

Background:

- Occurs due to disruption of sympathetic nerves to the eye and face.
- Incidence is 1 in 6,000, with 0.5% after neuraxial anesthesia.
- Common symptoms include ptosis, miosis and anhidrosis.
 - Symptomology depends on the location of the lesion.
 - Severity depends on the degree of denervation.
- Most often a clinical diagnosis (idiopathic causes are rare).

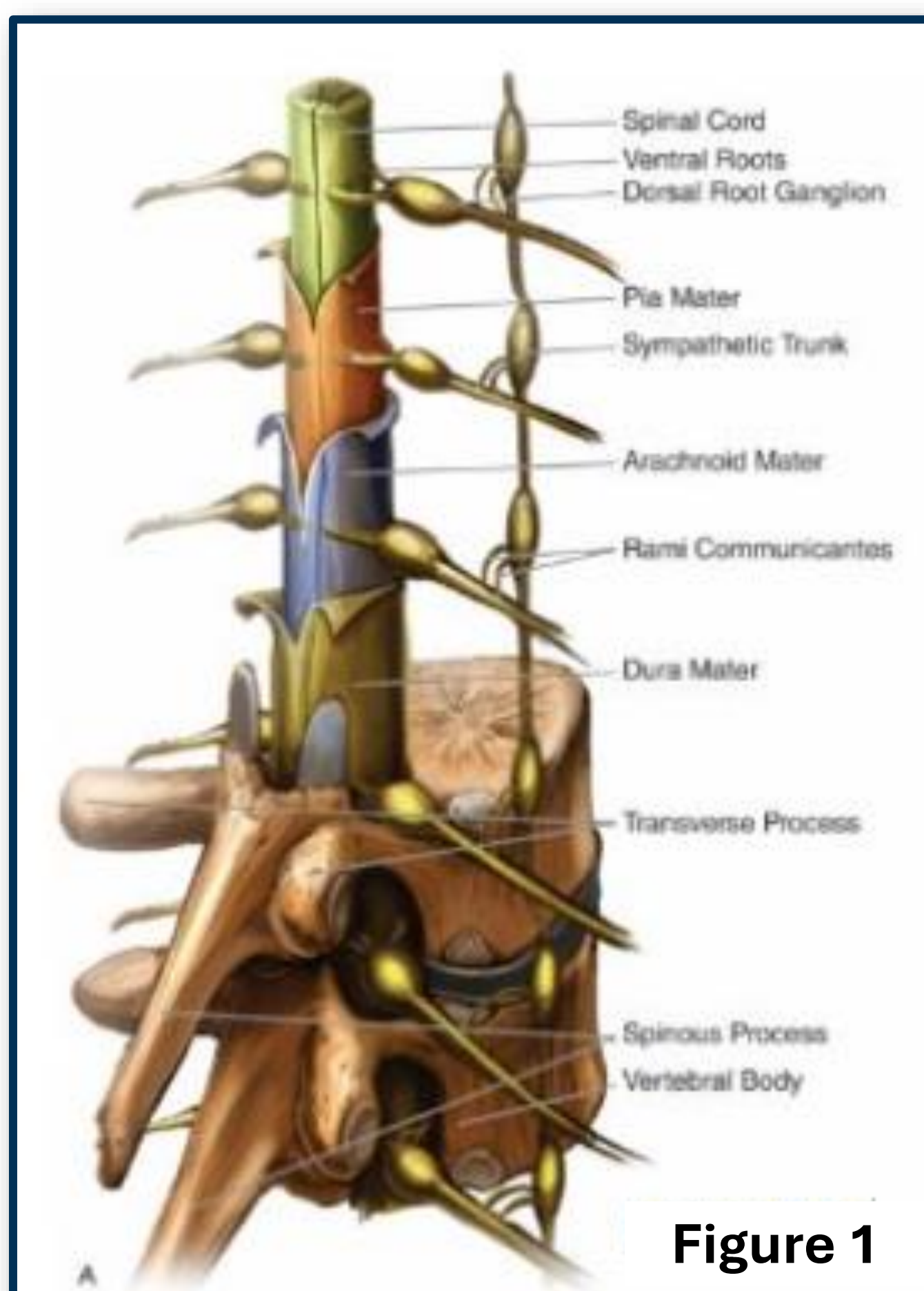


Figure 1

44-year-old female with right arm radiculopathy underwent a right-biased paramedian epidural steroid injection (ESI) complicated in the post-procedural period by transient unilateral Horner Syndrome.



To date, there remains limited existing literature on episodes of Horner Syndrome following cervical epidural injections.

