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ABSTRACTS

2026 LOUISIANA ANESTHESIOLOGY
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RENAISSANCE NEW ORLEANS ARTS HOTEL WAREHOUSE DISTRICT

ePoster #1| Case Study | Cardiac Anesthesia

Right Ventricle Perforation by Pulmonary Artery Catheter during Mitral Valve Repair Surgery

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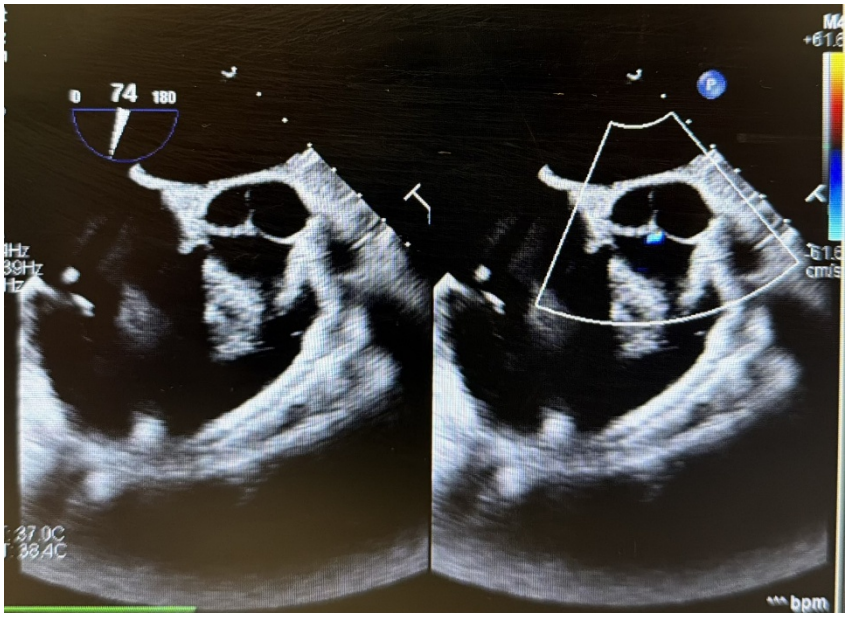
Case Project

Description: 57yo F presented with exertional dyspnea in setting of moderate to severe MVR. Patient with history significant for Vtach, single chamber ICD with hx of lead mass s/p AlphaVac aspiration with ICE, alcohol abuse and sarcoidosis. Diagnostic workup included TTE showing EF 25-30%, moderate to severe MR, normal RV size and function and EKG with frequent PVC's of Bigeminy. Post-induction an 8Fr PA catheter was floated through a 9MAC introducer without issue with initial PA P=24/17 (19) and CVP 16. Pre-bypass course notable for frequent PVCs causing hemodynamic instability treated with amiodarone and lidocaine boluses. PA pressures remained stable until 5 minutes before CPB, when they became non-pulsatile at 38/38 mmHg and later increasing to 213/213mmHg. After LAA clipping and mitral valve repair with closure of the left atriotomy, the PA catheter tip was visualized protruding from the RV apex. The catheter was withdrawn and repositioned, perforation closed, and the patient weaned from CPB on dobutamine and norepinephrine. ICU course included frequent PVCs; discharged POD 5.

Discussion:

Right-ventricular perforation from a pulmonary artery catheter is rare, with an estimated incidence of <0.2%. Most reported cases present with sudden hypotension and tamponade physiology; in contrast, our case appeared hemodynamically stable. Contributing factors included prior ICD lead placement with clot aspiration, sarcoidosis, alcohol abuse, and depressed EF. This case highlights that properly positioned PA catheters may migrate with cardiac manipulation. Prompt recognition, especially in non-cardiac surgeries, is essential; warning signs include rising CVP, hypotension, and loss of PA waveform pulsatility.



