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# 45 YEARS OLD FEMALE WITH POG 36 WEEKS WITH PREECLAMPSIA POSTED FOR CAESAREAN SECTION UNDER REGIONAL ANAESTHESIA

Anaesthesiology

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## ABSTRACT

Pregnancy induced hypertension is a hypertensive disorder, which occurs in 10% of all pregnancies. These parturients present to the labour room ranging from gestational hypertension to HELLP syndrome. It is essential to understand the various clinical conditions that may mimic preeclampsia and the urgency of cesarean delivery, which may improve perinatal outcome. The administration of general anesthesia (GA) increases morbidity and mortality. The provision of regional anesthesia when possible maintains uteroplacental blood flow, avoids the complications with GA, improves maternal and neonatal outcome.

## KEYWORDS

## INTRODUCTION

Preeclampsia is a hypertensive disorder of gestation, complicating 10% of all pregnancies. It is characterized by new onset of hypertension (≥140/90 mmHg) and proteinuria that develops after 20 weeks of gestation and usually resolves within 48 h of fetal delivery.

It can progress to a severe form in 25% of parturients when it is undiagnosed or untreated. It increases both maternal and fetal morbidity with the occurrence of eclampsia in 0.04-0.05% of the affected parturients with an estimated annual mortality rate of 50,000 parturients with preeclampsia world-wide

### Case Report

We report a case of 45 years old multigravida female of POG 36 weeks with FHS 146 bpm with high BP recordings i.e 160/110 mmhg on two occasions in a single day for caesarean section despite of taking antihypertensive drugs since 7 month of pregnancy.

No history of headache, blurring of vision, pain in epigastrium, tightening of rings, swelling of feet. Previous normal vaginal delivery 7 years ago. Cardiorespiratory system examination and all blood and urine investigations were normal. Airway assessment done.Before taking pt in ot fresh written informed consent was taken and airway cart was prepared.explaining anaesthesia risk and dif Aneasthetic plan decided for spinal anaesthesia with adjuvant. Patient taken in OT table under ambient room temperature, monitoring attached, iv line secured and iv left lateral position painting with betadine done for 3 min then cleaned with spirit to maintain asepsis. 26 gauge Quinckey's needle inserted in L4-L5 intervertebral space and free flow of CSF seen and then bupivacaine 0.5% heavy 2 c.c + inj. Fentanyl 25 mcg given. Sensory and motor blockade level until T4 achieved and surgery followed. Injection oxytocin infusion started 10IU in 500 ml after delivery of baby

## DISCUSSION

Spinal anesthesia is a generally preferred anesthetic technique as it is simple to perform; it provides rapid onset and a dense block. It also provides excellent post-operative analgesia when intrathecal opioids are used, It has no effect on Apgar scores and umbilical artery pH in preeclampsia as along as the systolic blood pressure is maintained greater than 80% or more of the baseline. The incidence of spinal induced hypotension and the vasopressor requirement were found to be two times lower in preeclamptic parturients when compared with normal parturients undergoing CS delivery. The increased production of circulating factors with potent pressor effect and the increased sensitivity to vasopressor drugs in preeclampsia along with the use of hyperbaric bupivacaine with opioids could decrease the spinal induced hypotension in preeclamptic parturients

## CONCLUSION

Parturients with mild preeclampsia may safely undergo regional anesthetic procedures for labor analgesia and CS delivery. A thorough evaluation to detect underlying coagulopathy or thrombocytopenia is essential prior to considering regional anesthetic procedures in severe preeclamptic parturients.

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