Epidural Abscess

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INTRODUCTION
Labor Analgesia is ideally maintained with epidural analgesia when possible. Parturients with hardware in the back can be difficult to place an epidural and the risk of colonizing the prosthesis.

CASE DESCRIPTION
A 35 year old parturient with a history of scoliosis following correction with Harrington rods presented in labor following an uneventful pregnancy. Labor pain was initially managed with IV Butorphanol Tartrate. However at 4.5 cm dilation she requested and received an epidural. Unfortunately, she only received unilateral analgesia so another was placed following multiple attempts spanning an hour. Afterward, patient had good analgesia, gave birth uneventfully and was discharged routinely. Four days postpartum patient developed fever, headache, back and right sided radicular leg pain. An MRI was done that demonstrated L3-L4 epidural abscess. Initially she was treated conservatively but her symptoms persisted. Patient required laminectomy and drainage of abscess. Her symptoms resolved and she did well postoperatively and was discharged.

DISCUSSION
The incidence of epidural abscess in patients undergoing epidural catheter placement is very rare. In patients with hardware near the spine, a site as far away should be used to reduce the risk of colonizing the prosthesis.\(^1\) If this is not possible, prolonged or many attempts at neuraxial access should be avoided. Despite this, neuraxial analgesia is usually successful in these patients when attempted. Remifentanil PCA is an acceptable alternative for labor analgesia.\(^2\) Ultrasound has also been used to confirm midline position, depth to epidural space and selection of an appropriate interspace for placement.\(^3\)

CONCLUSION
In case of difficult epidural placement for labor in patient with special risks, prolonged multiple attempts should be avoided. Remifentanil PCA is an acceptable alternative and ultrasound may assist in selecting the best insertion site.

REFERENCES