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MANAGEMENT OF PARTURIENT WITH NEW DIAGNOSIS OF CRITICAL AORTIC STENOSIS

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Critical aortic stenosis (AS) is a rare and life-threatening complication in pregnancy. Tachycardia in pregnancy increases cardiac output while decreasing ventricular filling time, which is deleterious in AS. Physicians often recommend termination of pregnancy for the sake of maternal health. In this case, critical AS diagnosed at 17 weeks gestational age (GA) was treated with emergent replacement of the aortic valve at 21 weeks GA with survival of mother and fetus. A 35 year old multiparous female at 17 weeks GA with past medical history of gestational hypertension and hyperlipidemia presented emergently with dyspnea on exertion and newly diagnosed left bundle branch block. The patient was found to have critical AS and moderate aortic regurgitation by transthoracic echo. She was admitted to the cardiac intensive care unit for medical management until the fetus reached viability. At 21 weeks GA, the patient acutely decompensated, experiencing a 4 minute asystolic episode and receiving cardiopulmonary resuscitation. Multidisciplinary discussions led by the intensivist resulted in emergent coronary artery bypass grafting as well as an aortic valve replacement and aortic root endarterectomy with survival of mother and fetus. Multidisciplinary discussions organized and executed by the critical care intensivist are imperative for appropriate and timely treatment of AS in the parturient patient. In mild AS, parturients may be treated with medical therapy and expectant management until delivery, after which the valve can be surgically repaired. In more severe cases, symptomatic AS in pregnancy may be treated with balloon valvuloplasty. In this case, conservative management was first attempted. The parturient also did not qualify for balloon valvuloplasty or TAVR due to concurrent moderate to severe AR. However, acute decompensation in the patient's cardiac status required emergent surgical intervention at 21 weeks GA. Intensivists managing parturients with severe symptomatic AS should consider surgical replacement and initiate multidisciplinary coordination between obstetricians and cardiothoracic surgeons.

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MULTIMODAL ANALGESIC TECHNIQUE

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Pain is one of the main predictable postoperative adverse outcomes, and is reason for distress in patients. Adequate pain control is important for perioperative period. Any single analgesic may not be capable of providing best pain control with minimum or no side effect. Multimodal analgesia is combining different entities to decrease pain as well as the side effects of medications and improve patient satisfaction. Combination of drugs allows modulation of pain at various points in the neurochemical pathway, resulting in synergistic and/or additive analgesia which is corner stone of multimodal analgesia. Multimodal analgesia not only decreases pain and discomfort, but also decreases overall cost by decreasing length of stay. My talk will focus on concepts of multimodal analgesia, its advantages, different modalities used and its impact on patient care.

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