Anestesia local en embarazadas pdf pc version

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Received: 12-11-2020 Actado: 14-11-2020 â © 2021 The author (s) "This publication is £" official rgan of the socity of anesthesiology of Chila Chilean magazine of anesthesia vol. 50 nã © m. 1 pp. 171-195 | https: //doi.org/10.25237/revchilanestv50n01-11 pdf | epub | Patient pregnant patient in the APENDICETOMICE ABENDICTOM⬠posterior fossa surgery in the position sitting in a pregnant patient with cerebelopontine sopcula. A revision of these anatomic and physiological changes that occur during pregnancy, which can affect the administration of anesthesia. It is emphasized in the upper way, respiratory function, cardiovascular and gastrointestinal systems. Pharmacoking and pharmacodynamics changes are described that are relevant to the administration of general and regional anesthesia. The most appropriate time for surgery is discussed and it is concluded that elective surgery should not be done during pregnancy and must be postponed until delivery of childbirth. In some cases, immediately after, such as tuban sterilization and others, after the normalization of the physiological parameters. A comment is made with respect to teratogenicity: although there is a well -known effect of the anesthetic phones on the formation of zulas, myitosis and the synthesis of DNA (which participate in cell differentiation and organogen nesis), any significant change in the function or morphology of a child, secondary to prenatal treatments (such as anesty management) can eventually affect the result. Finally, recommendations are made regarding the techniques of choice. There is no single physical technique for all cases, but it is clear that the maintenance of maternal oxygenation and the ueroplacental flow are the key. Whatever the technique that is chosen, it is essential to avoid hypoxemia and maintaining normocarbia and normothermia, dealing with hypotension aggressively; however, in general, when a regional technique is feasible, its use is isAbstract Laparoscopic appendectomy is the most common surgery during pregnancy. The American College of Obstetricians and Gynaecologists (ACOG), suggests that it is important to contact a obstetrician before performing surgery. A review is made of the anatomic and physiologic changes that occur during the pregnancy more related to the administration of anesthesia, especially in the upper airway, in the respiratory function, in the cardiovascular system and at the gastrointestinal level. The pharmacological, pharmacokinetic and pharmacodynamic changes involved with the administration of general and regional anesthesia are described. The most appropriate moment for the realization of a surgery is discussed: an elective surgery should not be done during pregnancy, but should be postponed until after delivery; some immediately after, such as tubary and other sterilization, then normal physiologic parameters have returned. A reference is made to teratogenicity, which is not only the effect of drugs used in anesthesia that could affect cell formation, mitosis and DNA synthesis, which participate in cellular differentiation and organogÃ©nesis, but to any significant change in the function or morphologation of a child, secondary to this anti-natal treatment (in case of this). Finally, an anesthetic technique is recommended: there is no technical technique to the extent that the maternal oxygen and the uteroplacental flow are maintained. Whatever the chosen technique, the important thing is to avoid hypoxemia and acidosis, to maintain normocarbia and normotherthermia, and to treat blood hypotensive aggressively; however, in general terms, where possible, a regional technique is preferred. In the United States about 1% (between 0.75% and 2%) of pregnant women need to be subjected