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Just Another Labor Epidural

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Introduction

There are many different types of anesthesia appropriate for the laboring individual; each with their own risks and benefits. No clear guidelines exist as to when to avoid placement of epidural catheters. The goal of this case is to provide information regarding the decision-making process in a complex obstetric patient.

Methods

A 32-year-old pregnant female presented to Labor and Delivery requesting an epidural be placed for mild abdominal pain. Patient was hemodynamically stable, and stated no fetal movement for at least 4 days, with her last obstetric visit greater than 4 weeks ago. The Obstetric team requested a labor epidural for vaginal delivery, with potential for possible c-section. CBC showed a platelet count of 110,000. Due to the fetal death, the anesthesiologist requested a coagulation profile which showed an INR of 1.5 and Fibrinogen level of 94mg/dL (373-619mg/dL, 3rd trimester normal). A thromboelastograph showed reduced clot strength. The laboratory values were concerning for potential early DIC. The patient was thought to be in the beginning stages of Disseminated Intravascular Coagulation (DIC) and was taken to the OR for immediate Cesarean delivery.

Abruptions risk severe peripartum hemorrhage and can occur at any time during the pregnancy. If the placenta completely separates from the uterus, the result can be life-threatening. Placental abruption can present either with vaginal bleeding or concealed bleeding. There are risks associated with any procedure, but placement of an epidural in a patient with thrombocytopenia, elevated INR, reduced fibrinogen and abnormal TEG. The presentation of this case reiterates how important it is to fully evaluate and surgical plan can be implemented with the ultimate goal of patient safety.

Results

This patient was a healthy 32 year old pregnant female who presented with at least 4 days intrauterine fetal death. Based on her lab findings, an epidural was not the recommended anesthetic plan. Her lab findings included mild thrombocytopenia, elevated INR, reduced fibrinogen and abnormal TEG. The patient was hemodynamically stable, and stated no fetal movement for at least 4 days intrauterine fetal death. Based on her lab findings, an epidural was not the recommended anesthetic plan. Her lab findings included mild thrombocytopenia, elevated INR, reduced fibrinogen and abnormal TEG. The patient was thought to be in the beginning stages of Disseminated Intravascular Coagulation (DIC) and was taken to the OR for immediate Cesarean delivery. Abruptions risk severe peripartum hemorrhage and can occur at any time during the pregnancy. If the placenta completely separates from the uterus, the result can be life-threatening. Placental abruption can present either with vaginal bleeding or concealed bleeding. There are risks associated with any procedure, but placement of an epidural in a patient with thrombocytopenia, elevated INR and reduced fibrinogen can present its own complications; most worrisome is an epidural hematoma.

The Couvelaire uterus occurs in instances of severe placental abruption in which blood extravasates into the myometrium. The uterus loses tone and increases the risk of postpartum hemorrhage and subsequent increased risk of developing DIC. The patients are also at increased risk of uterine rupture.

The presentation of this case reiterates how important it is to fully evaluate each patient. While the goal in patients who experience intra-uterine fetal death is usually to continue with a vaginal delivery with epidural placement for comfort, this is not a feasible option in a variety of cases. Obtaining a thorough history and appropriate labs, a unique anesthetic and surgical plan can be implemented with the ultimate goal of patient safety.

Discussion & Conclusion


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