CORRESPONDENCE

Anesthesiology
81:783, 1994

Neonatal Resuscitation and Anesthesiologist Liability

To the Editor:—Competence in the performance of neonatal resuscitation appears to be an important medicolegal as well as clinical arena for anesthesiologists. A recent issue* of a publication containing summaries of medical malpractice litigation cases submitted by involved attorneys described a $2,602,100 judgement against an anesthesiologist for negligent performance of neonatal resuscitation. This case involved a cesarean section performed because of abruptio placentae.

I obtained a list of all obstetric anesthesia-related law cases submitted to that publication since 1985. Of the 69 obstetric anesthesia lawsuit summaries published, 12 (17.4%) involved neonatal resuscitation claims against anesthesia personnel. Issues mentioned included delayed intubation, improper intubation, and failure to initiate neonatal advanced life support. There was a payout to the plaintiff in 10 of the 12 cases (85%).

Although these case summaries are not sophisticated analyses of closed-claims data by a panel of experts,[1] they represent a collection of data that appears to be of considerable interest to trial lawyers—and therefore should be of interest to all anesthesiologists who perform obstetric anesthesia. A suggestion for risk management could be that those anesthesiologists who are routinely expected to perform neonatal resuscitation maintain a reasonable level of skill in that area; however, consideration should be given to ensure that hospital rules and regulations clearly define the anesthesiologist's role in neonatal resuscitation. Those rules and regulations should be compatible with the statements in the American Society of Anesthesiologists "Guidelines for Regional Anesthesia in Obstetrics."†

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* Medical Malpractice Verdicts, Settlements, & Experts. Edited by Laska L. Nashville, 9: No. 11, 35, 1993.

† Guideline VII: Guidelines for Regional Anesthesia in Obstetrics. American Society of Anesthesiologists, Directory of Members, 1994, p 754.

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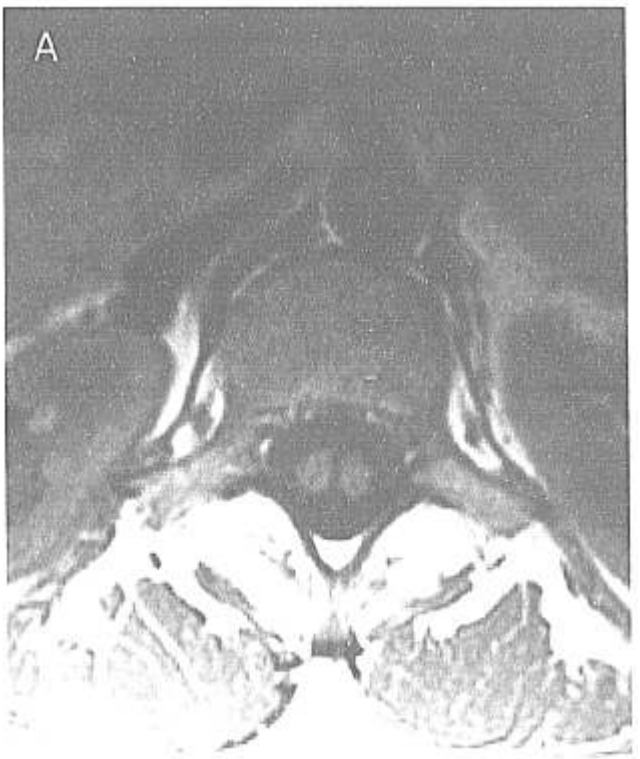
Spinal Dysraphism and Epidural Anesthesia

To the Editor:—Patients with spinal occult dysraphism have cutaneous stigmata including lumbar lipoma, dermal sinus tract, hemangioma, telangiectasia, abnormal tufts of hair, or lumbar dimple.[1] We examined a patient with occult spinal dysraphism who received epidural anesthesia during delivery and had leg weakness subsequently, although anesthesia was adequate.

A 30-yr-old gravida 1, para 0 woman presented at 37 weeks' gestation for examination. Because of preeclampsia and ruptured membranes, labor was induced with oxytocin. The patient had a medical history of multiple surgical procedures on the lumbar area to remove a giant hairy nevus. She denied prior neurologic dysfunction.

Epidural analgesia was performed when cervical dilation reached 4 cm. An 18-G Tuohy needle was placed with the bevel directed cephalad at the L3–L4 interspace, with the patient in the left lateral position. Neither cerebrospinal fluid nor blood was aspirated. After insertion and advancement of a catheter 4 cm, a test dose of 3 ml 1.5% lidocaine with epinephrine was given without incident followed by an initial dose of 9 ml 2% 2-chloroprocaine. Satisfactory analgesia ensued, with a bilateral T10 sensory level. Thirty minutes later, 11 ml 0.2% bupivacaine followed by an infusion at 13 ml/h was administered. After an additional hour, pelvic pain recurred and 2 μg/ml fentanyl was added to the infusion.