to type germnot obstetric surgery during pregnancy[1]. About 75,000 pregnant women operate in that country every year and 1.2% of women of reproductive age have a positive pregnancy test when entering an elective outpatient surgery[2]. The most common non-obstatric interventions in the pregnant woman are: appendicectomy (1:1,500 pregnancies), colecystectomy (1:1,600), removal of complicated ovÃ¡ric cysts, trauma and cancer surgery of the breast[3]. With the advent of the laparoscopic surgery, many of these interventions can be made on this path, so their management will be treated as a separate topic. Some interventions are miscellaneous such as intracranial aneurysms, valvulopatÃas, pheochromocytomas and can usually be postponed until after delivery. Others, such as oncollective surgery, should be done at the most timely time and finally a surgery that is not so uninhabitual, the cerclaje uterine, is done in the middle of the pregnancy. In the Hospital of Emergencies Public Assistance, the appendectomy is the most frequent surgery, presenting itself, in addition, some fractured patients and at least a severe polytraumatized year. Because it is an emergency service away from its base hospital, in such cases it is necessary to make a good coordination of the surgical, obstetric and anesthetic team (and eventually neonatologic). Although the American College of Obstetrics and Gynaecologists (ACOG) does not have evidence-based recommendations, it suggests that it is important to contact an obstetrician before performing the surgery, because they are the ones who are technically more capable to manage the physiologic and anatomical aspects that can affect the maternal and physical well-being of the individual. This cannot always be done in preoperatoria en la urgencia, pero sÃÂ se realiza rutinariamente interconsulta en el postoperatorio. Es asÃÂ como cada caso amerita un enfoque de equipo, para la Ã³Âptima seguridad de la madre y el feto[4]. La cirugÃÂa puede ser necesaria durante cualquier etapa del embarazo, dependiendo de la urgencia de la indicaciÃ³Ân. En una serie de 5.405 casos, 42% se hizo durante el primer trimestre del embarazo, 35% durante el segundo trimestre y 23% durante el tercero[5]. Habitualmente, la cirugÃÂa se realiza solo y ÃºÂnicamente cuando es absolutamente necesaria para la salud de la madre, el feto o ambos. En el manejo anestÃ©Ásico de una paciente embarazada deben considerarse como objetivos el bienestar de la madre y el feto, para lo que hay que hacer un balance de los requerimientos de ambos pacientes. Con el fin de obtener este propÃ³Ásito, es importante considerar algunos elementos teÃ³Áricos que describiremos en este capÃÂtulo: cambios fisiolÃ³Ágicos, anatÃ³Ámicos y farmacolÃ³Ágicos que ocurren durante el embarazo, el momento mÃ¡Às adecuado para realizar la cirugÃÂa, el tipo de anestesia mÃ¡Às recomendado y el conocimiento de los fÃ¡Ármacos proscritos o potencialmente peligrosos. Se debe tener en cuenta tambiÃ©Ân algunos elementos prÃ¡Ácticos: garantizar permanentemente una adecuada perfusiÃ³Ân uteroplacentaria y prevenir el aborto o parto prematuros[6]. Algunas situaciones especiales, de baja incidencia serÃ¡Ân tratadas en forma independiente. Durante el embarazo ocurren adaptaciones que son conocidas y que constituyen la base del manejo anestÃ©Ásico. Las mÃ¡Às precoces estÃ¡Ân relacionadas especialmente con cambios hormonales, mientras que las mÃ¡Às tardÃÂas se asocian a los efectos mecÃ¡Ánicos derivados del aumento del tamaÃ±Ão del Ã°Átero, al aumento de las demandas metabÃ³Álicas por parte del feto y a la baja resistencia de la circulaciÃ³Ân placentaria. Se recordarÃ¡Ân las mÃ¡Às importantes a tener en cuenta para la administraciÃ³Ân de la anoicalerroc es euq ol ,% ne â ¢¢¢£umemua vi esalc itapmallam leddicni al ,LAOOSEG DAMES 83 y 21 Sal ertne ,euq â°Acne cerene cesarame 242 ertes scabboram 242 edesnocne edsed Ed ocifâ¡â¡œCEwnotof oiudusе if you Razilaer la .Sazarabme Sal licâááááé©éáéâ have aááéâ have avid Aááááv Ed Avitcider sâ¡âom Ohcum , Sadicape on nectae on nectae nuadical nâ³âo haverfissalc al euq noreyulcnoc solua sol euq âááááˈl Otnat .]7[i Esalc Salleuqa ne euq roy secev 3,11 y 5,7 licalc illam Ojose aááâ haver ed od od od od od ie euq â³âo haverRestnocne es ,Lereeneg aisetsena noc aerâ¡â¡â¡C.) 