



C16 A patient with hypertrophy obstructive cardiomyopathy undergoing Liver transplantation

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Hypertrophic obstructive cardiomyopathy (HOCM) is a critical heart disease. In the meantime, conditions with lower afterload and preload, a relatively high heart rate and inotropy may worsen hemodynamic status in HOCM. Liver disease and liver transplantation operation could exacerbate those hemodynamic disturbances of HOCM. Here we presented a 67-year-old woman with HCV related end stage liver disease with HOCM. Anesthesia was induced with fentanyl 2g/kg, etomidate 4mg, midazolam 2mg and maintained with isoflurane mixed in air and oxygen. Neuromuscular block was maintained with Rocuronium. Monitoring included a pulse oximeter, left radius arterial line with cardiac output monitor (FloTrac Edward). A 7.5 Fr. Pulmonary artery catheter was inserted from left internal jugular vein. In order to avoid cardiovascular collapse when total inferior vena cava (IVC) clamping for graft implantation. Venous to Artery (VA) mode extracorporeal membrane oxygenation (ECMO) was prepared. A vein line cannulated via right internal jugular vein and exposure of right femoral area for emergency cannulation of right femoral artery. During the anhepatic stage, the patient developed low systemic vascular resistance (SVR) and increased cardiac (CO). Appropriate preload was replaced according to baseline pulmonary capillary wedge pressure (PCWP). VA mode ECMO was standby when total IVC clamped. SVR was maintained with norepinephrine infusion. On reperfusion the patient developed severe reperfusion syndrome. Systolic arterial pressure suddenly dropped to 30mmHg and norepinephrine titrated was performed. Fortunately the mean arterial pressure returned to normal range soon after norepinephrine titration. After reperfusion an infusion of norepinephrine was increasing to 5g/min to maintain SVR and was then slowly tapered to 1g/min as the operation commenced. Her postoperative course was uneventful and she was physically well since transplantation.