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THORACIC SPINAL ANAESTHESIA IN A PARTURIENT WITH EXTENSIVE MID- TO LOWER-BACK TINEA CORPORIS UNDERGOING ELECTIVE CAESAREAN SECTION: A CASE REPORT

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ABSTRACT

Background: Active cutaneous infection overlying the conventional lumbar puncture site is regarded as a relative contraindication to neuraxial anaesthesia because of the theoretical risk of introducing microorganisms into the epidural or subarachnoid space. Extensive dermatophytosis affecting the lower thoracic and lumbar region therefore poses a distinct challenge during elective caesarean section, where neuraxial anaesthesia remains the preferred modality. Thoracic spinal anaesthesia has been proposed as a safe alternative in such circumstances when performed with careful patient selection and meticulous technique.

Case Presentation: We describe the anaesthetic management of a 25-year-old gravida 2 para 1 living 1 woman at 38 weeks and 4 days of gestation, with gestational hypertension and a previous lower segment caesarean section, admitted for elective repeat caesarean delivery. Extensive active tinea corporis involved the lower thoracic, lumbar, gluteal, right hip, thigh, and leg regions, with erythematous scaly plaques extending across the intended lumbar puncture site; conventional lumbar spinal anaesthesia was therefore avoided. After multidisciplinary discussion and informed high-risk consent, thoracic subarachnoid block was performed at the T10–T11 interspace in the sitting position using a 25-gauge Quincke needle, with 2 mL of 0.5% hyperbaric bupivacaine and fentanyl 25 µg injected intrathecally over an uninvolved area of skin. Surgical sensory blockade developed within 1 minute 28 seconds, and intraoperative haemodynamics remained stable, requiring only a single dose of intravenous ephedrine. A healthy male infant weighing 2.8 kg was delivered with Apgar scores of 9 and 9 at one and five minutes. The perioperative course was uneventful, with no post-dural puncture headache, neurological deficit, or infective complication; the patient was discharged on postoperative day 3.

Conclusion: Thoracic spinal anaesthesia is a feasible and effective alternative neuraxial technique in carefully selected obstetric patients in whom conventional lumbar puncture is precluded by extensive lumbar dermatophytosis. Rigorous preoperative evaluation, strict asepsis, sound knowledge of thoracic spinal anatomy, and vigilant perioperative monitoring are essential prerequisites for a safe maternal and neonatal outcome.

KEYWORDS: Thoracic spinal anaesthesia; Caesarean section; Tinea corporis; Dermatophytosis; Obstetric anaesthesia; Thoracic subarachnoid block; Gestational hypertension; Regional anaesthesia.

INTRODUCTION

Caesarean section is one of the most commonly performed surgical procedures worldwide, and neuraxial anaesthesia remains the preferred technique for obstetric surgery because of its superior maternal safety profile [1], reduced risk of difficult airway management, lower incidence of aspiration, and minimal neonatal exposure to systemic anaesthetic agents [2,3]. Anaesthesia-related maternal mortality has fallen substantially since the shift from general to regional techniques for caesarean delivery [4-5]. Spinal anaesthesia, in particular, provides rapid onset, dense sensory and motor blockade, and excellent postoperative analgesia, making it the standard approach for elective caesarean delivery [6-7]. However, successful neuraxial blockade depends on the availability of an appropriate puncture site and the absence of contraindications such as local infection, severe coagulopathy, or patient refusal.

Skin disorders involving the lumbar region may present unique challenges to anaesthesiologists by limiting access to conventional lumbar interspaces and raising concern regarding the potential introduction of infectious material into deeper tissues [8-9]. Strict adherence to aseptic technique is a well-established determinant of infectious safety during neuraxial procedures [10], and although infectious complications of regional anaesthesia are rare overall, they remain a recognised, serious risk whenever a needle traverses compromised skin [11]. Although superficial fungal infections are generally

considered less invasive than bacterial infections, the presence of active lesions over the intended puncture site necessitates careful evaluation. In obstetric patients, where timely and safe anaesthetic management is essential for both maternal and fetal wellbeing, identifying alternative neuraxial strategies becomes particularly important [12].

