitted at 20 weeks with pneumonia that was treated with antibiotics and supplemental oxygen. She was known to have KDS, diagnosed after a MH reaction during cleft palate repair at the age of 2. She had chronic respiratory failure secondary to myopathy, kyphoscoliosis and pectus carinatum, had been tracheostomised and requiring overnight ventilatory support for two years. She weighed 28.5 kg and was 152.5 cm tall. She had the characteristic facial appearance of KDS with ptosis, micrognathia, low set ears and overcrowded teeth. Her laboratory investigations (including CPK) were normal except for low albumin. Arterial blood gases on 1 liter oxygen : pH: 7.34, pO₂: 57 mm Hg, pCO₂: 58 mm Hg, HCO₃: 30 mm Hg, SaO₂: 97.4 %. She had 2 subsequent admissions for premature labor that settled with rehydration. With each admission, the anesthesia machine in one of the operating rooms (OR) was flushed with oxygen, the vaporizers were removed and the soda lime was changed. Labor was induced at 37 weeks. We decided to manage labor in the OR where a "clean" anesthesia machine was ready. Her own ventilator, cooling aids and a MH emergency kit were immediately available. IV access, an arterial line and a lumbar epidural catheter were inserted before induction of labor. Ropivacaine 0.08% + fentanyl 2mcg/ml were used for patient-controlled epidural analgesia. EKG, pulse oximetry, respiratory rate, blood pressure and temperature were monitored. After 6.5 hours of labor, the patient requested to be ventilated. An outlet forceps was performed four hours later to deliver a male infant weighing 2080 gm (Apgar scores 7, 8). She was transferred to ICU where she was ventilated overnight, discharged the following morning and left hospital 4 days later. Discussion: Our main issues were MH susceptibility and potential cardiorespiratory decompensation due to the changes of pregnancy, labor and postpartum autotransfusion. The presence of a tracheostomy obviated potential airway problems. We managed labor in the OR with a clean machine to avoid possible mistakes in case of an obstetric emergency. An epidural was inserted prior to induction of labor as difficulty was anticipated due to severe kyphoscoliosis. The benefits of good epidural analgesia in this patient include: attenuation of the increased work of breathing and oxygen consumption during labor, stress reduction and facilitation of an anticipated assisted second stage.