ePoster #2| Case Study | Cardiac Anesthesia

Large T-cell Lymphoma Invasion of the Right Atrium

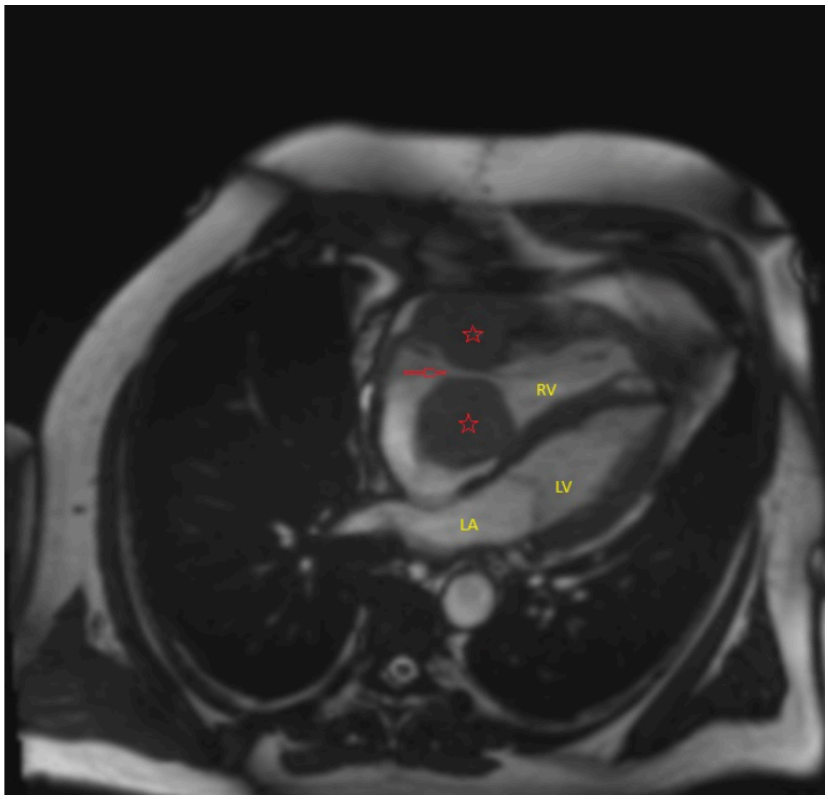
A Jacobs, H Liokumovich, K Ural, Tulane School of Medicine

Case Project: Primary cardiac tumors are rare and often present with nonspecific symptoms, making diagnosis challenging. Metastatic lesions to the heart are more common. Early recognition using advanced imaging techniques is essential for guiding management and improving outcomes.

A 63-year-old male with a history of tobacco use and idiopathic pericardial effusion presented to an outside hospital with a month-long history of progressive dyspnea and exercise intolerance.

The CT angiogram chest showed a locally invasive large anterior mediastinal and right heart mass with bulky upper mediastinal adenopathy. Following hospital transfer, his transthoracic echocardiogram identified a large mass in the right atrium abutting the tricuspid valve. Cardiac magnetic resonance (CMR) revealed a large homogenous mass extending into the epicardial space of the right atrium with pericardial involvement and encasement of the right coronary artery. Video-assisted thoracoscopic surgery (VATS) biopsy resulted in a diagnosis of T-cell lymphoma. After stabilization and initiation of oxygen therapy, he was discharged with plans for outpatient chemotherapy.

This case highlights the diagnostic value of cardiac MRI in evaluating intracardiac masses and the importance of considering primary cardiac lymphoma in patients with unexplained right-sided cardiac masses and pericardial disease. Early multidisciplinary evaluation allows for appropriate oncologic treatment and improved patient outcomes.



ePoster #3| Case Study | Cardiac Anesthesia

Unexpected Electrical Activity: Seizure after Mitral Valve Repair

S Ali, Tulane School of Medicine

Case Project: 34-year-old female with history of mitral valve prolapse and seizures underwent mitral valve repair. Her last seizure was a generalized tonic-clonic seizure nine years prior, and she was initiated on phenytoin therapy which she stopped taking after several years of being seizure-free. Intraoperative course was uncomplicated, and the patient was transferred to the ICU intubated and sedated. About 3 hours after surgery, patient had a witnessed generalized convulsive seizure that resolved with lorazepam. Phenytoin levels were undetectable prior to administering a loading dose and placing her on continuous electroencephalogram monitoring. The patient was extubated on post-operative day 1 with no further seizure activity. The remainder of patient's recovery was uncomplicated, and she was discharged on post-operative day 7 with phenytoin and strict seizure precautions. Seizure after cardiac surgery increases the in-hospital mortality for patients and is associated with longer bypass time and cases involving deep hypothermic circulatory arrest. Although we routinely use bispectral index monitors for cardiac surgery to assess depth of anesthesia, they are not reliable at identifying seizure activity during the intraoperative course. Further studies are needed to improve early detection of seizures in high-risk patients during the intraoperative and postoperative period.

