Correspondence

Anterior epidural haematoma following subarachnoid block

To the Editor:
We have observed an epidural haematoma (EH) in a 64-yr-old female patient admitted for a right-knee fracture. At admission she was not receiving any medication. There was a remote history, 17 yr earlier of possible primary biliary cirrhosis. The only abnormal tests were the serum alkaline phosphatase (ALP) (407 $U \cdot L^{-1}$) and serum gamma-glutamyl transpeptidase (GGT) (168 $U \cdot L^{-1}$). Prophylaxis against deep venous thrombosis was undertaken with 5000 U calcium heparinate *sc* every eight hours. Coagulation status, monitored at the time of surgery, showed platelet count 128.000 $\cdot ml^{-1}$, fibrinogen 397 $mg \cdot dl^{-1}$, prothrombin time 100%, and activated partial thromboplastin time 30 sec. Spinal anaesthesia was performed 16 hr after the last dose of heparin using a 25-ga Quincke spinal needle at L_{3-4}. Needle placement was easy and free flow of unstained cerebrospinal fluid was obtained at the first attempt. Postoperative medications included diclofenac sodium 75 mg *im* administered once.

Two days later, a magnetic resonance imaging (MRI) (required due to the appearance of paraesthesiae, perineal numbness and lower extremity weakness) showed an anterior extradural haematoma from L_2 to L_4 (Figure). Laminectomy was performed and a non organized haematoma was drained. One month after surgery the patient was able to walk with the aid of a cane and her bladder paresis was recovering. The EH was located in front of the spinal cord and this uncommon site for EH may be linked to the small bore of the spinal needle employed. The lack of feeling during needle placement and the long delay before CSF appeared at the hub may have been the cause of unrecognized dislocation of the needle tip in the anterior area of epidural space.

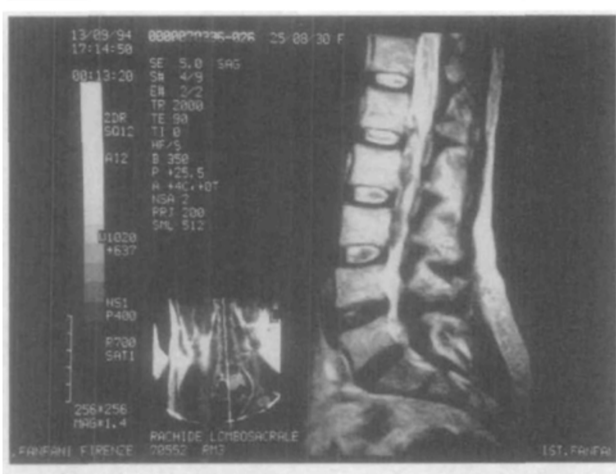

FIGURE MRI scan: Fusijam swelling anterior to the cord.

A crucial role in spinal bleeding might be attributed to the use of subcutaneous heparin[1,2] but other factors in this patient may have contributed and spontaneous bleeding is not excluded. An increase of portal pressure, which may occur with hepatic dysfuntion, may divert blood into epidural veins, which become dilated and prone to bleeding.[3] Although the platelet count was within the normal range, we do not know how well those platelets were functioning and what effect liver disease might have on platelet function. Finally, the association between heparin and NSAIDs is considered as a risk factor of bleeding following central neuraxial blockade.[4]

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Acute transient unilateral macroglossia following use of a LMA

To the Editor:
Postoperative complications involving the tongue are uncommon following use of the LMA. Pressure from the LMA cuff at the base of the tongue may occasionally cause neurapraxia of the hypoglossal nerve[1,2] where the nerve, accompanied by the lingual vein, passes between the hypoglossus muscle and the hyoid bone.[3] We report a case of transient postoperative unilateral macroglossia without nerve deficit following uneventful use of a laryngeal mask airway for a 30 min surgical procedure.

Case history
A 66-yr-old man weighing 70 kg with carcinoma of the prostate was admitted to hospital for urological investigation. His current medications were enteric-coated aspirin, lisinopril, amoxicillin, and ciprofloxacin. He underwent a cystoscopy under general anaesthesia with propofol, fentanyl, nitrous oxide and isoflurane plus prophylactic gentamycin and ampi-