Factors in epidural haematoma

Editor—Published case reports should serve to either raise awareness of a particular condition and or indicate how a similar problem might be dealt with in the future. In the case of an epidural haematoma, as reported by Tam and colleagues, these would come together with the aim of showing how this complication, or its consequences, might be avoided. However, this report raises as many questions as it answers.

First, the summary states that ‘standard guidelines’ were adhered to, but within the report it is revealed that the patient received an inadvertent dose of clopidogrel on the first post-operative day, and while she was also receiving dalteparin. This is certainly not according to guidelines and would be a very major aetiological factor. The patient was known to have a degree of chronic renal failure and to have been of fairly small size, yet a standard dose of dalteparin was administered. Again, this does not represent adherence to ‘standard guidelines’.

There is no specific mention of her preoperative analgesia, but it would be very unusual for a patient requiring knee arthroplasty to not require significant analgesia. In many cases this would be an NSAID, which would be another aetiological factor, but no information is given.

Finally, what is the risk/benefit balance of using a combined spinal–epidural anaesthetic technique, involving significant instrumentation of the vertebral canal, in a patient undergoing a primary knee replacement? Is not 72 h of continuous epidural analgesia more medicine than the condition warrants? If nothing else, it obscured the development of the early features of the haematoma although there seem to have been significant delays from other causes thereafter.

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Editor—We would like to thank Professor Wildsmith and colleagues for their interesting comments regarding our case report. The intention of publishing our case report was to raise awareness of an important, but fortunately rare, condition. The patient we reported highlighted the significant risk of developing an epidural haematoma following regional anaesthesia. Certain factors increase the likelihood of developing an epidural haematoma including patient factors such as age, female gender and bony spinal pathology. Factors such as stopping clopidogrel before operation, and in the administration of the LMWH in relation to the timing of the combined spinal–epidural (CSE) anaesthetic and subsequent removal of the catheter. Whilst the patient received an inadvertent dose of clopidogrel 75 mg the morning after surgery, retrospective analysis of the case notes revealed her abnormal neurology was already present, and it seems likely that the haematoma occurred at the time of insertion of the CSE. Furthermore, previous studies have shown that when clopidogrel is administered at a loading dose of 375–400 mg, maximal inhibition of platelet function occurs at 2–6 h but with clopidogrel 75 mg once daily this level of inhibition is only achieved after 3–7 days of repeat dosing.

The patient was not taking anti-inflammatory analgesics because she had a previous history of haemorrhagic gastritis following ingestion of low dose aspirin.

The case we reported highlighted the significant risk factors that can result in epidural haematoma following neuraxial blockade. Certain factors increase the likelihood of developing an epidural haematoma including patient factors such as age, female gender and bony spinal pathology. These factors should be taken into account when considering a regional anaesthetic technique, particularly in the presence of anticoagulants.

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References

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Propofol and memory

Editor—We were unsure from Dr Veselis’ editorial whether he approves of the possibility of patients being awake during general anaesthesia. Phrases such as ‘It will be a brave new world when we can tell a patient… “don’t worry—you won’t remember this” with confidence…’; ‘being aware but having no memory… is not a traumatic event… allows ethical research to be done…’; and ‘… the question is