Dermatophytosis, or tinea corporis, is a superficial fungal infection caused predominantly by species of Trichophyton, Microsporum, and Epidermophyton. It is characterised by erythematous annular scaly plaques with central clearing and may become extensive in humid climates, immunocompromised states, or following inappropriate use of topical corticosteroids [13-14]. Extensive lumbar involvement poses a particular challenge in obstetric anaesthesia because conventional spinal techniques rely on lumbar interspaces. Most literature addressing neuraxial anaesthesia in the presence of skin lesions focuses on bacterial infections, herpes zoster, or isolated dermatological disorders, and reports involving extensive lumbar tinea corporis in pregnant women are rare. Consequently, management is largely based on extrapolation from similar cases and expert opinion rather than established guidelines[15].

Thoracic spinal anaesthesia, initially described for abdominal surgery and later applied in obstetric practice, has gained acceptance following anatomical and radiological studies demonstrating a measurable posterior cerebrospinal fluid space in the lower thoracic region, since the spinal cord itself lies anteriorly within the thoracic canal [5,14]. Classic descriptions of spinal anaesthesia physiology similarly emphasise that the segmental spread and haemodynamic consequences of subarachnoid block depend heavily on the vertebral level of injection [13]. Advances in understanding spinal cord anatomy and improvements in needle design have contributed to renewed interest in this technique. Published case series and observational studies have reported favourable outcomes with low rates of neurological complications when performed by experienced clinicians, making thoracic spinal anaesthesia a potential option when lumbar access is limited or contraindicated [4].

Despite increasing evidence supporting the safety of thoracic neuraxial techniques, reports describing their use in parturients with extensive thoracolumbar dermatophytosis remain scarce. Such cases present a complex balance between avoiding puncture through infected skin and preserving the benefits of regional anaesthesia. We report the successful use of thoracic spinal anaesthesia at the T10–T11 interspace in a parturient with extensive mid- to lower-back tinea corporis undergoing elective repeat caesarean section, highlighting the clinical considerations, technical challenges, and perioperative outcomes associated with this uncommon scenario.

2. Case Presentation

2.1 Patient Information

A 25-year-old gravida 2 para 1 living 1 woman at 38 weeks and 4 days of gestation was admitted for elective repeat lower segment caesarean section in view of a previous caesarean delivery and gestational hypertension. Her antenatal period had been complicated by gestational hypertension, adequately controlled with antihypertensive therapy. Apart from dermatophytosis, no other significant systemic illness was present. A summary of her demographic and clinical profile is presented in Table 2.

Table 2. Demographic and Clinical Profile of the Patient

Parameter	Finding
Age	25 years
Obstetric history	G2P1L1 (previous lower segment caesarean section)
Gestational age at surgery	38 weeks + 4 days
Indication for surgery	Elective repeat LSCS (previous caesarean delivery + gestational hypertension)
Weight / Height / BMI	78 kg / 163 cm / 29.4 kg/m²
Systemic comorbidity	Gestational hypertension, controlled with antihypertensive therapy
Dermatological findings	Extensive active tinea corporis: lower thoracic, lumbar, gluteal, right hip, thigh, and leg regions, involving the conventional lumbar puncture site
Airway assessment	Mallampati class II, adequate mouth opening, normal thyromental distance, unrestricted neck movement
ASA physical status	II–III
Investigations	Haemoglobin, platelet count, coagulation profile, renal function tests, liver function tests — all within acceptable limits

2.2 Clinical and Dermatological Findings

Detailed examination of the skin revealed multiple erythematous annular plaques with peripheral scaling involving the lower thoracic region, lumbar area, gluteal region, right hip, thigh, and lower limb (Figure 1). The lesions extended over

the conventional lumbar puncture site. Because puncturing through infected skin is generally avoided owing to the theoretical risk of introducing infection into deeper tissues, conventional lumbar spinal anaesthesia was considered relatively contraindicated.

