Familial Mediterranean fever abdominal pain during spinal anaesthesia

Editor—Familial Mediterranean fever (FMF) is a hereditary syndrome characterized by recurrent episodes of fever and serositis. Onset of an episode of FMF is sudden and acute, with rapid development of symptoms within 1–2 h.\(^1\) Although it is not clear how attacks are triggered, they may be precipitated by emotional stress. Anaesthesia for patients with uncomplicated FMF does not present any particular problems.\(^2\) However, anaesthesia and surgery are associated with emotional and physical stress that might trigger FMF attacks.\(^3\) We report an FMF episode that developed immediately after spinal anaesthesia for pilonidal sinus surgery.

A 20-yr-old male was admitted for pilonidal sinus surgery. He had been taking colchicine 2 mg day\(^{-1}\) for treatment of FMF for 3 yr. He had no episodes within the last year. After placement of routine monitors, we gave hyperbaric bupivacaine 0.5\% (10 mg) intrathecally through a 25 gauge needle at the L4–5 interspace with the patient sitting. Immediately after administration, the patient complained of severe abdominal pain while he was in the sitting position. The patient said the pain is just like the one in an FMF crisis. The patient was placed in the Trendelenburg position to increase the level of blocks. Ten minutes later, pinprick block level was T8 and the patient was still having severe abdominal pain. The patient returned to the supine position, and diclofenac 75 mg and fentanyl 100 \(\mu\)g were given i.v. to reduce the pain. Within 8 min, the pain was resolved completely. The patient gave permission to proceed with the surgery. The surgery was started when the pinprick block level was confirmed to be at least two dermatomes higher than the surgical field. The abdominal pain did not repeat within the first 48 h after the surgery.

Abdominal crisis occurs in 95% of the patients with FMF.\(^1\) Treatment with colchicine is an effective preventative treatment, but it is ineffective for the treatment of established acute attacks. A crisis may be started by stress factors such as anaesthesia and surgery.\(^3\) The pain may be refractory to non-steroidal anti-inflammatory drugs and opioids.\(^4\) We thought placement of patients in the Trendelenburg position might help to extend the analgesic level of the local anaesthetic, but this did not ease the pain. In our case, the crisis was treated successfully with fentanyl and diclofenac. Such crises may develop in patients with FMF during spinal anaesthesia. When applied anaesthesia level is insufficient to resolve the abdominal pain, fentanyl may be a good option. We wish to draw attention to this potential problem during spinal anaesthesia in patients with FMF.

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