ePoster #4| Case Study | Fundamentals of Anesthesiology

Paralysis and gentle rotation of endotracheal tube over bougie prevents arytenoid dislocation

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Case Project: A 49 year old man fell from a roof and paramedics intubated him at the scene. In transit to hospital he self extubated. He required multiple orthopedic surgeries under general endotracheal anesthesia. Prior to the first surgery, the anesthesiologist noted his voice was only a whisper. His wife stated his voice was normal prior to the fall. We ordered a consultation with ENT surgeons who performed an awake nasal fiberoptic exam of the vocal cords. The right arytenoid apparatus was severely asymmetrical and hypomobile, with a little compensation from the left. Suggested surgical repair was planned for two to four weeks later. The patient had a sense of doom and impending death postoperatively, had fever dyspnea and required a CT scan of the lungs which showed bibasilar atelectasis. Upon discharge to rehabilitation facility two months later, he was still severely hoarse. Unfortunately, the patient was lost to follow up, except for a brief and focused orthopedic checkup 6 months later without mention of hoarseness. Discussion: We recommend prevention of vocal cord injury by gentle passage of a fiberoptic bronchoscope or gum elastic bougie and then railroading the endotracheal tube over that while continuously rotating. Similarly, oral airway and LMA can tear tissue by folding the tongue if placed directly, where damage is prevented by rotating 90 to 180 degrees. Recurrent laryngeal nerves can be permanently ischemic if the balloon pressure is above 25mmHg for prolonged periods and sitting high rather than in suprasternal notch which can be balloted.

ePoster #5| Case Study | Fundamentals of Anesthesiology

Anesthetic Management of a Patient with Maffucci Syndrome and Chronic Thromboembolic Pulmonary Hypertension

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Case Project

Introduction: Maffucci syndrome is an exceptionally rare nonhereditary mesodermal dysplasia, with fewer than 300 cases reported worldwide. It is characterized by multiple enchondromas and soft-tissue hemangiomas, resulting in both skeletal and vascular abnormalities that pose unique challenges for anesthetic management. These patients are at increased risk for airway difficulties, skeletal fragility, and intraoperative bleeding. Our patient in this case had the coexistence of chronic thromboembolic pulmonary hypertension (CTEPH), which further complicates perioperative care and hemodynamic stability.

Case Presentation: A 65-year-old male with known Maffucci syndrome, bilateral upper extremity angiolipomas, and a history of CTEPH (status post pulmonary thromboendarterectomy in 2013) presented for surgical excision of enlarging angiolipomas of the left hand and right elbow.
Past medical history included pulmonary embolism, dysrhythmia, chondrodystrophy, and OSA. Preoperative echocardiogram showed EF 60% with normal RV/LV function.
Anesthesia was induced with midazolam, fentanyl, lidocaine, propofol, and succinylcholine, and maintained with sevoflurane. During induction, oxygen saturation decreased from 100% to 94–95%, attributed to pulmonary hypertension and atelectasis. Increasing PEEP from 8 to 12 cm H_2O restored SpO_2 to 98%. $ETCO_2$ remained low (20s–30s) despite reduced minute ventilation and improved with IV fluids and phenylephrine. The patient required a higher anesthetic depth (MAC 1.2) for adequate sedation.

Discussion: This case highlights the perioperative challenges of managing a rare multisystem disorder. Airway involvement from hemangiomas increases bleeding and obstruction risk during intubation. Skeletal deformities from enchondromas necessitate gentle positioning to prevent fractures. CTEPH alters cardiopulmonary dynamics, making oxygenation and ventilation optimization critical to avoid right heart strain. In such patients, regional anesthesia should be avoided unless imaging rules out vascular lesions. A-line placement and multidisciplinary planning are valuable for monitoring and safety.