Figure 1. Clinical photographs demonstrating extensive thoracolumbar tinea corporis in the parturient. (A) Posterior view showing diffuse hyperpigmented scaly lesions involving the lower thoracic, lumbar, gluteal, and sacral regions, including the conventional lumbar puncture sites. (B) Magnified view of the gluteal region illustrating extensive active dermatophytic involvement and post-inflammatory hyperpigmentation.

After discussion with the obstetric team and obtaining informed high-risk consent from the patient, thoracic spinal anaesthesia was planned with preparedness for conversion to general anaesthesia if necessary.

2.3 Preoperative Planning and Multidisciplinary Discussion

After confirming informed consent and completing the preoperative evaluation, the patient was transferred to the operating theatre. A difficult airway cart, prepared in line with current airway-management guidelines [9], and facilities for immediate conversion to general anaesthesia were kept available in case of failed neuraxial block. Standard ASA monitoring was instituted, an 18-gauge intravenous cannula was secured, and balanced crystalloid preload was administered in anticipation of sympathetic blockade and hypotension. Blood products were cross-matched and kept available per institutional protocol. Emergency medications (atropine, ephedrine, phenylephrine, adrenaline) and drugs for induction of general anaesthesia, neuromuscular blockade, and airway management were prepared. Strict aseptic precautions were maintained throughout: the back was examined to identify an uninvolved area at the T10–T11 interspace free of active fungal lesions, and skin preparation was performed with chlorhexidine–alcohol solution, allowing adequate drying time before draping, consistent with established recommendations for regional anaesthesia asepsis [10]. A multidisciplinary discussion involving the obstetric and anaesthesia teams established a backup plan for conversion to general anaesthesia before proceeding with thoracic spinal anaesthesia.

2.4 Anaesthetic Technique

Following confirmation of informed consent and completion of the World Health Organization surgical safety checklist, standard ASA monitoring (three-lead ECG, SpO_2, NIBP) was instituted and baseline haemodynamic parameters recorded.

2.4.1 Performance of Thoracic Spinal Block

The conventional lumbar interspaces were completely involved by active lesions, making lumbar spinal anaesthesia undesirable because puncture through infected skin is generally avoided owing to the risk of introducing microorganisms into deeper tissues [10]. After identifying a relatively uninvolved area at the T10–T11 interspace, the patient was positioned sitting. Skin preparation was performed with chlorhexidine–alcohol, followed by sterile draping. Using a midline approach, the T10–T11 interspace was identified, and a 25-gauge Quincke spinal needle was advanced carefully until free flow of cerebrospinal fluid was obtained. Following confirmation of correct intrathecal placement, 2 mL of 0.5% hyperbaric bupivacaine combined with fentanyl 25 μg was injected slowly. The needle was withdrawn and the patient immediately placed supine with left uterine displacement using a wedge under the right buttock to minimise aortocaval compression. Key technical and pharmacological details are summarised in Table 3.

Table 3. Anaesthetic Technique and Pharmacological Details

Parameter	Detail
Patient position	Sitting
Interspace	T10–T11
Approach	Midline
Needle	25-gauge Quincke (cutting-tip)
Skin antisepsis	Chlorhexidine–alcohol solution

Local anaesthetic	0.5% hyperbaric bupivacaine, 2 mL
Intrathecal adjuvant	Fentanyl 25 µg
Onset of adequate surgical sensory block	1 minute 28 seconds
Vasopressor requirement	Ephedrine 3 mg IV (single dose)
Intraoperative IV fluids	≈1500 mL crystalloid
Estimated blood loss	≈350 mL

2.4.2 Characteristics of the Block

Sensory blockade adequate for surgery was achieved within 1 minute 28 seconds, permitting commencement of surgery without delay. No paraesthesia or patient discomfort was encountered during needle insertion or drug administration. Magnetic resonance imaging studies have demonstrated that the spinal cord lies anteriorly within the thoracic canal, leaving a posterior cerebrospinal fluid space of approximately 5–8 mm (mean close to 7.5 mm) at the T10 level, thereby providing a margin of safety for thoracic spinal puncture [5]. This anatomical relationship is consistent with classical descriptions of the subarachnoid space contained within the neural blockade literature [14]. These findings challenge the traditional belief that thoracic spinal anaesthesia inevitably carries a high risk of spinal cord injury and provide anatomical justification for its clinical application.