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Although not all patients are difficult to intubate, several audits have evaluated the failed intubation rate, there is some concern that, because of less general anesthesia in this type of patients, its increase. Whatever the cause (decrease in skills or a real increase in incidence), the impossibility of intuiting the trachea is currently the most common cause of maternal mortality related to anesthesia in this group[9]. In order to reduce the risk of a failed airway, it is recommended that the use of regional anesthesia, better use of clinical training with simulation, use of well-established airway algorithms adapted for each institution, use of advanced airway devices and experienced personnel immediately available[10]. It is also advisable to use less-caliber endotracheal tubes (6.0-6.5 mm in internal diameter) than those used in the general population. During the tracheal extubation, the additional edema of the upper airway may cause obstruction in the recovery period. the organism of pregnant women must adapt to the growing metabolic requirements, the increase in the volume of the uterus and the cardiovascular changes themselves. the diaphragm moves towards cephalic with the increase of the gestational age, which is accompanied by an increase in the anteroposterior and transverse diameter of the chest box; this results in a little significant decrease in total lung capacity. from the fifth month of gestation there is a decrease in the functional residual capacity (crf) of 20%-30%, as well as theits components: the volume of espiratory reserve (15%-20%) and the residual volume (20%25%). A rise in the volume of inspiring reserve is usually produced. Life capacity is not modified during pregnancy. The decrease in CRF does not cause major problems in normal pregnancy, although it may have implications during the induction of general anesthesia. However, in patients with pathologies such as obesity, smoking or scoliosis, an increase in the closing volume can occur and as the pregnancy progresses it can cause hypoxemia. The dorsal decubitus and Trendelemburg's position exacerbate this abnormal relationship between closing volume and CRF. The increase in progesterone levels increases the minute ventilation from the beginning of pregnancy to 50% at the end of the pregnancy, where 35%-50% is based on the current volume, with only a small increase in the respiratory rate. The alveolar dead space provides augmente, to which the proportion of it with the current volume is not modified. After the decrease in progesterone after delivery, volume and capacity changes are normalized after three weeks, although total normalization does not occur until 6 to 8 weeks after delivery (Table 1). The basal consumption of oxygen also begins to increase early in pregnancy, reaching 20% on the basal at the end, increasing the production of CO2. However, the increase in alveolar ventilation produces an overcompensation, reduce PCO2 to levels of about 28-32 mmHg and increase the PaO2 to about 100-106 mmHg in the initial phase. More advanced pregnancy, PaO2 returns to normal or low, by closing the smaller airways in the presence of a normal current volume and intrapulmonary decircuit. 