The article by Dr. Gorecha M et al on 'Trapped epidural catheter-a rare anesthetic dilemma' creates an awareness of the ever present danger of leaving behind a part of epidural catheter during attempted removal [1]. This problem is not too uncommon and a few years ago we faced a similar situation—the only difference being a length of epidural catheter got sheared off during attempted removal by the treating surgeon who was on rounds visiting the patient. It was subsequently found that nearly 4 cm of the catheter tip got left behind in the epidural space. The patient was informed of this complication and given all options about the management of the problem. The patient agreed to come for regular follow up once in 6 months and to report immediately in case he developed any symptoms like radicular pain, fever, bladder bowel dysfunction or any neurological problems.

Needless to say that it is the responsibility of the Anaesthesiologist who inserted the epidural catheter to remove it in toto at the appropriate time. Very often this procedure is handed over to junior Anaesthetists or nurses who are not informed about the proper way of carrying out this important step. An epidural catheter left behind in epidural space or anywhere between the skin and epidural space can be troublesome not only for the patient but also for the treating doctors. Patients are counselled about its presence if left behind and decisions have to be taken considering all the factors involved. As always prevention of this complication is always better and epidural catheter should be removed in a gentle manner with no undue force preferably in the same position in which the epidural catheter was inserted (left or right lateral position or sitting position bending forwards). If at any time removal of the catheter is difficult junior doctors should abandon any further attempts and call for help. Investigations like plain X-ray spine, CT scan or MRJ Scan may be done to ascertain the position of the catheter. Periodic follow up may be all that is necessary as the catheter is inert and may not cause any further complication. In case removal is necessary as per patient’s wishes or due to any development of symptoms like nerve root irritation, infection or pressure effects laminectomy and removal of the catheter piece may be necessary. In centres where facilities are available it may be a good option to insert a 2.8 mm Epiduroscope through the sacral hiatus under fluoroscopic guidance and remove the catheter left behind by a biopsy forceps inserted through the working channel. A major surgical procedure can be avoided and patients can be discharged early as day case.

References