2.4.3 Haemodynamic Management

Following intrathecal injection, maternal heart rate, oxygen saturation, and blood pressure were monitored continuously, with blood pressure recorded every two minutes during the first ten minutes and every five minutes thereafter, in keeping with recommended vigilance for spinal-anaesthesia-induced hypotension [17]. Maternal haemodynamics remained remarkably stable. A single episode of mild hypotension occurred and was managed with intravenous ephedrine 3 mg together with additional crystalloid, an approach consistent with international consensus recommendations on vasopressor use for spinal-anaesthesia-related hypotension during caesarean section [18]. No significant bradycardia, nausea, vomiting, respiratory distress, or excessive cephalad spread of blockade was observed — findings that compare favourably with the reported incidence of such side effects after conventional lumbar spinal anaesthesia [16]. This favourable haemodynamic profile is consistent with reports that thoracic segmental spinal anaesthesia produces a more limited sympathetic blockade and a reduced incidence and severity of hypotension compared with conventional lumbar spinal anaesthesia [6], an observation corroborated in larger series of thoracic spinal anaesthesia [4].

2.4.4 Intraoperative Fluid Therapy

Approximately 1500 mL of crystalloid solution was administered during the procedure. Estimated blood loss was approximately 350 mL and remained within acceptable limits; blood transfusion was not required. Judicious fluid administration combined with prompt vasopressor therapy is described as the cornerstone of preventing and treating spinal-anaesthesia-induced hypotension during caesarean delivery [2].

2.4.5 Neonatal and Surgical Outcome

A healthy male infant weighing 2.8 kg was delivered with Apgar scores of 9 at one minute and 9 at five minutes; no active resuscitation measures were required. This is consistent with previous reports of thoracic segmental spinal anaesthesia for caesarean section, which have described neonatal outcomes comparable to those following conventional lumbar spinal anaesthesia [7]. The procedure was completed uneventfully without the need for supplemental analgesia, sedation, or conversion to general anaesthesia; the patient remained conscious, comfortable, and haemodynamically stable throughout, and was transferred to the post-anaesthesia care unit at the conclusion of surgery. Segmental thoracic spinal anaesthesia was first described for laparoscopic cholecystectomy and subsequently applied to caesarean section, with excellent block characteristics and minimal cardiovascular disturbance [6,7]; larger clinical experience has since reported an exceedingly low rate of neurological complications when the technique is performed by experienced anaesthesiologists with a thorough understanding of thoracic anatomy [4].

2.5 Postoperative Course and Follow-up

The patient was transferred to the post-anaesthesia care unit in a conscious and haemodynamically stable condition, with continuous monitoring of heart rate, blood pressure, respiratory rate, and SpO_2. Serial neurological examinations were performed to assess recovery from sensory and motor blockade, in line with recommended vigilance for neurological complications following neuraxial procedures [12]; particular attention was paid to signs suggestive of meningitis, epidural abscess, or puncture-site infection given the unusual thoracic approach and the presence of extensive dermatophytosis. Postoperative analgesia was provided using a multimodal, non-opioid-based regimen (intravenous paracetamol and non-opioid analgesics), which provided satisfactory pain relief. Oral intake and ambulation were initiated early, and breastfeeding was successfully established. The patient remained afebrile throughout and was discharged on postoperative day 3 in satisfactory condition. Key postoperative findings are summarised in Table 4.

