

## Ultrasonography can unfold many Mysteries!

Madam,

A 7-year-old, 20 kg boy who was diagnosed with undescended testis and seizure disorders was posted for second stage laproscopic orchidopexy. The child was on T. Sodium valproate and T. clobazam for the focal seizure disorder. His last seizure episode was 6 months ago. He had no other known comorbidity. Preoperatively, the child was active and playful. Vital signs were normal.

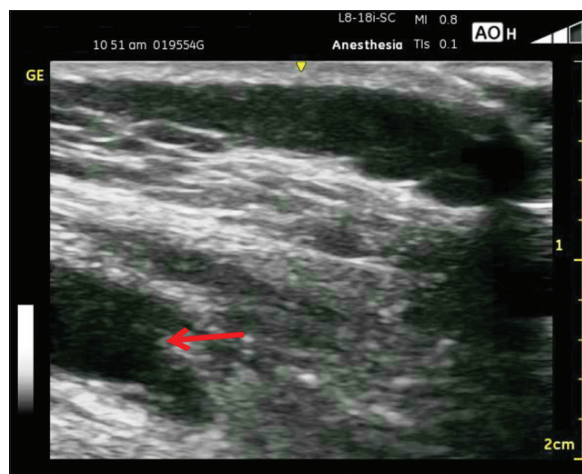
Local examination revealed absence of testes on both sides of the scrotum. There was no swelling palpable in groin, perineum, or medial side of thigh. There was a subcoronal penile hypospadias with no chordee, dorsal hooded prepuce, and grooved glans.

He had undergone laparoscopic first stage orchidopexy bilaterally previously. Anesthesia record was not available, and the parents were unable to give history of regional block and any complication related to anesthesia during previous anesthetics, except that the child came back to the ward postoperatively and was doing well in the ward. Investigations were within normal limits. Ultrasonography (USG) of the abdomen revealed both the testis in the inguinal region.

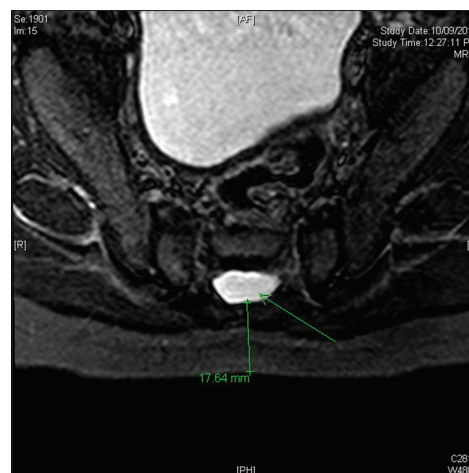
On the day of the surgery, antiepileptic medications were continued with sips of water and the child was kept comfortable. He accepted inhalational induction, hence, no premedication was offered.

Child was induced with  $N_2O:O_2$ ; sevoflurane and IV was established. LMA# 2.5 was secured. Child was positioned in left lateral position and caudal block was planned by landmark technique under strict aseptic conditions. Landmark technique is a routine practice in our hospital.

Once the give was felt with 23-G hypodermic needle, aspiration was performed to rule out blood and cerebrospinal fluid (CSF). On aspiration, clear fluid (1 ml of watery fluid with good flow) was aspirated. The fluid was not oily as CSF. Procedure was abandoned and USG [Figure 1] scan was performed by anesthetist which showed epidural cyst. Surgeons were informed and the surgery continued. Analgesia was managed with fentanyl 3 mcg/kg, morphine 0.1 mg/kg, and paracetamol 20 mg/kg intra-operatively. MRI [Figures 2 and 3] was done postoperatively under anesthesia on the same day.



**Figure 1:** Focused USG of caudal space highlighting the cyst marked with red arrow



**Figure 2:** Stir-transverse showing the cyst with same density as urine in bladder



**Figure 3:** MRI highlighting the spinal cyst with same contrast as urine in bladder

MRI showed S2–S4 shows an intraspinal cyst measuring 30 × 9 mm filling the spinal canal. Condensat L1 level. The child was followed up by the neurologist thereafter.

Since most of these cysts are asymptomatic and incidentally found. Usually, they do not require treatment, but when accompanied with neurological symptoms, treatments such as decompressive laminectomy, lumboperitoneal shunting, or percutaneous drainage of cysts are necessary. We suggest that USG scanning should be performed prior to blocks routinely, if available.<sup>[1]</sup> Ultrasound helps in identifying the incidental abnormalities,<sup>[2]</sup> anatomical variations<sup>[3]</sup> such as the dura sac termination,<sup>[4]</sup> occult spinal dysraphism, etc.

The centrineuraxial blocks are performed under anesthesia in children, hence, is a high-risk procedure. It is desirable to scan the spinal spaces for high risk patients<sup>[5]</sup> and high-risk procedures for spinal abnormalities prior to blocks.

### Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

### Conflicts of interest

There are no conflicts of interest.

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