



PAPILLOEDEMA IN PATIENT OF POST DURAL PUNCTURE HEADACHE (PDPH): AN ATYPICAL PRESENTATION

Anesthesiology

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KEYWORDS

We report here a case of a 37 year old patient weighing 65kg P2L2A1 who presented with multiple uterine fibroids and was operated for Open Myomectomy under spinal and epidural anesthesia. Her past history included an exploratory laparotomy for ectopic pregnancy and Laparoscopic appendicectomy both done under General Anaesthesia. She had undergone a caesarean delivery with bilateral tubal ligation under spinal anaesthesia 10 years back. She was a known case of essential hypertension and was taking antihypertensive medications. In pre-anaesthetic evaluation she was average built, with blood pressure of 120/80, pulse rate of 76 beats per minute and per abdomen examination showed a palpable abdominal mass arising from pelvis extending till umbilicus. Her blood investigations, Electrocardiogram, echocardiogram, kidney function and fundoscopic examination were within normal range.

An informed written consent for anesthesia was taken. After attaching NIBP, pulse oximeter probe and electrocardiograph, 18G intracath was secured & preloading with RL started. Under all aseptic regional anaesthesia was given in sitting position by loss of resistance technique with 18G Touhy and 25G Quincke type needles for epidural and subarachnoid blocks respectively. Both the needles were inserted with bevel parallel to the axis of spine. Patient underwent an uneventful surgery with good epidural analgesia in postoperative period. Epidural catheter was removed after 48hrs.

On fifth postoperative day, patient developed severe headache in occipito-cervical region with 5 episodes of non-projectile vomiting following food intake. Headache was aggravated with neck movement, upright posture and ambulation. There was no history of fever, blurring of vision, diplopia & altered sensorium. Her vital parameters were stable. Neurological examination showed neck stiffness but with normal higher functions & no neurological deficit. Fundoscopy was done to rule out raised intra-cranial pressure secondary to any CNS pathology. It showed early papilloedema with blurring of margins of optic discs which progressed to involve superior, inferior and nasal margins of optic discs in both eyes next day. Her headache was managed with head low position, complete bed rest and plenty of oral fluids. A Plain CT brain done to rule out any intracranial pathology was found normal. IV Inj. Mannitol 20% 100ml had been started twice a day. On follow up fundoscopy, papilloedema had subsided. On 7th post-operative day patient was comfortable, free from headache and was discharged from hospital.

PDPH is a common and incapacitating condition occurs particularly in young females especially in pregnancy. Young adults are at higher risk of developing this condition than older individual (14% vs 7%)¹. Patients having PDPH in previous SAB are more likely to experience PDPH in subsequent SABs². Incidence of PDPH with 25G Quincke needle is 25%³. It is found that, in 90% of cases PDPH begins in first three days and in 66% cases in first 48 hrs of procedure¹. In our patient headache appeared on 5th day.

New onset papilloedema in a patient presenting with findings of PDPH needs a comprehensive evaluation and investigations in order to detect any preexisting intracranial pathology or any post procedure complication due to regional anaesthesia or otherwise. In our patient a diagnosis of exclusion would be Idiopathic Intracranial Hypertension.

In conclusion, papilloedema may be present in patient with PDPH which is considered to be caused by decreased intracranial CSF pressure. However further studies need to be done in order to understand pathogenesis of same.

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