Sir,

Problems attributable to flawed epidural catheter and spinal needles are often reported to apprise anesthesiologist to check their catheter or needles before use. Problems because of pencil tip spinal needle (PTSN) though epidural needle are rather rare. We encountered an unexpected incident of PTSN entrapment over spinal ligaments resulting in a lurid experience for the anesthesiologist.

We had a case of 37-year-old male planned for bilateral mesh hernioplasty for bilateral inguinal hernia. As the patient was apprehensive and postoperative analgesia was essential, a combined spinal-epidural (CSE) technique was planned. Tuohy needle of size 18 G was introduced into at L3/L4 interspace and after confirming loss of resistance (LOR) for the epidural space, high-flow Whitacre pencil-point spinal needle with a variable extension adapter was advanced. After confirmation of breach of the dura by the Whitacre needle and cerebrospinal fluid flow from the subarachnoid space, the anesthesiologist administered the drug. However, after that, he was not able to remove the PTSN. The needle became intractable at that position. After several unsuccessful attempts to withdraw it, the team decided to remove the whole CSE set [Figure 1] in-toto (spinal needle along with the Tuohy needle). In the intervening time, the patient began to complain of pain at the puncture site in spite of infiltration of good amount of local anesthetic in the area of procedure. It was then decided to observe the patient for a while till the effect of the subarachnoid block came. We did not attempt for the placement of epidural catheter freshly. The patient was comfortable with the onset of the effect of the drug and the surgery was done successfully under spinal anesthesia only. In the postoperative period, the patient complained of pain over the neuraxial block site after the regression of spinal drug effect, local pain over the back was managed with oral analgesics. The patient went home without further complications.

Newer spinal needles with smaller diameters are mainly used for the added advantage of increased tensile strength.\[1\] In a CSE set, there is a luer lock which helps in fixing the needle after getting a LOR prior to remove the stylet. Moreover, it is discretionary to use an atraumatic pencil tip needle, preferably wider than 27 G in difficult spinal puncture. Common problems with smaller needles are shaft deviation, tip deviation, bending, and trauma. Most of the articles have advocated for a needle-through-needle technique when difficulties occur with narrower needles.\[2,3\] This “spinal needle trough epidural needle technique” can be used for more support of the spinal needle, where the spinal needle is guided by the epidural Tuohy needle. However, in our case, we faced a problem in needle-through-needle technique only. Till date, case reports are available for flawed catheter in epidural but not for the spinal needles as we faced in this case. In our case, we used a CSE set following the standard practice of using a 27 G PTSN [Figure 2].

The possible cause of PTSN entrapment is prior defective design of needle or resulted in deformation during procedure. We want to bring it into the notice to all the anesthesiologist that even if using a CSE set as a standard of practice for neuraxial block, one should keep in mind the possibility of needle fracture, including those related to material of needle itself, its position during insertion and the difficulty of the procedure.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have
given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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