Nerve blocks and negligence

Claims for damage associated with regional anaesthesia made up 44% of claims against anaesthetists in the UK between 1995 and 2007, considerably more than would be expected if the ratio of regional to general anaesthesia is taken into account.

The commonest successful claim against anaesthetists in the UK relates to pain felt during Caesarean section under spinal or epidural anaesthesia. While this is not negligent per se, we often fail to ensure an adequate block or to respond appropriately when the patient complains of pain. Good record-keeping – a recurrent theme when considering medicolegal claims – will often mean the difference between a successful defence and a finding of negligence.

Consent is another recurring theme. When the patient has a real choice to make between regional and general anaesthesia, or whether to undergo an epidural or nerve block for postoperative pain relief, they must be presented with a well-balanced explanation of the risks and benefits of the alternatives in order to make an informed decision. Again, good record-keeping will allow the defendant anaesthetist to demonstrate that he or she took these precautions.

Direct trauma to the spinal cord is difficult to defend, notwithstanding studies which show that it is commonplace to make an error of one to two levels when selecting an interspace for needle insertion. Frequent warnings in the literature, coupled with the increasing availability of and competence with ultrasound, make these cases even more likely to settle in the Claimant’s favour.

Traumatic nerve damage is not limited to central neuraxial blockade, and there are, in particular, a substantial number of cases of brachial plexus injury resulting from interscalene blocks. Nerves arising from the lumbar and sacral tracts are also prone to needle trauma by the over-exuberant anaesthetist, but they can also be damaged by surgical techniques, and neurophysiological tests are often required in order to accurately identify the culprit.

In recent years, several cases of severe adhesive arachnoiditis have arisen following seemingly innocuous spinal anaesthesia. At their worst, these lead to paraplegia or even tetraplegia, and CSF obstruction may necessitate multiple cranial decompression procedures. The cause of these cases is not yet fully elucidated, although some courts have found that, on the balance of probabilities, the spinal drugs had become contaminated with chlorhexidine, the antiseptic most commonly used for skin preparation. A high-profile Australian case where chlorhexidine was inadvertently used in place of saline to identify the epidural space has added some scientific validity to this view.

Postsurgical epidurals have been associated, both in the UK and Australia, with a significant incidence of complications. Haematoma and abscess can, if unrecognised, cause irretrievable spinal cord compression, and these cases often result in a finding of negligence on the grounds of poor quality postoperative observation. Spinal cord ischaemia can be an indirect consequence of spinal or epidural administration, particularly when combined neuraxial and general anaesthesia in the frail or elderly patient leads to a critical fall in
perfusion pressure during surgery. An increasing realisation that the benefits of postoperative neuraxial block do not always warrant the associated risks appears to be leading to these techniques becoming less popular.