Headache Society has published diagnostic criteria for this complication³ and several authors have proposed definitions for severity.^{4,5} Large observational studies are still needed to obtain sufficient numbers of PDPH. Researchers need to report the diagnostic criteria, onset, severity, duration, and therapeutic interventions used. Only then will clinicians be able to determine whether PDPH from a small gauge pencil-point spinal needle, such as the Whitacre 25-gauge, is self-limiting within a short period of time.

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Spinal anesthesia in a patient with Down's syndrome

To the Editor:

A 28-yr-old male patient with Down's syndrome was scheduled for excision of a testicular tumour by scrotal incision. When he was two years old he had undergone intubation followed by tracheotomy due to an acute laryngotracheitis with severe inflammatory airway obstruction. At the age of seven years the tracheostomy was closed and the anterior tracheal wall reconstructed. The parents reported episodes of inspi-

ratory dyspnea when the child suffered from a severe cold. The patient (75 kg, 160 cm) presented with the classical stigmata of Down's syndrome. At the level of the former tracheostomy, scar tissue about 6 cm in length was visible. The electrocardiogram (ECG) showed sinus rhythm and echocardiography revealed good myocardial function. Transcutaneous oxygen saturation was 95% on ambient air. The patient and the parents were informed about the planned anesthetic technique. The patient was premedicated with chlorazepate 10 mg orally one hour prior to anesthesia. Following the placement of an *iv* access 1000 mL Ringer's lactate solution were given, and the patient monitored with continuous pulse oximeter, ECG, and noninvasive arterial pressure. Spinal anesthesia was performed in the sitting position using isobaric bupivacaine 3 mL 0.5%, injected in the L3–4 space through a 25-gauge atraumatic spinal needle. A sensory block at the level of T–7 was achieved. The patient was given 3 L·min⁻¹ oxygen via a nasal cannula and cautiously sedated with a propofol infusion titrated to effect. A total of 96 mg of propofol was given during an uneventful surgery that lasted 80 min. The patient tolerated the surgery very well, and complete regression of spinal anesthesia occurred 220 min after its onset. The patient was discharged from the hospital five days later.

Given the patient's medical history, we elected to use spinal anesthesia. Another option would have been general anesthesia with the use of a laryngeal mask airway (LMA) to avoid tracheal intubation and its possible complications. However, our main concern with general anesthesia was the fear of an anesthetic-induced collapse of the reconstructed part of the trachea. Such a complication would have been difficult to manage via the LMA. Though not reported in the literature^{1,2} spinal anesthesia may be appropriate in selected patients with Down's syndrome.

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