**Título:** CESAREAN SECTION IN A PATIENT WITH SEPTIC SHOCK: AN ANAESTHETIC APPROACH

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**Área Terapêutica/Tema:** Anestesia Obstétrica (Obstetric Anaesthesia)

**Resumo:**

Introduction: Sepsis in pregnancy and the puerperium remains an important cause of maternal morbidity and mortality worldwide. Septic shock may potentially complicate most infectious disorders of pregnancy and once it has developed, mortality is high. Anesthesiologists play an important role in the optimization of maternal and fetal condition. We report a case of a pregnant woman with shock septic presenting for a cesarean and the clinical challenges during the anesthetic management.

Case Report: A 28 year old woman, with chronic hepatitis B, in the 33rd week of gestation sought medical consultation for left lumbar pain without fever. She was hospitalized for maternal-fetal surveillance and was transferred to the Emergency Room the following day due to acute beginning of hypotension, tachycardia, chest pain and fever. Transthoracic echocardiography, CT angiography, and abdominal ultrasound were normal. Fluid resuscitation and Ceftriaxone 2g were started due to high suspicion of septic shock, but she remained severely hypotensive and a noradrenaline infusion was started. Decreased fetal variability and fetal heart rate decelerations prompted an urgent caesarean delivery. A rapid sequence induction was performed with propofol and rocuronium, the airway was secured, and maintenance was achieved with sevoflurane. A female infant weighing 1950 g was delivered 5 min after induction and Apgar scores were 2/5/7. During surgery, the noradrenaline infusion was maintained to obtain MAP above 60 mmHg. Uterine hemostasis was difficult, and she was transfused with 1 unit of red blood cells. The postoperative period occurred in an intensive care unit, were she maintained vasopressors and mechanical ventilation for 24 hours. The pyelonephritis diagnosis was confirmed with a renal ultrasound and isolation of an E. Coli in blood cultures. She was discharged from the unit after 3 days.

Discussion: Early recognition of sepsis is associated with improved mortality and outcome. However, in the young, healthy pregnant patient, delays in identification of sepsis may occur. Maternal sepsis may induce both labour and fetal death, as the well-being of the fetus is compromised if maternal arterial pressure and placental perfusion are reduced. Once it is suspected, restoration of perfusion should take priority by initiating antibiotics as well as fluid infusion. Septic vasodilated hypotensive patients may not tolerate the sympathetic block associated with spinal anesthesia during a cesarean section. There may be associated coagulopathy or thrombocytopenia and there is a risk of epidural abscess or meningitis. General anesthesia was chosen in this case to avoid those risks and to obtain a rapid and reliable onset of induction. A multidisciplinary approach to these patients among anesthesiologist, obstetrician, neonatologist and intensivist is essential.

References: Curr Opin Anaesthesiol, 2014 Jun;27(3):259-66

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