A 32 year old female with past medical history of anemia presented for an elective repeat Cesarean section. A spinal anesthetic was placed with difficulty but the patient did not have a sufficient level for surgery so the patient was put in the lateral position and an epidural was attempted. Locating the epidural space took several attempts but there was no clear indication of dural puncture. The patient underwent surgery and both the mother and baby did well and were discharged home on post-operative day (POD) 3. The patient presented to the emergency room 12 days after being discharged complaining of a very severe headache. The headache was described as starting in the occipital region and radiating to the frontal area. On presentation to the emergency department, her blood pressure (BP) was 166/94 and she had evidence of proteinuria; suggestive that she had developed post-partum pre-eclampsia. Initially, the patient stated her headache started on POD1, but resolved, and recurred on POD 10. Later, the patient described the headache as positional. Given the atypical presentation for a post-dural puncture headache (PDPH), neurology was consulted and a brain MRI and head CT were obtained. Imaging showed a 6-7 mm left sided subdural hematoma with some small mass effect. The patient denied any trauma, photophobia, neck stiffness or any other associated symptoms. A neurosurgical consult was obtained. The patient was closely observed and had a repeat CT scan done within a few hours, which remained stable. The option of doing an epidural blood patch (EBP) for possible PDPH was discussed with neurosurgery. After clearance by neurosurgery, on POD 13, the patient received a successful EBP with 20 cc of blood. This resulted in relief of the patient’s headache for 2 hours. The patient was evaluated by neurology and it was thought that her symptoms were from an unintentional dural puncture causing low intracranial pressure which caused cerebral sagging and possible shearing of a bridging vein. She had a repeat CT scan on POD 14 which remained stable so the patient was discharged home on oxycodone with outpatient follow up. The patient was contacted a week after discharge and stated that her headache persisted but improved with oxycodone. The outcomes and possible causes of this case are unique. The patient’s headache had some characteristics of a PDPH such as the distribution and improvement with lying down. The subdural hematoma may have been from an unrecognized dural puncture during epidural placement. The headache may also have been from the intentional dural puncture with the initial spinal anesthetic that was attempted; however this is less likely given the smaller gauge of the spinal needle. Interestingly, the patient had minimal relief from the EBP, which is the gold standard for treatment of PDPH. It is possible that her postpartum pre-eclampsia and associated hypertension may have contributed to
the development of her subdural hematoma. Fortunately, the patient’s findings were stable and did not require neurosurgical intervention. Although uncommon, it is important for Anesthesiologists to keep subdural hematoma in their differential diagnosis when evaluating a headache after epidural anesthesia.