CORRESPONDENCE

LUMBOVERTEBRAL SYNDROME AFTER EXTRADURAL BLOOD PATCH

Sir,—I read with interest the case report of Seeburger and Urwyler [1] describing severe back pain after extradural blood patch (EBP). I recently managed a patient with an almost identical problem, and I dispute the authors’ conclusions that “this complication...does not place into question the value of therapeutic EBP”.

Whilst relief of headache after EBP is indeed dramatic for many patients, the findings of a large survey of inadvertent dural punctures occurring over a 20-yr period at Birmingham Maternity Hospital [2] are not as encouraging as earlier reports—EBP successfully relieved headache in only 69% of 135 patients (including seven cases requiring repeat blood patch). The same survey revealed that it is unusual for post-dural puncture headache to last for more than 10 days. In common with the patient described in the case report, my patient suffered immobilizing back pain. She was readmitted to hospital 6 days after the procedure and underwent invasive investigation to exclude extradural abscess. Clearly, the value of EBP must be questioned if it can result in greater pain and distress than the condition it is intended to treat. (Incidentally, immobilizing back pain after EBP was first described by Cornwall and Dolan [3].)

The authors state that “severe backache after extradural block should be attributed to an extradural abscess or other serious pathological process until proved otherwise”. In fact, the evidence confirms that severe backache may follow EBP in the complete absence of any demonstrable pathological process. Such was also the case in the patient I managed.

Two of the cardinal features of extradural abscess—pyrexia and leucocytosis [4]—were absent in the patient described and it is debatable if urgent investigation was indicated. Where there is strong suspicion of an extradural abscess, invasive radiological investigation is clearly undesirable and may be avoided if MRI scanning facilities are available.

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2. Stride PC, Cooper GM. Dural taps revisited. Anaesthesia 1993; (in press).

Sir,—We appreciate the interest of Dr Stride in our recent case report [1] and we share his opinion that the extradural blood patch (EBP) has some potentially serious side effects. We further agree with him that when extradural abscess is suspected, invasive radiological investigation is undesirable unless computed tomography has shown no pathological findings, as in our patient. We look forward to reading his review of experience with EBP at the Birmingham Maternity Hospital, as the surprisingly low success rate contrasts not only with our own limited experience, but also with several reports published on this topic [2–8].

However, we disagree with Dr Stride’s conclusion that the value of an effective therapy introduced 31 years ago [9] and in widespread use today [10] must be questioned after three reports of painful side effects (fortunately, none of them with permanent damage). We agree that most patients with post-dural puncture headache (PDPH) do not need an EBP, but this therapy should be offered to the small percentage of patients with severe PDPH not responding to conservative treatment. Moreover, the syndrome of continued leakage of CSF after dural puncture may be complicated in rare cases by cranial nerve palsies [11], and even fatal subdural haematoma [12].

The most important point of disagreement, however, results from Dr Stride’s statement that “it is debatable if urgent investigation was indicated”. Many publications confirm that the extent of permanent neurological sequelae is related directly to the time required for diagnosis and surgical correction of haematomas [13–17] or abscesses [18, 19] associated with lumbar punctures. Indeed, Saady mentioned that an a priori presentation of extradural abscess may be a cause for delayed diagnosis [19]. Therefore, we reaffirm our statement that immediate investigation is warranted in any patient with immobilizing back pain after lumbar puncture.

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