

In response to ‘A Good Outcome Following Delayed Debridement of Lumbar Paraspinal Abscess after Postoperative Epidural Catheterization: Case Report’

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Dear Editor,

We read the recently published ‘A Good Outcome Following Delayed Debridement of Lumbar Paraspinal Abscess after Postoperative Epidural Catheterization: Case Report’ by Salim *et al.*¹ We would like to thank the authors for this interesting read. We have made the following observations with a similar personal experience of diagnosing an epidural abscess while attempting spinal anaesthesia in a diabetic patient with multiple drug allergies.²

According to the authors, the patient had long standing diabetes with a recent short course of steroids. The effect of steroids on his glycemic control is not clearly mentioned even though discussion briefly describes it as ‘uncontrolled’. Similarly, details on the clotting profile is also not mentioned. Epidural anaesthesia could have led to a haematoma which subsequently got infected and spread locally. The reason for delayed definitive orthopaedic intervention (until day 10) is not clear while details of any associated vertebral fractures in this potential high velocity injury (not documented) are unavailable, which could

have led to prolonged immobility and infection seeding from lungs precipitated by multiple rib fractures.

Tibial plateau and pelvic bone grafting generally do not need prolonged post-operative analgesia. It is unclear why the authors have opted for epidural analgesia in this instance. Even though unrelated to the topic of discussion, performing epidural analgesia in an anaesthetized patient could lead to disastrous outcomes.

In the initial diagnosis of the superficial collection, it is not clear whether it was the entry level of epidural catheter as ‘upper lumbar region’ contained the former. A percutaneous ultrasound guided aspiration could have been performed to make a microbiological diagnosis at this point. The reason for discharging the patient on empirical antibiotics (drug, dosage and duration not mentioned) and not arranging a clinic follow up sooner both in surgical point of view (with a prosthesis insitu) and conservatively managed spinal infection is also unclear. The prevailing pandemic may possibly have contributed.

Paraspinal infection in this patient could possibly be due to poorly controlled diabetes complicated by steroid therapy and escalated stress response subsequent to polytrauma. Underlying splenic injury may also have contributed to his transient immunosuppression. Even though unlikely, the paraspinal infection could, as authors have correctly suggested, be resultant of the epidural catheterization as well, as the site of abscess correlates with the point of entry of the catheter.

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Lastly, while clarifications are kindly requested, we acknowledge the authors on their clinical work and efforts in academic output of their experience.

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