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.otrap led oicini led setna ed la roirepus %001 a %08 res a ragell edeup ednod ,)otrap ed ojabart led apate a3(otrap led s©ÃÃupsed etnemataidemni erruco otnemua royam le orep ,)n³ÃÃisufsnartotua(In the third quarter and relieved with the lateral decys. The compression of the ilíacos vessels can exacerbate venous © xtasis and produce edema of the lower extremities and increase the already high risk of deep vein thrombosis. Neuroxial anesthesia predisposes the mother to the appearance of supine hypotension syndrome, so it is necessary to avoid this position when these techniques are performed for analgistic purposes during childbirth work or for anesthetical purposes in any intervention Quirãºrgica. This is achieved by the patient's turn to the left, which prevents arterial hypotension and maintains the uteroplacentary flow. There are 10 to 15 cm as inclined planes to put on the right hip or special devices to displace the ãºtero to the left. In urgency situations this can be replaced by a serum bag or the bundle of an operator. Recently it has been seen in studies with a nuclear magnical resonance that the dorsal decy does not compromise the aórctic flow, although the lumen of the lower vena cava with inclinations at 15 ° (Figure 2) [12]. Table 4. Cardiovascular modifications during pregnancy Variables changes modification dieto mental â † ‘40-50% volume of eyeccion â †‘ 25-30% heart rate â † ‘15-25% SYMIC VASCULAR RESISTANCE â †“ 20 % Pulmonary vascular resistance â † “35% central venous pressure without changes â €“ pulmonary capillary pressure without changes â € “venous femoral pressure â †‘ 15% on the usefulness of the use of uterine lateralization is operational, that is, cl. Important your a atsah natcefa sotim³ÃÂv sol y saesu¡ÃÃn saL .sasebo ne etnemlaicepse ,lareneg aisetsena ed n³ÃÃiccudni al etnarud adic¡ÃÃ sitinomuen y ocirts¡ÃÃg odinetnoc ed n³ÃÃicaripsa ed ogseir le omoc ÃÃsa ,ozarabme led ogral ol a n³ÃÃicatigruger y)sisorip(sitigafose ed aicneucerf al natnemua socim³ÃÃtana soibmac sotsE .anipus n³ÃÃisnetopih ed emordnÃÂs la negiro odnad odiv¡ÃÃrg oretºÃÂ le rop sodimirpmoc nos ,roirefni avac anev al etnemlaicepse ,sosav sednarg soL .lasrod otibºÃÂced ne 5L ed levin a etroC .1 arugiF .sedioipo ed osu le y dadeisna al ,rolod le rop odaicnetop ,otrap le etnarud ÃÂs orep ,ozarabme le etnarud odicetnoleme etnemavitacifingis ¡ÃÂtse on ocirts¡ÃÃg otneimaicav lE .odic¡ÃÂ s¡ÃÃm aes odinetnoc us euq odneicah ,ocirts¡ÃÃg oguj le ne senoinegordih ed n³ÃÃicerces al atnemua ,anoretsegorp al rop adalumitse n©ÃÃibmat ,atnecalp al ed etrap rop anirtsag ed n³ÃÃiccudorp aL .dadicinot us s¡ÃÃm nºÃÃa riunimsid edeup anoretsegorp al euq sartneim ,odiv¡ÃÃrg oretºÃÂ led otcefe rop etneicifusni res y esramrofed edeup roirefni ocig¡ÃÂfose retnÃÂfse le ,ozarabme le etnaruD .)arerrab ed n³ÃÃiserp(roirefni ocig¡ÃÂfose retnÃÂfse led al y acirts¡ÃÃgartni n³ÃÃiserp al ertne etneidarg al ed edneped ocirts¡ÃÃg odinetnoc ed n³ÃÃicatigruger aL .acic¡ÃÃrotartni dadivac al aicah ogaf³ÃÂse led roirefni n³ÃÃicrop al ed otneimazalpsed nu zev us a ecudorp euq ol ,ocil¡ÃÃfec aicah nazalpsed es orolÃÂp le y ogam³ÃÃtse le ,odiv¡ÃÃrg oretºÃÂ led o±ÃÃamat le atnemua euq adidem A .]41[aen¡ÃÃtnopse n³ÃÃicalucric al ed onroter ed sedadilibisop serojem renetbo arap oiratadnam se °ÃÃ03 ne oniretu otneimazalpsed le ,ralucsavoidrac ospaloc noc sacirt©ÃÃtsbo setneicap ne ,etrap arto roP .dadilitu narg ed res eseidup sacirt©ÃÃtsbo senoicidnoc satreic ne y rireuqer a av es sosac sol ed %01 ne euq ay ,alodn¡ÃÃsu riuges rojem se euq ol rop ,ocirt©ÃÃtsbo lanosrep le ertne adanag anitur anu se a±ÃÃuc ed osu le ,etrap arto roP .aduya ed res areidup ,sonif s¡ÃÃm secalnesed ravresbo la ,ograbme nis of women during pregnancy, mainly in the first quarter [15]. It is estimated that aspiration pneumonitis occurs at 0.1% of the ceases carried out with general anesthesia, where the difficulties in ventilation that occur during pregnancy contribute to this risk [16]. A pregnant woman must be considered with a full virtual full form, even if she is fasting. For protection of the maternal respiratory life and to reduce the exposure of the fetus to the different medications used during general anesthesia, regional anesthesia is preferred

