



To Patch or Not To Patch?
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BACKGROUND

Postdural Puncture Headache(PDPH) is a well known complication of neuraxial anesthesia. It can occur after spinal anesthesia or after unintentional puncture of dura during epidural placement(1). Incidence of inadvertent dural puncture during epidural is ~1.5% and more than 50% of these patients develop PDPH(2).

Patient risk factors for PDPH:

- young age
- pregnancy
- female gender
- h/o PDPH
- low BMI

These factors put obstetric patients at increased risk of development of PDPH. PDPH usually occurs within 5 days after dural puncture. Headache significantly worsens with sitting or standing and improves with lying flat. It can be accompanied by neck pain, tinnitus, hearing changes, photophobia, nausea. Treatment options include hydration, bed rest, analgesic medications, caffeine, sphenopalatine block and epidural blood patch (EBP). EBP is considered the treatment of choice for moderate and severe PDPH (2). Although EBP has a high rate of success, it is not without risks. Before performing EBP, anesthesiologist has to exclude other potential causes of headache such as tension-like headaches, hypertensive disorders, and cerebral venous thrombosis(3).



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Case: Brief PMH

We report the case of accidental finding of cerebellar tumor in patient with postpartum headache who was referred to anesthesia team for evaluation for possible PDPH

32 y.o. P4034 female

Reason for consult: Anesthesiologist was consulted for possible PDPH and performance of EBP

PMH:

- gestational DM
- 2 prior Cesarean sections
- resolved COVID19 infection
- day 3 after vaginal delivery for which she had an uncomplicated epidural

Prior to consult patient received IV fluids, ketorolac, acetaminophen and caffeine with minimal improvement.

Evaluation

Headache characteristics:

- started ~48hrs after delivery
- localized to the middle of her posterior neck with radiation to the shoulders upper chest and forehead
- only modestly improved with lying flat

Pt denied nausea/vomiting, photophobia, focal deficits or vision changes. Physical exam and vital signs were unremarkable.

We requested brain imaging to rule out intracranial pathology prior to proceeding with other treatment modalities as headache was not consistent with classic PDPH. MRI of the head showed a large cerebellar lesion.

Neurosurgery and neurology teams were consulted and concluded that lesion likely did not contribute to patient`s symptoms.

We didn't perform EBP as we didn't feel that risk of serious complications outweighed low likelihood of symptomatic improvement.





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Conclusion

- Headaches are common in postpartum period and Anesthesiologists are often consulted to assess the headache in patients who had a neuraxial anesthesia. (3)
- Differential diagnosis for the postpartum headache is broad and includes but not limited to PDPH, tension-like headaches, migraines, cluster headaches, hypertensive disorders, cerebral venous thrombosis. (2)
- PDPH usually presents as a dull throbbing headache with a frontal-occipital distribution. The headache is usually worse with sitting or standing, and is significantly reduced by lying down. If a postural component of the headache is not present the diagnosis of PDPH should be questioned. (2)
- It is crucial for the Anesthesiologist to be able to recognize and exclude, potentially life threatening causes of headache before performing EBP for postpartum headache.

References

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