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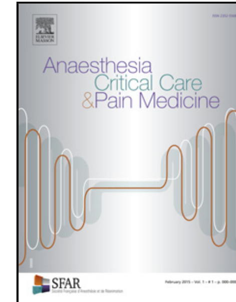

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Letter to the editor

Coma complicating a subdural haematoma after thoracic epidural anaesthesia

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The subdural haematoma (SH) is a rare complication of dural puncture following epidural anaesthesia. SH is mainly described in obstetric settings and symptoms are generally mild. We present the case of a (non-obstetric) patient who went into a coma in association with a subdural haematoma after a thoracic epidural anaesthesia. A 60-year-old, ASA 2 woman had video-assisted thoracoscopic right upper lobectomy surgery for cancer (lung adenocarcinoma). Her weight, height and BMI were respectively 55 kg, 157 cm and 22.3 kg/m^2. Before the general anaesthesia, we had inserted an epidural catheter (Perifix®) at the T4-T5 intervertebral space. The epidural space was found at 7 cm after two attempts. The major difficulty with epidural space access was due to marked spinous processes tilt. We used the loss of resistance technique using saline and a Tuohy needle (18G x 80 mm). There was an accidental dural punction with cerebrospinal fluid (CSF) reflux. The catheter was removed. No particular event was reported during the surgery. The surgeon placed a paravertebral catheter to complete postoperative analgesia. At the end of surgery and before chest closure, a 18 G Tuohy needle was inserted by the surgeon and a catheter (Perifix®) was placed in the T5-T6 paravertebral space under direct vision. A bolus of 15 ml of 0.5% ropivacaine was given via the catheter and continuous infusion with 0.2% ropivacaine at a rate of 0.1 ml/kg/h was programmed. The surgery and general anaesthesia times were respectively 120 and 150 minutes. The patient was observed for 2 hours in the postoperative care unit.

The immediate postoperative period was simple. Analgesia was controlled by the paravertebral catheter and standard analgesics (paracetamol and nefopam) .We didn't need rescue morphine. On postoperative day 1, mild post-dural puncture headaches (PDPH) were supported by analgesics (paracetamol, nefopam and tramadol), intravenous fluid therapy and bed rest. The VAS pain score was 5. On postoperative day 2, the patient went into a sudden coma with anisocoria. The Glascow coma score was 4. A CT scan was performed after intubation, sedation and osmotherapy. The CT-scan showed a large frontotemporal SH (16 mm) with an large mass effect (Figure 1).

A neurosurgical craniotomy with SH evacuation was performed. We also found active arteriolar bleeding. Recovery was complicated by ventilator associated pneumonia. The patient was extubated on day 3 in the intensive care unit. She had right arm paresis without cognitive sequelae. She was able to return home 12 days after her lobectomy. Motor recovery was complete after 15 days.

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