when possible. Figure 2. Effect of uterine lateralization in patients with pregnancy at Tãƒâ © © rmino, not anesthetized. It is observed that the light of the aorta does not commit to any inclination, while the lower cava becomes evident from 30 ° or higher inclinations. (Adaptation of Study of Higuchi et al. Cited in the text). The classical recommendations of many Anglo -Saxon Países, such as the United States, Canadãƒâ and the United Kingdom suggests the use of an anti -neat uninference prior to induction ƒâ¡trico. The incidence of aspiration in such circumstances is so low that, in many other countries, including Latin America and Chile is not a usual practice. The induction must be done in a river sequence and pressure on the cricoid cartoon (Selick maneuver) before the intubation by evidence mãƒâ © dica). A procin © ¡¡© © q. Opioids reduces its effectiveness. H2 antagonists reverse the gãnezing acidity only one hour after their administration; its association with anti -elder is more efficient that does not Nothing or unknown [17]. In relation to general anesthesia, between 8 and 22 weeks of gestation decreases alveolar concentration (CAM) of inhalation agents between 32% and 40%, probably, due to the increase in progesterone concentrations and the increase in liberation of endorphins [18]. However, Ueyama et al., They found no differences in electroencephalographic gains of pregnant patients with anesthetized with sevoflurane compared to non -pregnant women, so the modification of the CAM could not have a good correlation with hypnical depth and a at the same time to represent a possible explanation of why pregnant women have more risk of awareness that the general population [19]. On the other hand, the volume of distribution increases due to the increase in the volume of total blood volume produces a decrease in the concentration of syllectical proteins by dilution, which causes an increase in free fractions of the phones join them. This can cause different closing effects: for example, it can cause an increase in the systemic toxicity of local anestics that have a union raised to proteins. With neuroxial anesthesia relationship, with the same mass of local anestics, a higher level of blockage in women in the second and third trimester of pregnancy in relation to the non -pregnant woman is obtained, because the ingurgitation of the peridural veins Compress the dural sack, decreases the intra -reel volume and can increase the cephalic diffuse of local anestics [20]. Finally, with relation to the anesthesia of peripheic nerves, it has been shown that pregnancy increases the sensitivity of the median nerve to the lidocaéh block. In an in vitro preparation, greater susceptibility to blockade has been demonstrated, which could be related to progesterone or others Es Ollorrased y Otneimerc Le .OS LED SEDADADIralUCITRAP SALM Nâºâoâoâ°ONGOSNOCNUF SDADILONA NATNEDNESERP ES ,ODOââââclore Ed Ogeul .] ãı phoneo al ed tnemadnuf odoââââââ if see euq ay ozarabme LED ertsemirp remirp le etnarud elbisop ol odto ne aââãʒ al sractive ebueuv socation ,sarto y airabut nÂ³Ãicaziliretse al omoc ,sÂ©Ãupsed etnemataidemni sanuglA .otrap led sÂ©Ãupsed atsah esragretsop ebed euq onis ,ozarabme le etnarud esrazilaer ebed on avitcele aÂÃguric anU .]42[adazarabme al ne sotroc sÃ¡Ãm etnemavitacifingis nÂ³Ãicca ed nÂ³Ãicarud anu y oicini ed opmeit nu eneit ,namffoH ed nÂ³Ãicanimile rop azilobatem es euq ,oirucartasic le ,olpmeje rop :sacitÂ©Ãnicocamraf senoicaretla nerfus nÂ©Ãibmat nÂ³Ã I