Sir,
Disconnection of epidural catheter and filter is not unknown.[1] However, damage to the injection port of the epidural catheter filter is uncommon. We encountered such a problem during the use of an epidural catheter set for postoperative pain relief.

A 68-year-old man posted for right total knee replacement for which lumbar epidural catheter (B. Braun Melsungen AG, Melsungen, Germany) was placed at L3–L4 space through the midline approach. The catheter assembly was used uneventfully for the initial 48 h while the patient received intermittent top-up doses of bupivacaine and morphine mixture. After 72 h, we witnessed slight leakage of the analgesic solution from injection port of the epidural catheter filter during injection of the top-up dose [Figure 1a]. On closer evaluation, we noticed that there was a crack in the catheter filter port leading to the spillage.

While investigating the possible cause of this occurrence, we came to know that different brands of disposable 10-ml syringes are supplied to our hospital. On closer observation, we also noticed that there exists slight difference in nozzle diameter of these syringes [Figure 1b]. We suspect use of a syringe with a slightly larger diameter might have led to the damage to injection port of epidural filter. We inadvertently try to snugly fit the syringe nozzle into the injection port of the catheter filter applying excessive force. We speculate that such an attempt might have contributed to the damage and the consequent leakage of medication. If gone unnoticed, such a spillage might cause inadequate pain relief and patient dissatisfaction, apart from creating other problems.

Although this event shows a lack of regulatory standardization, we suggest keeping in mind this unusual complication while administering the epidural top-up doses. Gentle application of syringe in the filter port and looking for any leakage during drug administration should be practiced. Another possible solution is use of syringes and epidural set of the same manufacturer to avoid these types of problems.

Written consent for publication was obtained by the patient.

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 The patient understand that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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None declared.

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Sir,
Anesthetic management of vallecular cyst excision is one of the most challenging procedures encountered in anesthetic practice. Vallecular cyst, though a rare entity, can lead to airway obstruction as a result of mass effect in the hypopharynx and by posterior and inferior displacement of the epiglottis. They are usually associated with laryngomalacia where there may be flaccid epiglottis, poorly supported arytenoids, or short epiglottic folds.[1] Airway collapse occurs during inspiration leads to inspiratory stridor and also accompanied with feeding difficulties, apnea, cyanosis, and failure to thrive. Here, we discuss the successful management of a case of vallecular cyst posted for excision and marsupialization.

A 3‑month‑old male infant weighing 3 kg presented with noisy breathing and respiratory distress for the past 1 month following an episode of upper respiratory tract infection. The child was treated as pneumonia based on chest X‑ray findings in primary centers before presenting to our hospital. On examination, the child had intercostal retraction and inspiratory stridor. A differential diagnosis of laryngotracheobronchitis, laryngomalacia, vocal cord palsy, and aspiration pneumonia was made. The computed tomography report showed the presence of vallecular cyst at the base of the tongue extending into the left tonsillar fossa. The patient was posted for endoscopic assessment followed by cyst excision. On preanesthetic checkup, the child was term baby born by normal vaginal delivery. On examination, the respiratory rate was 50/min, and intercostal recession and inspiratory stridor were present. Oxygen saturation on nasal prongs with oxygen therapy was 96%. His preoperative blood investigations were within normal limits except for serum potassium levels which were persistently between 5.5 and 6.0 meq/dl. The infant was shifted to the operation theater with oxygen support. The patency of 24‑G intravenous cannula was confirmed. Electrocardiography, pulse oximetry, and noninvasive blood pressure monitoring were started. Premedication with atropine was avoided as the initial heart rate was between 140 and 160 beats/min. Plan was to check for mask ventilation after intravenous anesthesia induction, and if it was adequate, a check laryngoscopy followed by endotracheal intubation was planned in deeper plane. Surgeons were asked to be standby for emergency tracheostomy, considering the high risk of losing the airway and nonavailability of a neonatal fiber‑optic bronchoscope. The child was induced with injection fentanyl $1\mu g/kg$ and ketamine 1 mg/kg. After checking the adequacy of mask ventilation, the infant was maintained on 100% oxygen with sevoflurane titrated from 1% to 8%. Succinylcholine was avoided willfully in view of raised potassium. Once the minimum alveolar concentration reached around 3.0, a check laryngoscopy was done using a video laryngoscope. There was complete obstruction of the glottis with a thin‑walled cyst with impending rupture. No attempt was made for intubation. Since the surgeon was confident in ablating the cyst in <1 min, the plan was modified to intermittent apneic oxygenation. After mask ventilating the patient with 100% oxygen and sevoflurane 6%–8% for 3 min, the patient was handed over to the surgeon for procedure. Coblation of the cyst was done, and the cyst contents were aspirated leading to reduction in the size of the cyst [Figure 1].

References

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