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AMNIOTIC FLUID EMBOLISM IN A PARTURIENT WITH AN UNDIAGNOSED PHEOCHROMOCYTOMA *Ansa, E.M. DeSimone, C.A.; Eberle, R.L. Anesthesiology, Albany Medical Center, Albany, NY* Introduction: Amniotic fluid embolism, a rare complication of pregnancy is often characterized by peripartum hypoxia, hemodynamic collapse and coagulopathy. Mortality can be as high as 80%.(1) Pheochromocytoma, another rare disease, is difficult to diagnose during pregnancy due to it's variable presentation with similarities to preeclampsia.(2) We report a case of a parturient whose spontaneous vaginal delivery was complicated by an amniotic fluid embolism and an undiagnosed pheochromocytoma. Case: A 29-year-old black female with no significant medical history and a normal prenatal history was admitted to the labor floor at 38 weeks gestation with spontaneous rupture of membranes in active labor. Combined spinal and epidural analgesia was provided. With an uneventful labor, she delivered a healthy female infant and an intact placenta. Vaginal bleeding increased over the next hour and was treated with IM methergine 0.2mg and IM carboprost tromethamine 250mcg. In the operating room, a 3cm posterolateral cervical tear was repaired but profuse vaginal bleeding continued with evidence of disseminated intravascular coagulation. A decision was made to perform an emergency exploratory laparotomy, possible uterine artery ligation or hysterectomy. Rapid sequence induction was accomplished with ketamine 70mg and succinylcholine 110mg, soon after which she experienced labile blood pressures, with severe hypertension. Volume replacement with crystalloids, blood and clotting factors ensued. PA catheter showed low filling pressures and TEE performed, showed good left ventricular function, a hyperdynamic myocardium with profound hypovolemia. A hysterectomy was performed and EBL was 10 liters. At conclusion of surgery, the patient was transferred to the SICU, were she continued to receive blood products and was maintained on a nicardipine drip for blood pressure control. She developed sudden hypotension 5 hours later. A repeat TEE showed a severely distended right ventricle with global depression and mitral regurgitation. Cardiac arrest followed with a failed resuscitation. Post mortem report: Pheochromocytoma of the left adrenal gland, Pulmonary amniotic fluid embolism, Disseminated intravascular coagulation. Discussion: The unexplained coagulopathy in this patient, we believe was as a result of an amniotic fluid embolism. The expected hypotension was not seen. In retrospect, the release of excessive catecholamines from the pheochromocytoma, probably each time the abdomen was manipulated acted as a source of endogenous catechols, which maintained good left ventricular function and high systemic pressures in spite of continuous hemorrhage. *(1) Clark SI. Obstet Gynecol survey 1990; 45: 360-8. (2) Wissler RN Chestnut's Obstet Anes1999; 41:828-32*

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ATYPICAL SENSORY NEUROLOGIC CHANGE ASSOCIATED WITH POSTDURAL PUNCTURE HEADACHE IN A PARTURIENT: A UNIQUE CASE OF LHERMITTE'S SIGN *Obray, J.B. Long, T.R.; Brown, M.J.; Wass, C.T. Anesthesiology, Mayo Clinic and Mayo Foundation, Rochester, MN* Postdural puncture headache (PDPH) is a complication of neuraxial anesthesia. A variety of associated symptoms have been reported.[1] We present a case of PDPH associated with Lhermitte's sign in a parturient. A healthy term G1P0 19 yo parturient had an uneventful spontaneous vaginal delivery with epidural analgesia at another hospital. She developed a PDPH 2 hours after delivery. After negative head CT and lumbar puncture were obtained 24 hours later, an epidural blood patch (EBP) promptly resolved the headache. However, the PDPH recurred the next day and worsened over the ensuing 48 hours along with the onset of severe, sharp pain radiating down her neck and both arms, and chest tingling that worsened with neck flexion. She was admitted to our institution for neurologic evaluation and treatment. Magnetic resonance imaging(MRI)of the head and spine showed a peridural fluid collection from C4 to the lumbar spine. She was diagnosed with low CSF pressure headache associated with Lhermitte's sign. The symptoms resolved over 7 days with bedrest, intravenous fluids, caffeine, and morphine PCA. A repeat MRI demonstrated resolution of the peridural fluid collection. PDPH with associated neurologic symptoms is a potential complication of neuraxial anesthesia.[1] We were unable to find other previously reported cases of PDPH with concurrent Lhermitte's sign in a parturient. Kelly et al[2] reported the case of a patient who developed postural bilateral sharp, shooting pains down both arms following dural puncture. The symptoms improved with EBP. Lhermitte's sign consists of transient sensory symptoms usually produced upon flexion of the cervical spine. Clinically, this presents as an electrical or tingling sensation radiating down the spine or extremities. Although this sign is not pathognomonic for a particular disease, it has been reported to occur in patients diagnosed with: multiple sclerosis, cancer, Chiari malformation, spondylosis, and vitamin B12 deficiency. It has also been observed folowing cisplatin chemotherapy.[3] In the case of PDPH, the etiology of Lhermitte's sign is unknown. However, our patient's clinical findings clearly abated with the resolution of her headache and increase in CSF volume as demonstrated on repeat MRI. *1. Lybecker H. Postdural puncture headache (PDPH): Onset, duration, severity, and associated symptoms. An analysis of 75 consecutive patients with PDPH. Acta Anaesthesiol Scan 1995;39:605-612 2. Kelly JB. A new presentation of post-dural puncture complication. Anesthesiology 1991;75:548-9 3. Hogancamp WE, Noseworthy JH. Demyelinating Disorders of the Central Nervous System. In: Goetz CG, ed. Textbook of Clinical Neurology. 1st ed. Philadelpha, PA: WB Saunders Company; 1999:976.*