Original Research Paper

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Anaesthesiology

ANAESTHESIA MANAGEMENT OF OVARIAN TORSION IN SECOND TRIMESTER OF PREGNANCY

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ABSTRACT The ultimate goal is to provide safe anaesthesia to the mother while simultaneously minimizing the risk of fetal demise.

KEYWORDS :

INTRODUCTION:

Normally, nonobstetric surgeries during pregnancy are carried out when there is a definitive indication considering well-being of the mother, fetus or both. The incidence of non-obstetric surgeries during pregnancy ranges between 0.75% -2%. Ovarian torsion is one of the commonest non-obstetric surgery among them.Torsion of ovary is the total or partial rotation of the adnexa around its vascular axis or pedicle. Torsion of ovary occurs when it is moderate to large in size with long pedicle and mobile. Incidence of ovarian torsion is being more in pregnant (22.7%) than in non-pregnant (6.1%) women. The risk of any surgery like abortions, intrauterine growth retardation and low birth weight will depend on the gestational age. The goal is to provide safe anaesthesia to the mother and minimizing the risk of fetal demise.

Case Report:

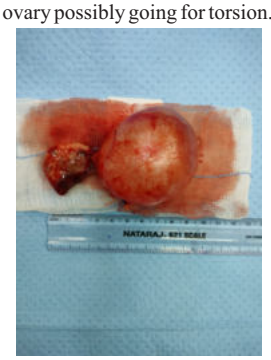
A 27 year old female G4P2L2A1 with gestational age of 21 weeks + 3 days admitted with complaints of abdominal pain and vomiting. She was diagnosed to have right ovarian torsion and planned to be taken up for emergency laparotomy.

Investigations:

Blood group: o +ve, Hb-11.6, WBC-11,600, plt-1.50 lakhs. Serology – negative. TFT – normal , ECG – normal. Urea-22, creatinine-0.6, MPC – 2, spine and airway examinations are normal. The weight of the patient is 45kg.

Usg Abdomen:

A cyst measuring 10x 7 x 6cm with thin internal septation noted in the right ovary on colour doppler twisted vascular pedicle noted. Features suggestive of right ovary possibly going for torsion.



Anaesthetic Management:

Patient was assessed and taken up under ASA 3E. Patient was shifted to OT. ECG, Saturation(SPO2) & NIBPmonitoring was instituted. preop vitals noted.BP-80/50mmhg HR120/min.peripheral IV line secured with 18G and 16G venflon in right and left hand, after which rapid sequence intubation was planned.patient was induced with inj. Thiopentone 180mg and paralyzed with inj.succinylcholine 75mg ,patient was then intubated with 7 size endotracheal tube. After confirming B/L air entry.tube fixed @ 18cm.plane of anaesthesia maintained with 02+N2O+SEVOFLURANE+ATRACURIUM. Inj.dexamethasone 6mg given.

Intraoperative:

Intraoperatively there was blood loss of 300ml and urine output of 50ml

Analgesics used:

- inj.fentanyl 50mcg iv
- inj.paracetmol 1g iv

Total duration of procedure: one and half hours

Postoperative:

post operative period was uneventful

DISCUSSION:

Whatever the period of gestation ,particular attention is to be paid to airway examination as this subset of population invariably have edema of airway as a result of hormonal impact. Safe anaesthesia must be provided to mother ensuring well being of baby by avoiding unwanted drug effects on the fetus.

While delivering anaesthesia to pregnant patient for non obstetric surgery following precautions to be taken:-

1. maintain stable hemodynamics
2. avoid drugs having teratogenicity
3. maintain good utero-placental blood flow
4. prevent intra-operative fetal hypoxia and acidosis
5. achieve good perioperative analgesia

CONCLUSION:

Nonobstetric surgeries during pregnancy are not uncommon. General Anaesthesia is not an absolute contraindication but regional Anaesthesia does avoid the potential risk of failed intubation and aspiration in addition to reducing the exposure of fetuses to potential teratogens. Multidisciplinary approach in peri operative period should be considered for better outcome.

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