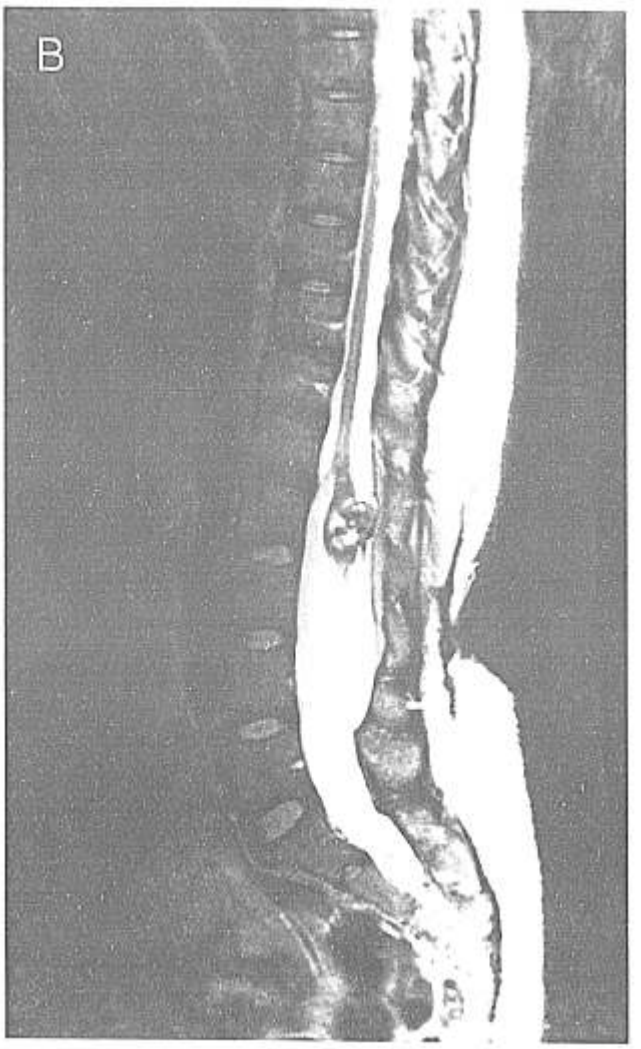


Fig. 1. (*A*) T1-weighted axial magnetic resonance imaging scan at the L1 level demonstrating the split spinal cord (diastematomyelia). (*B*) T1-weighted sagittal image demonstrating the lipoma of the conus medullaris. Caudal descent of the conus and abnormalities of the posterior vertebral elements and soft tissue are also shown.

Spontaneous vaginal delivery of a 3,310-g infant occurred. Position was occiput anterior, and no forceps were used. Total duration of labor was approximately 8 h. Unfortunately, postdelivery physical examinations were not well documented. The patient complained of left leg weakness with walking and nonradiating, aching left thigh pain after discharge from the hospital. The first recorded neurologic examination was 2 months after delivery, when a referring physician noted 4/5 Medical Research Council grade strength on left hip flexion, knee extension, and knee flexion without sensory changes. At 3 months after delivery, her strength was normal. Reflexes were mildly brisk in all extremities except for an absent right ankle jerk. Plantar responses were flexor. The right foot was smaller than the left. There was no sensory loss, and urine post void residual was normal. Multiple scars were present over the lumbar spine.

Because of the history of giant hairy nevus, a magnetic resonance imaging scan was obtained of the thoracolumbar area. This disclosed a tethered cord and diastematomyelia (fig. 1A). There was also a lipoma of the conus medullaris that was primarily intradural but had extradural extension (fig. 1B).

This patient had a lumbar hairy nevus that was a clue to underlying spinal dysraphism. Despite this, epidural anesthesia was successful during delivery. The etiology of the patient's left leg weakness after delivery is uncertain and may have been due to fetal compression of neural structures during delivery. The diminished size of the patient's right foot and absent right ankle jerk is suggestive of a long-standing neuropathic process affecting this region and is probably due to chronic radiculopathy related to her tethered cord. At this time, we have no definite evidence that the epidural anesthesia caused the patient's transient leg weakness. However, we believe that recognition of cutaneous defects associated with spinal dysraphism in the lumbar area is important, because the risks of epidural anesthesia in these patients are uncertain.

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Stellate Ganglion Block: What's Old, What's New?

To the Editor:—I read with interest Elias and Chakerian's recent report[1] in which they describe the use of a catheter technique for stellate ganglion block in a pediatric patient. The authors are to be commended for thus sparing the child the trauma and discomfort of repeated stellate blocks by separate injection.

However, although the authors state, ". . . to our knowledge, this is the first report of placement of a catheter to perform a series of stellate ganglion blocks, thereby avoiding repeated needle placements . . .," I published the first case report of a continuous catheter stellate ganglion block in this journal[2] in 1967! Although my patient was an adult, the concept and goals were similar.

What may have been considered an innovative approach by the authors is a technique that, in fact, is almost 30 yr old.

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2. Geraci R: Continuous stellate ganglion block. ANESTHESIOLOGY 28:632, 1967

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In Reply:—Geraci's comments regarding our case report[1] are appreciated. The authors apologize for overlooking his report of the first use of the stellate ganglion catheter technique.[2]

We agree that this technique is not new. However, we believe that Geraci missed the point of our report, which was management of pain in a pediatric patient. Children's pain management presents special difficulties, especially when invasive procedures are involved. This also is an age group whose pain is often undertreated. The authors hope to increase awareness of these issues and offer an alternative treatment. The end of the sentence Geraci quoted is, ". . . and general anesthetic administration in a pediatric patient."

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