INTRODUCTION
Epidural abscesses in the perioperative period are extremely rare. Most cases in the literature are in the form of single case reports. In fact, several centers have done retrospective reviews and found no cases of reported abscesses out of 1,620 patients with an estimated incidence of 1-3 per 10,000. We report a case of a perioperative epidural abscess in an 8-month-old female with a history of MRSA skin colonization, which may raise the question of whether skin colonization should be a contraindication to epidural placement.

CASE REPORT
An 8-month-old, 6.5 kg female presented for exploratory laparotomy and bilateral adrenalectomy for Stage 4S bilateral Neuroblastoma which was diagnosed at 3 months of age. The anesthetic plan included a general endotracheal anesthesia and placement of a thoracic epidural for postoperative analgesia. She had a history of complications related to her disease and immunosuppression including several central line-associated infections with pseudomonas and MRSA bacteremia prior to this procedure. She ultimately was treated with 21 days of antibiotics with resolution of the infections.

Three months later, at the age of 8 months, she presented for her adrenalectomy. Given that the MRSA cultures were obtained three months prior and she received treatment for her MRSA infection we proceeded with epidural placement. A T7/8 thoracic epidural was placed midline with the patient in the left lateral decubitus position after prepping the back with two chloraprep sticks and full sterile technique. The epidural worked well and was removed on POD 4, at which time purulent drainage was noted from the insertion site.

An MRI was ordered which revealed an epidural fluid collection measuring 2.3 x 0.6 cm consistent with an abscess at T7-8 as well as phlegmonous changes from T2-12. Neurosurgery and infectious disease were consulted. Given that the patient had good motor strength and movement of her lower extremities it was determined that she would be best managed with antibiotics. She completed 3 days of Vancomycin and was discharged home to complete 14 days of Clindamycin. She was seen the following week for a repeat MRI that revealed interval decrease in the extent of the abscess. As the abscess was improving radiologically, it was then determined to continue medical management and follow her clinically. She has recovered fully and has no residual symptoms of the abscess.

DISCUSSION
Traditionally the low risk of infection and high level of pain control makes epidural catheters an excellent analgesic technique, especially for children. The true incidence of epidural abscesses in the perioperative period is hard to calculate given the rarity, although it has been estimated to be 0-3 per 10,000. Absolute contraindications for epidural placement include systemic or local infection at the insertion site but there is no mention of known skin colonization being a contraindication to neuraxial anesthesia in the literature.

Given the abscess in our patient, one must question what implications bacterial colonization of the skin has in contributing to this complication. One might also ask if a repeat skin swab should be collected and documented as negative prior to placement of a catheter in a previously infected individual.

REFERENCES