

distal side by a hypodermic needle (it may be the needle that will be used as an introducer), a spinal needle may be introduced through the hypodermic needle from the proximal side. If the hypodermic needle is removed, only the male Luer-lock injection cap pierced by a spinal needle will be left. This may reduce the tactile feel during spinal needle advancement, but if the introducer is correctly directed, it does not appear to cause problems.

Owing to the length of the head of introducer and the male Luer-lock injection cap, the effective length of a spinal needle would be reduced by about 3 cm; thus a longer spinal needle may be required.

Jae-Hyon Bahk, M.D.
Department of Anesthesiology
Seoul National University Hospital
Seoul, Korea

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Cauda Equinopathy Is Not Necessarily Cauda Equina Syndrome

To the Editor:

After haunting visions of a modern-day Woolley and Roe catastrophe (1), it was a considerable relief to learn that the two patients suffered no worse effects than transient sacral sensory deficit and sphincter incompetence. Grace be, they were spared leg weakness or, far worse, paralysis.

If one recalls how paraplegia and incontinence following subarachnoid administration of trace contaminant (2) stifled spinal anesthesia in the United Kingdom, then the cavalier misnomer "cauda equina syndrome" for minor postspinal neurologic sequelae carries the seeds for a chilling downturn in the modern practice of spinal-epidural anesthesia.

Even though the abstract reinforces the title's grim conclusion that "...two patients developed cauda equina syndrome following [subarachnoid] bupivacaine..." the actual case descriptions lead one to an altogether more benign (albeit no less unfortunate) neurologic picture of sensory cauda equinopathy with resolving sphincter incompetence (3). Even attributing the latter to neurologic causes is tenuous: in case 1, transurethral prostate resection may well have cut into bladder sphincter muscle; in case 2, blaming laxative-responsive constipation in a 70-year old on rectal sphincter dysfunction is akin to faulting the local anesthetic rather than Mother Nature.

Let us be clear: in spinal anesthesia, flord cauda equina syndrome follows injury to delicate subarachnoid dorsal and ventral lumbosacral rootlets (4). The syndrome proper manifests with bilateral paraparesis or paraplegia, atrophy of leg and buttock muscles, saddle analgesia with sensory loss below the groin, and incompetence of bladder and rectal sphincters (5), whereas the full spectrum cauda equinopathies ranges from transient mild radiculopathy through patchy lumbosacral sensory changes, monoparesis, and sphincter incompetence, culminating in full-blown chronic cauda equina syndrome (4).

I urge *Regional Anesthesia's* reviewers to guard against letting loosely applied, potentially incendiary, trigger words slip through the editorial screening process and trust that appropriate mellowing of the errant title was published as an erratum. The unnerving impact on public and press—not to mention fuel for litigation—could well set back regional anesthesia for years to come. Subarachnoid hyperbaric lidocaine already is under a cloud; let me make sure that bupivacaine, too, receive an impartial hearing rather than a media trial.

Rudolph H. de Jong, M.D.
School of Medicine
University of South Carolina
Columbia, South Carolina

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Response of Editor-in-Chief to Dr. de Jong

Dr. de Jong makes his point respectfully and appropriately. Precision in terms is critically important in a journal's editorial review.

David L. Brown, M.D.
Editor-in-Chief, *Regional Anesthesia & Pain Medicine*
Department of Anesthesiology
University of Iowa Medical Center
Iowa City, Iowa

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