Resources:

1. Jangra, Kanupriya, et al. “Maffucci’s Syndrome: A Rare and Unknown Disorder.” Journal of Rare Diseases and Orphan Drugs, vol. 3, no. 2, 2023, https://pmc.ncbi.nlm.nih.gov/articles/PMC10433447/

2. “Maffucci Syndrome: A Rare and Unknown.” Open Access Journals, 2023, https://www.openaccessjournals.com/articles/maffucci-syndrome-a-rare-and-unknown.pdf

3. “Maffucci’s Syndrome.” Stanford Health Care, Stanford Medicine, 2024, https://stanfordhealthcare.org/medical-conditions/blood-heart-circulation/maffuccis-syndrome.html

ePoster #6| Case Study | Fundamentals of Anesthesiology

Managing Anesthesia in Hereditary Hemorrhagic Telangiectasia: Lessons from a Complex Case

A Siebert, M Lipsmeyer, R Naramore, Edward Via College of Osteopathic Medicine (VCOM) - Louisiana

Case Project: Hereditary hemorrhagic telangiectasia (HHT), once estimated to affect approximately 1 in 100,000 individuals, is now recognized to have an estimated prevalence closer to 1 in 5,000, underscoring its growing clinical relevance for anesthesiologists. HHT poses unique challenges due to fragile vascular malformations, recurrent bleeding, and risk of shunting leading to hemodynamic instability. We present a 72-year-old male with transfusion-dependent HHT who presented with epigastric pain and new-onset hemoptysis, found to have a left-sided hydropneumothorax and an ingested foreign body. His extensive comorbidities, including end-stage renal disease, congestive heart failure, chronic obstructive pulmonary disease, and chronic anemia, compounded his risk profile. Early in treatment, a significant decline in hemoglobin necessitated treatment of packed red blood cells. A chest tube was placed under conscious sedation, followed by total intravenous anesthesia for combined esophagogastroduodenoscopy and colonoscopy, which revealed a plastic bottle cap lodged within the distal esophagus. Through coordinated care between anesthesia and gastroenterology, gentle esophageal dilation and retrieval was performed with minimal bleeding and stable hemodynamics. This case highlights the anesthetic complexities of HHT, emphasizing preprocedural screening for arteriovenous malformations, careful airway and hemodynamic management, readiness for blood product support, vigilant postprocedural monitoring for delayed bleeding, and interdisciplinary coordination. As awareness of HHT's true prevalence grows, anesthesia clinicians are increasingly likely to encounter such patients, where tailored assessment and anesthetic strategies are essential to ensure patient safety and demonstrate that even high-risk patients can safely undergo complex procedures.

ePoster #7| Abstract | Neuro Anesthesia

Anesthetic Management of Severe Dextroscoliosis During Posterior Spinal Fusion

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Introduction: This case describes the anesthetic and surgical challenges in the management of a severe case of adolescent idiopathic scoliosis. A 15-year-old female presented with progressive thoracic back pain and was found to have a 134° dextroscoliosis spanning T2–L3.

Methods: Her treatment plan involved posterior spinal fusion with pedicle screw instrumentation under total intravenous anesthesia (TIVA). Airway management required placement of a wire-reinforced endotracheal tube to minimize kinking during prone positioning. Anesthetic goals included maintaining stable hemodynamics and optimizing mean arterial pressure to preserve spinal cord perfusion while allowing reliable neurophysiologic monitoring.

Results: Intraoperatively at the time of screw placement near T7, motor evoked potentials (MEPs) revealed loss of left lower extremity function. Despite removal of the implicated pedicle screws, MEP signals did not return. A wake-up test was performed after completion of proximal screw placement, which confirmed absent voluntary movement in the lower extremities. The procedure proceeded with rod placement and closure. Two days later, the patient underwent re-exploration with removal of right-sided pedicle screws from T2–T4, resulting in partial motor recovery intraoperatively. Postoperatively, the patient demonstrated gradual bilateral motor improvement.

Conclusion: The anesthetic management of major spinal deformity correction presents unique challenges requiring close coordination with surgical and neuromonitoring teams. This case underscores the importance of meticulous anesthetic planning, vigilant intraoperative monitoring, and readiness to respond to neurologic changes to ensure patient safety during complex spinal procedures.