Mortality in hydatidiform mole: Should we blame thyroid?

Sir,

We read with interest the case report “Hydatidiform mole: A sour encounter with a grapy case” by Madhuri S Kurdi. It is laudable that Dr. Madhuri and her team tried their best to save the life of a patient with the available resources. We have a slightly different perspective on the probable diagnosis of the case report, although that would not have altered the management and the outcome of the patient.

“Pulmonary artery hypertension with inadequately controlled hyperthyroidism resulting in cardiac failure and pulmonary oedema” is cited as the possible cause of death of this patient by the author, but no investigation was done to confirm the same. The preoperative pulse rate of the patient was 100/min after injecting Metoprolol and, in fact, there was an improvement in the thyroid functions postoperatively. The patient was restless and tachypnoeic after extubation, developed crepitations in the lungs and became hypoxic, requiring high positive end expiratory pressure (PEEP) and high fraction of inspired oxygen (FiO₂). All these signs suggest the possibility of trophoblastic embolisation during the intraoperative period leading to pulmonary artery hypertension (PAH) and pulmonary oedema rather than uncontrolled hyperthyroidism, as suggested by the author. The incidence of embolisation as reported in the literature is more than 50%. A bedside echocardiography could have been useful in this case. It could also have helped in knowing the functional status of the right ventricle. Bossone et al. have recommended the use of echocardiography as an essential component of the diagnostic algorithm of PAH and to differentiate PAH related to congenital shunts or secondary to thromboembolic phenomenon and pulmonary venous hypertension. It also helps in predicting the prognosis, monitor the efficacy of specific therapeutic interventions and detect the preclinical stage of the disease.

Computerised tomography of the chest should have been performed to confirm the diagnosis of pulmonary embolisation by trophoblastic tissue.

Regarding the management, general anaesthesia (GA) was preferred by the author over regional anaesthesia (RA) with the aim of providing haemodynamic stability, although in her article she has listed the advantages of RA. Considering the fact that the patient became haemodynamically stable even in the preoperative period after injection Metoprolol, we feel that RA could have been a better choice in this patient. A conscious patient under the RA may help in the early diagnosis of embolisation by complaining respiratory distress. RA would have decreased the cardiac preload as well. Safe use of spinal anaesthesia in patients with hydatidiform mole and hyperthyroidism has been reported in the literature.

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A rare complication of epidural anaesthesia a case report with brief review of literature

Sir,

A 29-year-old, G1-P0, woman presented to our delivery suite at 39 weeks of gestation, in early labour. 70 minutes later, at 4 to 5 cm cervical dilatation, she requested an epidural labour analgesia. Her medical and obstetric history was unremarkable, and she was not taking any medication. The epidural space was identified in the L3-4 interspace at a depth of 7 cm using the loss of resistance to saline technique, with an 18-gauge Tuohy needle and the catheter was easily inserted with the patient in left lateral position. The catheter was threaded to the 15 cm mark, the needle was removed and the catheter was left with 11 cm mark at the skin. This left 4 cm of catheter in the epidural space. Following a test dose of 3 ml of lignocaine 2% with 1:200000 epinephrine, the catheter was taped in place. 10 ml of bupivacaine 0.125% solution with 50 µg fentanyl was administered after no signs of intravascular or subarachnoid cannulation. Then, the catheter was connected to bupivacaine 0.125% and fentanyl 2 µg/ml infusion at a rate of 7 ml/hr. The patient was attached to the automatic blood pressure measurement machine, foetal heart monitor and an intravenous (iv) fluid of Ringer's lactate was run. Patient was comfortable and stable all through her labour which lasted around 4 hours.

After vaginal delivery, the catheter could not be removed. Repeated attempts to remove the catheter continued to be unsuccessful; however, after four attempts, we pulled out the catheter by steady increase in the traction force. Fortunately, the epidural catheter was removed intact without shearing. The patient experienced no paraesthesia or other symptoms during the procedure. However, inspection of the catheter revealed a tight knot about 1 cm from the tip and slight catheter stretching proximal to the knot was also observed [Figure 1] (epidural catheter knotting). However, the subsequent postnatal period of the patient remained uneventful.

Epidural analgesia still is the most effective way of labour pain relief but unfortunately this luxury comes at a price of some complications. Though serious complications to epidural anaesthesia or analgesia are uncommon, rarely knotting of lumbar and caudal epidural catheters has been reported,[1-3] which has an estimated incidence of 0.0015%.

Several sources have suggested that advancing the catheter beyond a certain distance into the epidural space increases the incidence of epidural knotting,[2] but still there is no consensus about the optimal length of catheter insertion. Conceptually, an epidural catheter may tend to curl or coil if threaded more than 4 or 5 cm. However, development of a knot in a catheter that was inserted <3 cm has also been reported.[4] Thus, signifying the role of other factors, like the type of catheter and the level of catheter placement. Depending on catheter type and level of insertion, insertion lengths from 2 to 8 cm have been proposed.[1,3] Since the catheter placed in our patient was inserted upto 15 cm and then withdrawn and fixed at 11 cm mark in the lumbar region; this must have probably allowed the catheter to turn 180° and form a knot.

The management proposed for an irretrievable epidural catheter includes change of the patient's

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