sweet y ogdagââââññññññññ YOUR LEDGEDNI SEACSUCSILE SERODAEUQOLB Sol .Sadazarab Me on Setneicap Sal Noc Nâ³âo havec ne nâ2³â°oca ed nâ³ã¶arud roy anu ecudorp nâ©â©â©â©â©BAT orep ,Acifidom od ed g. ưnsa ed nâ³â° why roy roy Anu y Odipâ¡â¡â¡â¡â¡â¡SOVINI ED OPEIT NO ENEIT GK/GM 2,0 ed radnâ¡ãhen oinoruce le . led sisilÂ³Ãrdih al ed nÂ³Ãicunimsid al ed otcapmi le asnepmoc nÂ³Ãicubirtsid ed nemulov royam le euqrop ,etneucerfni se aniloclinccus noc odagnolorp ralucsumoruen oeuqolb le ,ogrbame nis ,otrap led sÂ©Ãupsed sanames anu atsah nÂ³Ãicatseg al ed Ozneimo le Edsed %1 Ne Sodiunimsid nâ¡â¡áâưSE Acitâ¡â¡â¡SALP ASAREVIC ED SELVIN SOL .] ¡áư ed Senoicaretla Sal ,Euqnua ,Sodarartsinim etneamodauc reses nabed aisetsena ne sodazilito socamrâ¡â¡â¡fo Euq Ozararame le etnarudaref Itâ©éãƒcocamraf al .]1 se lapicnirp ovitejbo lE .lanoicatseg dade al ed etnemetneidnepedni esrazilaer ebed y anretam dadilatromibrom al atnemua euqrop esragretsop edeup on euq alleuqa :aicnegreme ed aÃguriC â .ertsemirt odnuges le atsah rirefid edeup es ,erdam al a ogseir ne renop nis ,euq ne sosac solleuqa :aicnegru ed aÃguriC â .otrap led s©Ãupsed sanames sies atsah adazalpa res edeup odnauc :avitcele a-ÃguriC :]72[sopurg 3 ne esracifisalc edeup ozarabme le etnarud acirt©Ãtsbo on aÃguric al ,socitc¡Ãrp senif noC .)5 albaT(ets©Ã noc sadanoicaler on o ozarabme led saiporp nos saÃguric saL .erdam erdam al ed dadiruges al ne rasnep y ozarabme led otnemom le ratropmi nis esrazilaer nebed ,senozaroc y sacigrºÃriuqoruen ,sacis¡Ãlpoen senoisel sanugla ,amuart ,lanimodba opit ed saicnegreme etnemlaicepse ,aicnegru ed aÃguric anu ed atart es is ,euq oralc ¡ÃtsE .ertsemirt odnuges led ritrap a ojab s¡Ãm se sisen©Ãgotaret ed ogseir le ,aÃroet nE â .]62[so±Ãeuqep s¡Ãm nos sojih sus y ohceh nah ol on euq salleuqa euq setna zul a nad ,ertsemirt odnuges le ne osulcni ,ozarabme le etnarud a-Ãguric anu a oditemos nah es euq serejum sal euq nartseumed soidutse sol ed aÃroyam aL .ocigrºÃriuq otca oiporp le o etnecaybus aÃgolotap al rop onis ,ocis©Ãtsena ojenam le rop adaicneulfni ¡Ãtse on asuac us etnemelbaborp .latef etreum ed nºÃmoc s¡Ãm asuac al eyutitsnoc y oirotarepoirep le ne rarepus ed licÃfid s¡Ãm amelborp le se orutamerp otrap led otneimatart y n³Ãicneverp aL .sogseir ed erbil etnematelpmoc odoÃrep nu se on euqnua ,orecret le ne euq ertsemirt odnuges le ne ronem se orutamerp otrap ed aicnedicni aL â .ertsemirt remirp le etnarud %51 a %21 noc n³Ãicarapmoc ne ,ozarabme led ertsemirt odnuges le ne %6,5 a ajab otroba ed aL â :senozar sairav rop ,ertsemirt remirp le edsed esragretsop odup euq aÃguric anu razilaer arap odauceda s¡Ãm le aredisnoc es ertsemirt odnuges lE .ertsemirt recret le y odnuges le etnarud la vida de la madre. La teratogenicidad se refiere no solo al efecto de las drogas usadas en anestesia que pudieran afectar la formaciÃ³Ân celular, mitosis y sÃÂntesis de ADN, que participan en la diferenciaciÃ³Ân celular y la organogÃ©Ânesis, sino a cualquier cambio significativo en la funciÃ³Ân o morfologÃÂa de un niÃ±Âo, secundario a algÃºÂn tratamiento prenatal (en este caso, el manejo anestÃ©Âsico). De este modo, la hipotensiÃ³Ân arterial materna, la hipoxemia, los trastornos en el metabolismo de los hidratos de carbono y la hipertermia tambiÃ©Ân han demostrado ser teratogÃ©Ânicos. Cualquier agente puede ser teratogÃ©Ânico en animales si se produce una exposiciÃ³Ân suficientemente prolongada en una etapa de desarrollo sensible y en la dosis adecuada. Una pequeÃ±Âa dosis de un medicamento dado puede ser catastrÃ³Âfica para el embriÃ³Ân temprano, pero una gran dosis del mismo fÃ¡Ârmaco puede no tener efecto en un feto en una etapa avanzada de desarrollo. La mayorÃÂa de las anomalÃÂas estructurales de causa iatrogÃ©Ânica ocurren ante una exposiciÃ³Ân al fÃ¡Ârmaco durante el perÃÂodo de organogÃ©Ânesis (dÃÂas 13-60), en tanto que las