Epidurals in septic patients

Editor—Ballantyne should be congratulated on such a balanced and timely editorial. She is right to question the widely held belief that epidural analgesia improves surgical outcome and specifically mortality. As an intensivist, conflict often arises in clinical situations when epidural catheters are sited at the time of emergency laparotomies. Enthusiastic anaesthetic trainees often feel compelled (sometimes instructed) to place an epidural catheter for intraoperative ‘control’ and for the provision of undoubted high quality postoperative analgesia. This well-meaning intervention then potentially prevents those high-risk patients who develop severe sepsis and septic shock (say from a perforated viscus) from receiving a truly evidence-based life-saving therapy such as activated protein C.

Administration of activated protein C in the presence of an epidural catheter is contraindicated according to the summary of product characteristics for the drug. Faced with this dilemma, and reminding oneself of the risk of epidural/spinal haematoma associated with anticoagulants, one could nevertheless go ahead and give activated protein C. This quandary has been expanded upon in more detail elsewhere. Alternatively, as suggested in Ballantyne’s editorial, the time may have arisen when, in emergency patients who are at highest risk of developing severe sepsis after surgery, the routine placement of an epidural catheter should be reconsidered, or other options for postoperative analgesia employed such as single-shot, long-acting spinal opioids.

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Editor—It is certainly compelling to be able to provide excellent postoperative analgesia with few side-effects using a good working epidural. In addition, trials have shown that there are other benefits, including, of particular relevance in the context of Dr Wyncoll’s letter, easier weaning from mechanical ventilation. A dilemma arose, then, when our surgical and medical colleagues, for various and valid reasons, started using highly effective antithrombotic agents such as low-molecular weight heparin, clopidogrel and activated protein C, which greatly increase the risk of epidural haematoma after neuraxial block. Where does the risk/benefit balance lie now? Clearly, there is a complex set of factors that contributes to the risk/benefit assessment, and which differs from patient to patient. But as Dr Wyncoll suggests, part of this assessment must be to try and predict what might happen to the patient during recovery. Present evidence does not support any important benefit from combined epidural/general anaesthesia during surgery—only from postoperative epidural analgesia. In the ICU setting, it seems that the major benefit is at the time of weaning from mechanical ventilation, when an epidural can be inserted de novo, provided there are no remaining risk factors. In the case of sick patients presenting for emergency surgery, it would seem prudent to wait for patients to stabilize before

1Conflict of interest: Dr Wyncoll acts as a consultant to Eli Lilly and is involved in on-going research studies with activated protein C.
considering epidural placement, particularly knowing that sepsis and clinical shock, and sometimes their optimal medical management, place patients at increased risk of epidural complications.

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3 Wyncoll DLA, Mythen M. Should activated protein C be given to a patient who has an epidural? Hosp Med 2003; 64: 692

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