CASE REPORT

ANAESTHETIC MANAGEMENT OF LSCS IN A PATIENT WITH LUMBAR PERITONEAL SHUNT (OPERATED FOR PSEUDOTUMOUR CEREBRI) - A CASE REPORT
D.A. Hiremath

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ABSTRACT: Idiopathic intracranial hypertension, also known as pseudotumour cerebri, is a disorder of elevated intracranial pressure of unknown etiology. Patients present with daily headache, pulse-synchronous tinnitus transient visual obscurations, papilledema with its associated visual loss, and diplopia from sixth nerve paresis. Many disease associations have been alleged, but few besides obesity, hypervitaminosis A and related compounds, steroids withdrawal and female gender have been proven [1]. Here we are going to present a case report of anaesthetic management of cesarean section who was operated for pseudotumour cerebri by lumbar peritoneal shunt by giving general anaesthesia.

KEYWORDS: caesarean section, pseudotumor cerebri, spinal anaesthesia, general anaesthesia.

INTRODUCTION: Lumbar peritoneal shunt is treatment of choice in a case of pseudotumour cerebri. If subarachnoid block was given for LSCS, with a lumbar peritoneal shunt in situ the needle may accidently puncture the catheter. So the epidural anaesthesia is also considered as an alternative to the general anaesthesia.

CASE REPORT: A 25 years old female G1P2, weighing 55 kg was admitted for delivery. She was operated previously for pseudotumor cerebri with lumbar peritoneal shunt in situ. All her routine investigations were normal. Patient was premedicated with glycopyrrolate 2mg and was pre-oxygenated with 100% oxygen for 3 minutes. Anesthesia was induced with propofol 2.5 mg /kg, and intubated with 7mm cuffed endotracheal after giving vecuronium 0.01 mg/kg prior to the induction agent. The vocal cords were sprayed with 10% xylocaine to suppress the pressor response which will increase the intracranial pressure. She was maintained with 50% oxygen 50% nitrous oxide, fentanyl [1 ug/kg] and intermittent halothane. Reversal with neostigmine [2.5mg] and glycopyrrolate [2mg] was done and extubated. Patient was monitored by oximetry, capnography and vital signs were maintained. The post-operative period was uneventful.

DISCUSSION: Lumbar peritoneal shunt is performed for reducing intracranial pressure to reduce the morbidities like visual loss. Many have managed LSCS with lumbar epidural anaesthesia [2], but here there is a risk of dural puncture. Spinal block may puncture the shunt catheter, and it does not serve the purpose. A single shot spinal anaesthetic is not practical in a patient with a lumbar peritoneal shunt. Neuro-axial block and a blood patch (if necessary) may be performed in a patient on enoxaparin therapy if current guidelines for managing patients on anticoagulant therapy are followed [3].
Considering above factors, we managed this case with general anaesthesia. We instilled 10% lignocaine over base of tongue, vallecula, glottis to suppress pressure response to the laryngoscopy and intubation. The risk of puncturing the dura and shunt catheter is avoided.

The lumbar peritoneal shunts are effective in controlling all the clinical manifestations of pseudotumour cerebri in the immediate post operative period. So it is wise not to touch the lumbar peritoneal shunt catheter during anaesthetic management of LSCS. (4) Shunt failure with relapse of pseudotumour cerebri occurs as late as 7 years after insertion. (5).

REFERENCES: