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CASE REPORT

A Case of Myxomatous Mitral Valve for Hysterectomy managed with Continuous Spinal Anaesthesia

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ABSTRACT

An 70 year old female weighing 41kg and 151 cm tall came with complaints of mass per vagina since 10 years and discharge PV since 2 months. Patient gave history of cough for which pulmonologist opinion was taken and patient was started on Tab Montair LC 0-0-1 and Inj Hydrocort 100 mg 1-0-1. No other known comorbidities.

Preop vitals were stable Preop investigations revealed a haemoglobin of 10.3 besides which rest all investigations were within normal limits. 2D echo revealed myxomatous Mitral valve with moderate MS; AV sclerotic with mild AR. Mild TR with mild PAH with PASP-50 mmhg and EF-55%. Cardiac opinion was sought and patient was deemed fit for surgery and to be taken under moderate risk. Inj LASIX 20 mg was advised 1hr prior to surgery. Pulmonologist also gave fitness and advised patient can be taken up for surgery under moderate risk. Primary anesthetic plan was under subarachnoid block and alternative was General anaesthesia.

Preoperatively patient was given Tab Anxit 0.25 mg and Tab Rantac 150 mg. Nebulisation Duolin and Budecort was advised before shifting the patient to operation theatre. 1 pint PRBC was reserved. Preop Blood pressure was 140/80 mm hg. Intraop anaesthetic plan was changed to continous spinal anaesthesia Intrathecal catheter was inserted in L3-L4 space with the help of 18 G Touhys needle. Inj Bupivacaine 0.5% heavy-0.8cc was given initially at 10 am and a dose of inj Bupivacaine 0.5% heavy-0.6cc was repeated at 11:10 am. Patient maintained sensory block till T8. Patients vitals, urine output and blood loss was closely monitored and was uneventful.

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KEYWORDS

• Continuous Spinal Anaesthesia • Myxomatous Mitral Valve • Pulmonary Artery Hypertension

INTRODUCTION

Mitral Valve Prolapse (MVP) is a common valvular heart disorder characterized by the systolic displacement of one or both mitral valve leaflets into the left atrium. It affects approximately 2–3% of the general population and is more frequently diagnosed in young women.

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DISCUSSION

In Myxomatous mitral valve disease there is a cause of prolapse of mitral valve leaflet(s) into the left atrium. There is a loss of collagen from the leaflet and an accumulation of glycosaminoglycan.[1]

Patients presenting with myxomatous mitral valve disease may have infective endocarditis, mitral regurgitation, sudden death and stroke.[1]

Tight fluid control with appropriate monitoring and adhering to the haemodynamic goals, Smooth extubation with a pain-free post-operative period, cardiac support will go a long way for better clinical outcomes and uneventful recovery.[2]

Myxomatous mitral valve disease and pulmonary artery hypertension (PAH) face increased risks during anesthesia and surgery due to the potential for right ventricular (RV) failure and other complications.

PAH provides indirect evidence of exhaustion of left atrial reserve in MR patients and can be regarded as a trigger for surgical treatment of asymptomatic MR with preserved pump function indices.[3]

With continuous Spinal Anaesthesia, we are using lesser volume of drug to achieve the sufficient block with minimal hypotension and need for volume resuscitation, which is very important in these sort of patients with mitral valve prolapse and PAH, which may land up in cardiac failure and pulmonary oedema.[4]

CONCLUSION

Continuous spinal anaesthesia was used as an alternative to regular subarachnoid block. The haemodynamic were very stable with the titrated doses of Inj Bupivacaine and patient did not need much of intravenous fluids and the polypharmacy and side effects were avoided.

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Conflict of Interest: None

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