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**ORAL JEWELRY IN THE PARTURIENT: A NEW CONCERN FOR THE ANESTHESIOLOGIST** *Kuczkowski, K.M. Benumof, J.L. Anesthesiology and Reproductive Medicine, University of California, San Diego, CA* Introduction: We present a case of an obstetric patient who presented for an emergency postpartum surgery with fixated tongue jewelry in-situ, which resulted in trauma to the tongue and difficult airway management. Since the popularity of body piercing is increasing in our society (1), it is reasonable to expect that the incidence of oral jewelry interference with airway management will increase. Report of case: A 27 y/o G3 P3 hypotensive female with severe postpartum hemorrhage required emergent evacuation of retained fragments of placenta under general anesthesia. Spontaneous vaginal delivery had been accomplished without anesthesia. Pre-anesthetic evaluation revealed barbell type oral jewelry piercing through the middle segment of her tongue. Otherwise her airway was normal. Time constraints to stop the uterine hemorrhage did not allow for removal of the oral jewelry. Rapid sequence induction of anesthesia was performed in a standard manner. Direct laryngoscopy with a Macintosh #3 blade caused significant bleeding from the pierced surface of the tongue; fortunately tracheal intubation was successfully accomplished. The tongue bleeding was controlled with a pressure gauze pack. During the case the tongue was noted to swell; fortunately the degree of swelling was not considered significant enough to prevent tracheal extubation at the end of case. Discussion: We consider the tongue bleeding at the time of laryngoscopy and the tongue edema at the time of extubation to be near misses of "cannot intubate" and "cannot ventilate" situations respectively. This case clearly demonstrates that piercing of the body in "unconventional" sites such as tongue may impact anesthetic management, especially in an emergency when prompt removal of oral hardware is not feasible. Airway engorgement in pregnancy may further increase the incidence if complications in presence of oral jewelry. Conclusion: When airway management in the presence of oral jewelry is indicated, trauma to highly vascular oral tissue, bleeding, difficult intubation, aspiration and airway obstruction by loose hardware should be anticipated. *Anesthesiology*, 1998; 88: 279-280.

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**ONCE A POST-DURAL PUNCTURE HEADACHE PATIENT, ALWAYS POST-DURAL PUNCTURE HEADACHE PATIENT** *Kuczkowski, K.M. Benumof, J.L. Anesthesiology and Reproductive Medicine, University of California, San Diego, CA* Introduction: It is known that symptoms of post-dural puncture headache (PDPH) are more likely if there has been a preceding PDPH. We report a case to show that this general rule applies even after the passage of 50 years. Report of case: A 72 y/o 160cm, 59kg otherwise healthy female underwent a diagnostic cystoscopy for persistent hematuria under uneventful single dose spinal anesthesia with bupivacaine performed with 25 GA Pencan needle. Eighteen hours after the procedure she developed severe positional headache and other symptoms consistent with the diagnosis of PDPH. The positional nature of the headache and patient's admission of similar symptoms following spinal anesthesia she had received for Cesarean section 50 years ago led to a prompt diagnosis. The neurological examination revealed no deficits. Epidural blood patch (EBP) with 14 ml of autologous blood successfully treated the symptoms. Discussion: PDPH is a well-known complication of procedures in which the dura mater of the spinal cord is punctured. The incidence of this complication is affected by many factors and varies from 0.2-24%. In general PDPH is more common in young women particularly in pregnancy. History of a previous PDPH is a strong risk factor for another PDPH if spinal anesthesia is administered in these patients. Elderly patients are considered at low risk for CSF leak and development of PDPH, particularly when small gauge non-cutting edge, pencil-point needles are used. In the elderly, the dura may be less elastic and more likely to retract to a closed position. In addition, CSF leakage may be impeded by adhesions and calcifications. Finally, the elderly are less active physically and less likely to complain. Gentili has suggested that PDPH in the elderly may be less pronounced and have different temporal symptomatology, further decreasing the likelihood of prompt diagnosis (1). Conclusion: In summary this case should serve as a reminder that patients with a history of previous PDPH may be at higher risk for subsequent PDPH, even after the passage of as many as 50 years. *Anesth Analg* 2000; 91: 1311.