

10-2010

Epidural Hematoma

Stanlies D'Souza

Baystate Health, dsouzastan@yahoo.com

Follow this and additional works at: https://scholarlycommons.libraryinfo.bhs.org/all_works

Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Hseuh S, D'Souza S. Epidural Hematoma. ASA Annual Meeting, October 2010.

This Presentations, Research is brought to you for free and open access by Scholarly Commons @ Baystate Health. It has been accepted for inclusion in All Scholarly Works by an authorized administrator of Scholarly Commons @ Baystate Health.

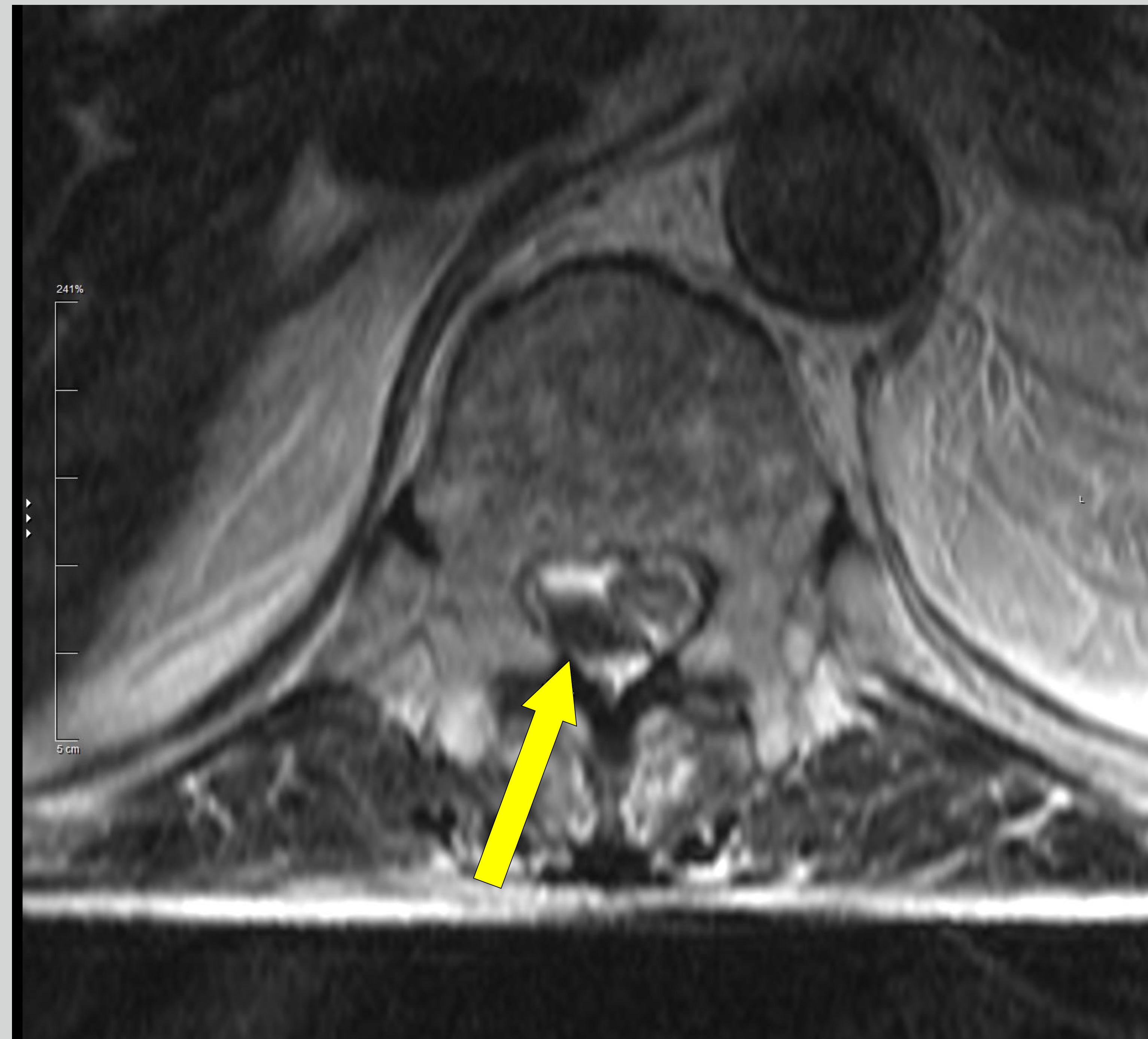
Introduction

Patients at risk for epidural hematoma include those with a coagulopathy or on a combination of anti-coagulants and anti-platelet agents. Early detection and management are essential.

Case Description

A 75 year old female (49 kg) had multiple vascular stents and amputations for lower extremity ischemia. She received lumbar epidural anesthesia for right below the knee amputation preoperatively. She had an INR of 1.2 and was on aspirin. Patient also had been receiving therapeutic LMWH until one day before surgery. Postoperatively, she had an episode of atrial fibrillation and was started on a heparin drip. She developed lower extremity paraplegia and lost sensory ability from T12 downward.

An unknown amount of time followed symptom onset and clinical suspicion. A further delay followed clinical suspicion and MRI, which demonstrated a thoracic epidural hematoma extending from T11-L2. Decompression and laminectomy was done but follow up MRI demonstrated C7-T1 epidural hematoma. The patient had a second laminectomy. Despite this patient remained paraplegic and had urinary incontinence. She was discharged but subsequently readmitted with sepsis from decubitus ulcers and infected amputation stumps. She decompensated and was allowed to expire.



Discussion

Epidural hematoma is a rare but potentially devastating complication of neuraxial anesthesia. Caution should be taken with patients on multiple anticoagulants, even if there is no specific contraindication.¹ Motor weakness is the most specific and ominous symptom.² Regular neurologic monitoring is important, especially in high risk patients or those that are not ambulatory. Once clinical diagnosis is made an immediate MRI is necessary, followed by emergency laminectomy.²

Conclusion

Specific monitoring protocol for neurologic deficits, especially motor weakness should be in place as well as immediate MRI and neurosurgical team availability anywhere neuraxial anesthesia/analgesia is performed.

References

1. Reg Anesth Pain Med 2010;35:64-101
2. Br J Anaesth 2008;101:400-4