Discussion:

- A PubMed search of “Horner’s Syndrome” and “Epidural Anesthesia” in humans yielded 39 reports, 24 in the parturient.
 - Anatomic / hormonal changes influence cephalic spread.
 - Long infusion durations cause thoracic accumulation.
- Sympathetic blocks spread epidurally ... could also in reverse?
- The subdural space communicates intracranially!
- Symptom onset / resolution should correlate with LA half-life.
- Coordinate a diagnostic workup specific to the clinical scenario.

Differentials:

- Ventral spread to spinal roots due to anatomic narrowing.
- Caudal approach in setting of large LA volume resulted in cervical ganglia involvement.
- Fluoroscopic confirmation ruled out subdural placement and traumatic needle insertion.
- Unintentional migration of local topicalization.
- CVA if specific focal neurological deficits were present.
- Carotid injury / dissection unlikely given normal hemodynamics.

Full Text Below!

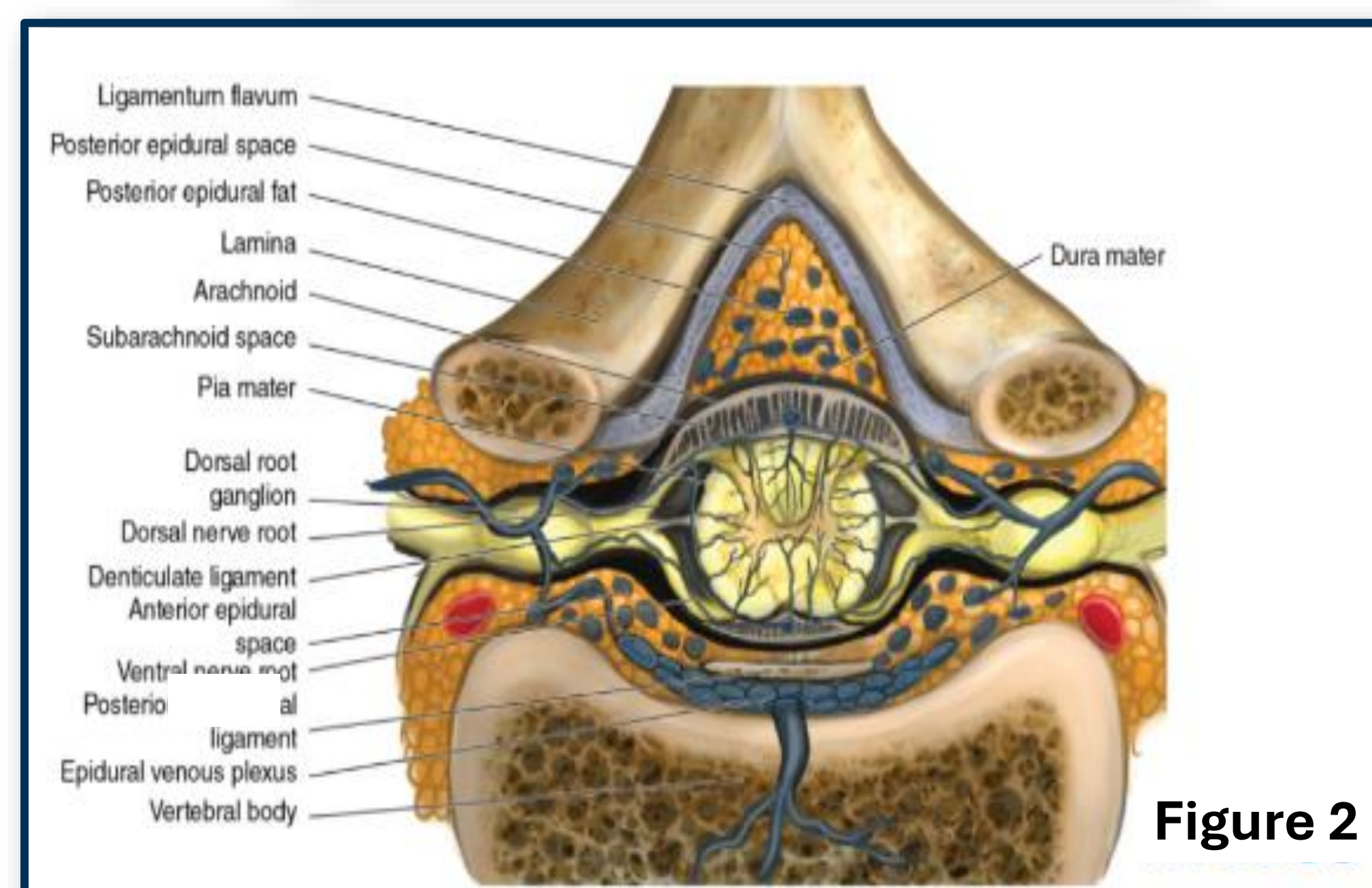


Figure 2