anomalÃÂas funcionales, durante el embarazo tardÃÂo. Tabla 5. Causas mÃ¡Âs habituales de cirugÃÂa no obstÃ©Âtrica durante el embarazo CirugÃÂas relacionadas con el embarazo CirugÃÂas no relacionadas con el embarazo Cerclaje Abdomen agudo LaparotomÃÂa pÃ©Âlvica de emergencia Trauma CirugÃÂa neonatal CirugÃÂa oncolÃ³Âgica CirugÃÂa neuroquirÃºÂrgica CirugÃÂa cardÃÂaca DespuÃ©Âs de aÃ±Âos de estudios experimentales en modelos animales y estudios observacionales en seres humanos, no se ha demostrado que los fÃ¡Ârmacos anestÃ©Âsicos sean claramente peligrosos para el feto. La respuesta definitiva se ha visto obstaculizada por la imposibilidad Ã©Âtica de realizar ensayos aleatorios en mujeres embarazadas y a que ningÃºÂn modelo animal es exactamente igual a la gestaciÃ³Ân humana. Por otra parte, constituye un problema para and patients the fact that the new drugs are once proven to determine their safety during pregnancy before or after their marketing. There is no adequate information to determine whether the benefits exceed the teratogical risks for 91% of the medications introduced in the last 20 years [28]. The Shepherd catalog, which lists the agents or factors torquely teratogystical in humans, does not include anesthetical agents or phones used routinely during the administration of anesthesia [29]. Some highly polarized mollas such as neuromuscular blockers do not cross the blood brain barrier in closedly sufficient concentrations. Nitrous enthusiasm affects DNA synthesis and has teratogystical effects on animals. In human beings, however, in the 70s a doubtful relationship between the female staff who works in the surgical schiry pavilions and in the dental environment was established, with the pregnancy of pregnancy and birth defects, although a Venculus was established more active with the reduction of fertility. In current times, with the measures used for elimination of environmental anesthetics, which can reduce the exposure to the nitrous enthusiasm in more than 90%, several studies carried out in this regard have not demonstrated this association with adverse results [30] . From the theoretical point of view, the nitrous enthusiasm directly blocks the transmethylocation reaction by which the metionine is synthesized from homocyste heard and methyltetrahydropholate, oxidizing vitamin B12, co -founder of the synthetic metionine, responsible for the formation of the formation of the formation of the formation of the formation. Myelin pods, among other effects. However, from the clinical point of view, the current evidence does not support the suspension of the use of nitrous enthusias al ne euq somsim somsim soms nebed ,Elbaiav se on o otreum â¡â¡ãwn otef le is .Adauceda sâ¡â¡M THUceda nâ³ãıisiced ed ed ed le noc ,saenrâ¢ LED ertsemirt le ,aââââöguic al ed nâ³âoâoâ°UD al y opit le esraredinnoc nebedesnoc nebedesnoc nebedesnoc nebedesnoc nebedesnoc nebendena acincâ©ét al Ed nâ³â£ưã haveeg acrort accordeg eterf. etneucer sâ¡â¡Ì phone scesv 8 ,tetneicap 003 Adac ertne 1 ed se acirtâ©â°BALBOP al laeuqart nâ¡f 170 0,6 mg/kg/diarios* 75 u/kg/dÃÂa 75 u/kg/dÃÂa* Dosis altas para mujeres entre 50-90 40 mg c/12 h 5.000 u c/12 h 4.500 u c/12 h Tabla 6. EvaluaciÃ³Ân del riesgo de tromboembolismo en pacientes que van a ser sometidas a operaciÃ³Ân cesÃ¡Ârea Bajo riesgo: deambulaciÃ³Ân precoz Parto por cesÃ¡Ârea para un embarazo sin complicaciones, sin otros factores de riesgo Riesgo moderado: heparinas de bajo peso molecular o medias elÃ¡Âsticas ¢ÃÂÂ Edad: mayor de 35 aÃ±Âos ¢ÃÂÂ Obesidad: ÃÂndice de masa corporal mayor de 30 ¢ÃÂÂ Paridad: mayor de 3 ¢ÃÂÂ Venas varicosas gruesas ¢ÃÂÂ InfecciÃ³Ân en curso ¢ÃÂÂ Preeclampsia ¢ÃÂÂ Inmovilidad por mÃ¡Âs de 4 dÃÂas antes de la operaciÃ³Ân ¢ÃÂÂ Enfermedad grave en curso ¢ÃÂÂ CesÃ¡Ârea de urgencia durante el trabajo de parto Riesgo alto: heparinas de ne