further decrease in BP. Simultaneously, the surgeon observed brain swelling and diffuse bleeding from the dural edges, muscle and skin. Transfusion reaction was suspected and hydrocortisone and crystalloids were administered. Blood sent for re-grouping and cross-matching did not reveal incompatibility. Haemostasis was possible only after administration of fresh frozen plasma. Following this, diffuse ooze stopped, brain swelling reduced and BP improved. Thirty minutes later, hematuria was observed, which cleared with frusemide. Post-extubation, coagulation status was normal. Rest of the hospital course was uneventful.

Transfusion reactions under anaesthesia are observed even when compatibility exists. Various immune and non-immune mechanisms have been described for hemolytic transfusion reactions. Intra-operative brain bulge as a consequence of diffuse oozing subsequent to transfusion reaction has not been previously reported. We postulate that the vascular permeability changes noted in scenario such as transfusion related acute lung injury might occur in the cerebral microvasculature leading to capillary leakage and diffuse oozing. Though haemodilution can also lead to increased oozing, normal coagulation parameters excluded this cause. Recently, a French group observed 4.5% incidence of hypotensive transfusion reactions in a series involving 1159657 transfusions. This occurred mostly at the beginning of the transfusion, as in our case. Although this is more pronounced and reported with platelet transfusion, all blood products may be involved. Moore SB suggested the possible role of bradykinin in this reaction.

We speculate that the hypotension, brain bulge and diffuse operative site bleeding could be a rare complication of blood transfusion. Recently, new mechanisms of red blood cell destruction have been postulated. These patients have little success with continued transfusions or steroids. Earlier, Eom et al have reported increased bleeding during scalp closure due to disseminated intravascular coagulation in a patient undergoing metastatic intracranial tumor resection. Kamitani and Sakai have reported occurrence of intraoperative haematuria following transfusion. We believe that the normal coagulation parameters, positive compatibility test and the temporal relationship between transfusion and occurrence of this complication, suggests the possibility of transfusion as the most probable cause. Our experience highlights the importance of early recognition of such unusual manifestation of transfusion reaction.

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Defective Spinal Needle: Failure in Piercing the Skin During Lumbar Puncture

Sir,

Through this letter I wish to highlight a failure to pierce the skin with a defective single use Quincke type spinal needle. A standard and apparently normal looking 26 G x 9.0 mm Quincke type needle failed to pierce the skin despite use of moderate force in a 50 yr old patient posted for vaginal hysterectomy. The needle was replaced with another 26G needle of the same company and the lumbar puncture was performed easily.

Careful naked eye examination of the first needle revealed slightly elevated tip of its stylet. Since this incidence occurred in multispeciality camp in a remote area of this mountainous state, we did not have microscopic equipment. However a digital photograph on magnification of image revealed that bevel of the stylet was rotated at 180°, was

Figure 1
Magnified photograph of the defective needle
facing the bevel of needle and was acting as a fork (Fig. 1-2). Application of force was possibly further separating the needle from the stylet (Fig. 3). Deformed\textsuperscript{1} and broken\textsuperscript{2,3} needles have been reported previously but this type of defect is a new experience. It is therefore suggested that in case of excessive resistance or grating feel while inserting a spinal needle, it should be minutely examined for any deformity of its stylet.

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Surinder Singh

Department of Anaesthesia and ICU, Indira Gandhi Medical College Shimla, India - 171001
Correspondence: Dr. Surinder Singh
E-mail: ss.igmc@gmail.com