hypertension. We also suggest no cervical traction, and maintaining the head and neck in a neutral position throughout the case to ensure adequate circulation; this includes both anterior and posterior cervical spine surgery. Furthermore, cerebral vascular insult should be mentioned preoperatively as a risk of surgery, for all patients with vascular disease or comorbidities at risk for vascular disease.

Rob D. Dickerman DO PhD
Ashley S. Reynolds RN
Jeff Cattorini MD
Plano Presbyterian and Baylor Garland Hospital, Plano, USA
E-mail: drrdd@yahoo.com
Accepted for publication March 20, 2006.

References

Anesthesia for Cesarean delivery in a parturient with rigid spine syndrome

To the Editor:
Rigid spine syndrome is a rare myopathic ailment characterized by axial and proximal muscle weakness. Muscle contraction in these patients causes limitation of neck and trunk flexion, scoliosis, and mild joint deformity. First described by Dubowitz in 1965,1 the illness begins at an early age with a delay in motor development, marked limitation of flexion of the cervical and dorso-lumbar spine, scoliosis, restrictive ventilatory dysfunction, respiratory muscle weakness, and cardiac abnormalities.2,3 Anesthetic implications include a potentially difficult airway, cardiovascular problems, malignant hyperthermia susceptibility, altered response to depolarizing and non-depolarizing neuromuscular blocking agents.4,5 There are no previous reports describing anesthetic care for Cesarean delivery for this rare condition.

A 21-yr-old primigravid patient (weight 41 kg, height 151 cm) was scheduled for elective Cesarean delivery at 34 weeks’ gestation as a result of worsening respiratory symptoms. She had marked scoliosis, a restrictive ventilatory defect, and nocturnal alveolar hypoventilation requiring regular nocturnal nasal continuous positive airway pressure (CPAP) ventilation for three years prior to the current admission. Her chest x-ray revealed marked thoracic kyphoscoliosis and loss of lung volume. Arterial oxygen saturation (SaO₂) on room air was 94%, and spirometry revealed that the forced expiratory volume in one second and forced vital capacity were 38% and 37% of predicted, respectively. The electrocardiogram and echocardiogram were normal. Airway assessment revealed a Mallampati class 2 view. The patient received a 250 mL bolus of lactated Ringer’s solution, followed by a slow continuous iv infusion. An arterial line was inserted under local anesthesia, and a combined spinal and epidural (CSE) was established without difficulty at the LA/5 level with the patient sitting. Intrathecal 0.5% bupivacaine (7.5 mg) injected with 250 µg diamorphine achieved a bilateral sensory block to ice to T7. Epidural top-up doses of 0.25% bupivacaine (8 mL in total) extended the block height to T4 over a period of 30 min with good hemodynamic stability. The patient did not experience any discomfort throughout the surgery, and required only two phenylephrine boluses of 50 µg iv each, to maintain mean arterial pressure within ± 10% of preinduction values. Supplemental oxygen with a Hudson mask maintained SaO₂ over 95%. A live healthy male baby was deliv-
ered, and the mother recovered in a high dependency unit where she continued her nasal CPAP without any other problems.

In this case, CSE was chosen as it avoided the risks of general anesthesia unique to rigid spine syndrome. Titrated extension of the block with direct arterial pressure monitoring helped to avoid cardiovascular or respiratory compromise. This is the first reported case of a successful Cesarean delivery employing a CSE technique in a parturient with rigid spine syndrome.

Senthil Kanniah FRCA
Belfast City Hospital, Belfast, Northern Ireland
E-mail: s_enthil@yahoo.com
Accepted for publication March 22, 2006.

References