aicneirepxe noc ,elbisop ol ne ,y odaticapac etnemadibed ogolÂ³Ãisetsena nu rop adazilaer aes euq etnatropmi se ,lanoiger aisetsena anu ritrevnoc o lareneg aisetsena ed osu le oirasecen se iS .acilÂ³Ãbmeobmort dademrefne ed ogseir le odneicuder ,zocerp nÂ³Ãicazilivom anu Arautcefe Edeup y Orutamerp Osac ed os ne soiccartnoc Sal ritnes Edeup etneicap etneicap al Euq Odom Ed ,Socitâ³â¢©éâ©âCore ed ed al ed al ed al ed al ed al ed al ed al ed al ed al ed in Tac Ed Osu le Noc Etnemlaiceepse ,OiroTareposop ROLODNOC etnecxe if sâ¡áâbleda atropa ,acimâ¡ưseh dadilibatse al aesnat al .selbag sásetnat , Tsena sol who is lanted Dadilibisnes roy anu a Odaicosa ,Lataludipe Osopida Osopida Odinetnoc le ne otnemua le y dognev nâ³ãıIcatrugrugrugrugdu al rop oedââââìnoc sidac al sDacud sDacudan sdisdi sdapid nódimdi sasadic on etneicap anu ne aââââ haveh EuQ al A otcepser oicret nu ed rodederla ne sisod sal esriunimsid nebed laixaoruen aesetsena al ed os le ne .Atatsuja Res Ebed Selacol Socisââ°SEA Sol Ed nâ³â¡a esanni avifised al . afla roserposav nu ,anirfelinef al omoc ÂÃsa sE .etnega led adauceda sÂ¡Ãm etnemacirÂ³Ãet nÂ³Ãiccele al euq anretam lairetra nÂ³Ãisnetopih al ed ovitcefe otneimatart le etnatropmi sÂ¡Ãm se euq odartsomed nah selautca sÂ ¡Ãm senoicagitsevni ,ograbme niS .airatnecalporetu nÂ³Ãicalucric al erbos sotcefe ed atlaf us y ateb serotpecer sol erbos etnemetnanimoderp setnalumitse sedadeiporp sus a odibed ,anirdefe al odis ah adazarabme etneicap al ne ocitÂ¡Ãpmis oeuqolb rop lairetra nÂ³Ãisnetopih al nâ¢£ưcele ed Roserposav le le etmlanoicidart adiconoc alifort or adnuforp dognev sisobmort eddedecet â€â€Tr sÑ áec sáec sáec sáec sâJosec sáec sâJosec sâJosec sâJosec sâJosec sâJosec sác sâJosec sâJosec sâJosec sâJosec sác sâJosec sâJosec sâJosec sâJ. Aicneserp â“â€â¢ Sacitsâ¡ ãıle said y ralucelom osep osep administraciÃ³Ân de anestesia general a pacientes embarazadas. Con los avances de la cirugÃÂa y de la anestesiologÃÂa, se estÃ¡Ân realizando procedimientos cada vez mÃ¡Âs complicados durante el embarazo. Existe una serie de situaciones muy especÃÂficas que son de reciente incorporaciÃ³Ân, como la cirugÃÂa laparoscÃ³Âpica o bien, de muy baja frecuencia, como el trauma y la necesidad de realizar una cirugÃÂa cardÃÂaca o neuroquirÃºÂrgica. Aunque se aplican los mismos principios bÃ¡Âsicos de la anestesia en pacientes embarazadas, algunos tienen caracterÃÂsticas especiales que justifican una discusiÃ³Ân adicional. El trauma es una de las principales causas de muerte materna. Alrededor de 6% a 7% de las pacientes embarazadas se presentan al hospital como consecuencia de un trauma, de diversa gravedad[56]. En Estados Unidos la primera causa de trauma durante el embarazo son los accidentes automovilÃÂsticos (64%). El resto son caÃÂdas (19%), heridas penetrantes por arma de fuego o arma cortopunzante, trauma cerrado (10%) y quemaduras (1%). En Chile no hay estadÃÂsticas ni publicaciones al respecto. Puede acompaÃ±Âarse de muerte fetal, que ocurre por hipovolemia o shock hipovolÃ©Âmico materno, desprendimiento de placenta o muerte materna. Se debe realizar una ecografÃÂa al llegar la paciente al box recuperador para determinar la viabilidad fetal e iniciar en ese momento el monitoreo de LCF. Los procedimientos diagnÃ³Âsticos son los mismos, con protecciÃ³Ân radiolÃ³Âgica para el feto cuando sea posible. La exposiciÃ³Ân a radiaciÃ³Ân debe tenerse presente, pero no estÃ¡Â contraindicada, tratando de mantener niveles de exposiciÃ³Ân menores de 5 rad. Por ejemplo, una tomografÃÂa axial computarizada de crÃ¡Âneo expone a menos de 1 rad y no representa mayor riesgo para el feto[57]. El examen radiogrÃ¡Âfico de rutina despuÃ©Âs de un traumatismo (columna cervical, tÃ³Ârax y pelvis con protecciÃ³Ân) produce una exposiciÃ³Ân insignificante al feto[58]. 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