POST-NEURAXIAL ROUNDING

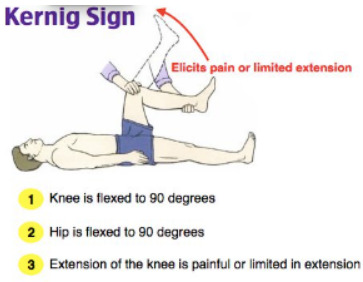
RULE OUT PDPH

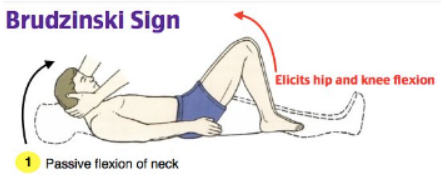
Pt should report no headache, no sensorimotor deficits, and be able to walk around.

Suspect PDPH IF:

1) **Headache** (usually delayed 12-48h post-procedure. H/A within 1hr more likely pneumocephalus from AIR w/ LOR)

- **Bilateral:**
  - Dull/aching, throbbing, or pressure-type
- **Fronto-occipital**
  - [(Opth nerve off trigeminal ($CN5_1$) = frontal pain)(CN9,10 = occipital pain)]
- **Photophobia**
  - Worsens w/ lights on - (CN 3, 4, & *6)
- **Positional**
  - Worsens sitting upright, improves lying down
- **+ Dizzy/vertigo**
  - R/t diplopia/poor accommodation 2/2 CN palsy 3, 4, *6... (often unilateral)
- **+ Shoulder/neck pain&stiffness/nuchal rigidity**?
  - Cervical nerves C1-3
- **+ Nausea/vomiting**
  - CN10: vagal stimulation





*** * * * Headache must rule out: * * * ***

- **Postpartum PreE? :** obtain BP

- **Meningitis? :** + ***Fever*** AND Kernig, Brudzinski, nucchal rigidity, n/v, dizziness, photophobia, or confusion
  → neuro consult [CBC, LP, CT scan]

2) **Visual changes?** (often unilateral)
   - double vision (diplopia) and poor accomodation [transient CN palsy 3, 4, 6 (extraocular eye muscles) esp CN6 (abducens: lateral rectus muscle)]

3) **Auditory changes?**
   - tinnitus [decreased perilymphatic pressures in inner ear → imbalance btwn endolymph & perilymph]

ANY OF ABOVE ***AND*** Documented wet tap? Normotensive & afebrile? → **likely PDPH** → conservative tx +/- EBP

Consult always indicated if serious non-PDPH h/a is suspected or cannot reasonably be ruled out. Lateralizing neurologic signs, fever/chills, seizures, or change in mental status are not consistent with a PDPH or benign h/a.
- Because PDPH generally resolve spontaneously, h/a that worsens over time and looses positional nature should be strongly suspected to be 2/2 to **SDH** (esp if focal neurologic signs or decreased mental status)

Contraindications to the EBP similar to any neuraxial: **coagulopathy, systemic sepsis, fever, infection at the site, and pt refusal.**
Theoretical concern of neoplastic seeding CNS in cancer pts - can use slower injections of smaller blood volumes in pts whose CNS may be vulnerable to injury from increased epidural pressures generated with EBP (eg: multiple sclerosis.)
- EBP has been safely provided to both acute Varicella and HIV pts.

Although alternative/conservative tx has been proposed, EBP remains only proven tx for PDPH and therefore can be encouraged and performed early (within 24 hr of diagnosis) if symptoms are severe.

RULE OUT HEMATOMA:

SENSORIMOTOR ASSESSMENT:

Determine delayed recovery of select dermatomes vs *.recovery followed by return of sensorimotor loss/NEW ONSET of s/s:*

NEW onset numbness, NEW onset motor loss → STAT MRI

- Pt on blood thinners? Higher index of suspicion for hematoma
- Isolated dermatomes sensory deficit that never recovered – likely delayed recovery – was block one-sided? (more common w/ heavy top-offs)
    - reassure pt it should continue to improve, ***but if worsens, alert anesthesia immediately.***
    - ***new or worsening*** sensorymotor loss? STAT MRI
    - Motor involvement? – further workup: ***new*** motor deficit (esp if + back pain)→ STAT MRI
- Loss of bowel and bladder control? → STAT MRI
- New/progressive sensorimotor loss w/ back pain: Does it *radiate* down leg(s)? Unilateral or bilateral? → STAT MRI
- Isolated back pain/radicular pain without sensorimotor loss – neuro consult.
    - Foot drop? Assess for CPN injury from stirrups, if used.
    - Just soreness over/around site? – Check for infection/inflammation at site. Soreness is normal.
    - Thoracic back pain/soreness? IF muscular in nature soreness/strain? – likely 2/2 labor.
        -Tx: Can use NSAIDS+/-Flexeril 5mg. NO diazepam/valium in breastfeeding.
- Burning leg pain: **Meralgia Paresthetica**?
    - Injury from pushing: LCFN (sensory only) entrapment under inguinal ligament as hips pulled back with pushing/lithotomy. Usually resolves within max 3-6 mos.
    - S/S: burning pain over LFCN innervation: anterolateral thigh (L2-3) **No motor involvement.**
        - Usually one-sided but can be b/l if both LFCNs each compressed.
    - *Leg pain that is NOT meralgia paresthetica, and requires further workup:*
        - If pt had c/s with no lithotomy and no pushing – M.P. unlikely
        - pain not localized to lateral thigh
        - ***Any motor deficit is NOT M.P.***