Sir,

While practicing anesthesia in developing and underdeveloped countries, it is important to consider not only the quality of anesthesia but also the cost-effectiveness. I read the article by Singh et al. where the author mentions cost-effective indigenous drug delivery system for nerve blocks. The mentioned technique is an attempt and concentrated mainly on cost-effectiveness. We do regularly practice peripheral nerve blocks with or without ultrasound guidance. We do take care of each material used. Our technique is more cost-effective, less cumbersome, airtight, easy, takes care of sterility, and is also readily available. We routinely use a male to female pressure monitoring tubing for the delivery of local anesthetic during peripheral nerve block, which is available in various lengths and anesthesiologist can choose depending on comfort. One end of it is connected to needle and the other end to a 20-ml syringe, as shown in the Figure 1. We prime the tubing and needle with local anesthetic before we proceed for the block to remove air. The assistant injects the drug from the syringe after negative aspiration for the blood. The operator can hold the needle with great comfort and can concentrate on locating nerve or plexus. This technique saves time, is sterile, uses less resources, is easy, cost-effective, airtight, and readily available.

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Surgical removal of broken epidural catheter

Sir,

Although broken epidural catheter is an uncommon recorded complication and there is no many cases reported in the literature it is an area of debate because the catheter itself is made from inert material and foreign body reaction should not be expected[1] but unfortunately reactive epidural mass surrounding the catheter fragment has been
reported leading to lumbar compression\cite{2} and in spite of the location of the catheter is usually will not permit its extrusion but there is no guarantee that it will not occurs as it is recorded that the catheter may migrate and lead to nerve root irritation or dural fistula with or without a persistent CSF leak.\cite{3,4}

The broken end of the catheter is usually not smooth due to traction which may lead the pin prick like sensation with the movement all of these expected complication in addition to the psychological burden of the patient motivate surgeon to remove it.

Removal of the broken catheter should be smooth without any resistance or violence and under vision to prevent any further sequel as the catheter may be curled around the nerve root which may lead to neurological deficit also the catheter may be hanged in contracted muscle or lamina specially these patient become irritable and most of the time they cannot relax their back muscle so any violence may lead further break so we recommend to remove the catheter under vision using general anesthesia.

We recorded A 33-year’s-old female patient presented to our clinic with back pain and painful spinal movement after delivery of her 3rd kid by normal vaginal delivery under general anesthesia after failed epidural anesthesia with missed broken epidural catheter. The patient denied the appearance of this pain in the first and second delivery.

Clinical examination of the patient revealed tenderness over the spinal process at the level of L3-4 space with pin prick like sensation during spinal flexion but no motor or sensory deficit.

X-ray lumbar spine showed looped foreign body extending from spinal canal to subcutaneous tissue [Figure 1].

The patient informed about the finding and the two option whether to remove the catheter surgically or to leave the catheter with follow up and after confirmed consent the patient operated in the prone position under general anesthesia using intra operative X-ray guidance small skin incision has been don and dissection of subcutaneous tissue has been done using mosquito forceps until the lumbar fascia where the catheter could be identified immediately below the spinal process of L3.

Trial of removal by gentle extraction has been failed so small incision has been done in the sheath and dissection of the muscle all around the catheter was performed until the level of the lamina and ligamentat that time a second trial was performed and the catheter this time extracted smoothly which was found 17 Cm missed loop of the epidural catheter with sharpened external end.

Post extraction X-ray was done to avoid any other missed peace [Figure 2].

Postoperative there is no CSF leak or any collection and the patient discharged in the 2nd day.

Follow up of the patient showed that the previous pain disappeared and the patient become satisfied without any neurological compromise.

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Spinal anesthesia for hernia surgery in a child with laryngomalacia

Laryngomalacia is the most common cause of stridor in the newborn. The definitive diagnosis of laryngomalacia is made by direct laryngoscopy in a spontaneously breathing child, as the vocal cords collapse during the inspiratory phase of spontaneous ventilation.

General anesthesia was administered for initial evaluation of the airway in our case as previous studies have shown more accurate diagnosis of laryngomalacia with a drug-assisted technique using anesthesia than a clinic-based awake laryngoscopy.[2]

Sir,

Spinal anesthesia has been accepted as a safe option for inguinal hernia repair surgery in ex-premature infants, mainly for reducing the incidence of apnea.[1] We report the use of spinal anesthesia in an infant with laryngomalacia with stridor to minimize the airway-related complications.

A four-month preterm male baby, weighing 3.4 kg was posted for inguinal and umbilical hernia repairs. A history of noisy breathing and respiratory distress was present since birth. On examination, there was stridor which was more pronounced with crying and decreased with sleep. There was no change in the stridor with position. An initial presumptive diagnosis of congenital laryngomalacia was made. The cardiovascular system was within normal limits. Examination of the airway showed mild retrognathia. Investigations for history of failure to thrive revealed metabolic acidosis with renal tubular acidosis (RTA) type II and respiratory compensation. The child was on sodium bicarbonate, calcium, and potassium chloride syrup for the management of RTA. On the day of surgery, serum calcium was 0.60 mmol/L (normal range: 1.1-1.3 mmol/L). The child was fasted for four hours. After intravenous atropine 0.06 mg, sevoflurane in 100% oxygen (O2) was used for induction, with continuous positive airway pressure (CPAP) applied using Jackson Rees circuit. After attaining the required depth of anesthesia and ensuring adequate mask ventilation, the inhalational agent was changed to halothane in 100% O2. Mask ventilation was easy and stridor disappeared under anesthesia. Then, direct