Table 4. Key Postoperative Findings

Parameter	Finding

Post-dural puncture headache	None
Neurological deficit / transient neurological symptoms	None
Meningitis / epidural abscess / puncture-site infection	None
Postoperative analgesia	Adequate (multimodal, non-opioid based)
Breastfeeding / maternal–neonatal bonding	Successfully established
Recovery and discharge	Uneventful; discharged on postoperative day 3

Table 5. Chronological Timeline of Perioperative Events

Time Point	Event
Antenatal period	Gestational hypertension diagnosed and controlled with antihypertensive therapy
Admission	Elective admission for repeat LSCS; dermatological examination revealed extensive active tinea corporis over the thoracolumbar/gluteal region, involving the conventional lumbar puncture site
Preoperative	Multidisciplinary discussion (obstetrics + anaesthesia); informed high-risk consent obtained; thoracic spinal anaesthesia planned with general anaesthesia backup
On arrival in OT	ASA monitoring established; 18G IV access secured; crystalloid preload started; emergency drugs and difficult airway cart prepared
Immediately before block	Uninvolved skin identified at T10–T11; chlorhexidine–alcohol asepsis; sterile draping; sitting position
Time 0	Thoracic subarachnoid block: T10–T11, 25G Quincke needle, midline approach; 0.5% hyperbaric bupivacaine 2 mL + fentanyl 25 µg
+1 min 28 s	Sensory block adequate for surgery achieved; patient repositioned supine with left uterine displacement
Intraoperative	Single episode of mild hypotension treated with ephedrine 3 mg IV; ≈1500 mL crystalloid infused; EBL ≈350 mL
Delivery	Live male infant, 2.8 kg, Apgar 9/9 at 1 and 5 minutes
End of surgery	Patient conscious, comfortable, haemodynamically stable; transferred to PACU
Postoperative day 0–2	Multimodal non-opioid analgesia; serial neurological assessment; early ambulation and breastfeeding established
Postoperative day 3	Discharged; uneventful course; no neurological or infective sequelae

3. DISCUSSION

Regional anaesthesia remains the technique of choice for caesarean section because it minimises maternal airway manipulation, reduces aspiration risk, provides excellent postoperative analgesia, and promotes early maternal–neonatal bonding [2], and is well established as the standard approach in modern obstetric anaesthesia practice [19]. Conventional lumbar spinal anaesthesia, performed below the termination of the spinal cord, is a safe and reliable technique. However, circumstances occasionally arise in which lumbar puncture becomes undesirable or technically impossible, necessitating alternative approaches.

In the present case, extensive active dermatophytosis involving the lower thoracic and lumbar regions presented a unique challenge. Active infection over the intended puncture site is generally considered a relative contraindication to neuraxial blockade because of concerns regarding the introduction of pathogens into deeper tissues and the theoretical possibility of meningitis or epidural infection [1]. Although dermatophytes are usually confined to superficial keratinised tissues and invasive fungal complications are exceedingly uncommon, puncturing through visibly infected skin is conventionally avoided, in keeping with established principles of aseptic technique in regional anaesthesia [10] and recognised, if rare, infectious risks of neuraxial procedures [11]. Consequently, an alternative neuraxial approach was considered.

General anaesthesia represents another option for caesarean section; however, obstetric general anaesthesia is associated with increased risks of difficult airway, aspiration, failed intubation, maternal awareness, and neonatal exposure to anaesthetic agents [2], risks that current difficult-airway guidance seeks specifically to mitigate [9]. Since our patient had

no contraindication to neuraxial blockade apart from the infected lumbar region, thoracic spinal anaesthesia was considered an attractive alternative.

Thoracic spinal anaesthesia was historically avoided because of concerns regarding spinal cord injury, a concern reinforced by early reports of conus medullaris damage following inadvertently high or misjudged spinal puncture [15]. Nevertheless, magnetic resonance imaging studies have demonstrated the existence of a posterior cerebrospinal fluid space even at thoracic levels; Imbelloni and colleagues showed that the distance between the dura and spinal cord is several millimetres at the T10 level, thereby allowing safe needle placement when performed carefully [5], a relationship consistent with classical anatomical descriptions of the subarachnoid space [14].

Several authors have reported the successful use of thoracic spinal anaesthesia for laparoscopic cholecystectomy, upper abdominal procedures, and caesarean section [6,7]. Lower thoracic puncture at T9–T10 or T10–T11 provides reliable segmental blockade with comparatively lesser sympathetic blockade and better haemodynamic stability than conventional lumbar spinal anaesthesia [4]. A comparative overview of thoracic and lumbar spinal anaesthesia for caesarean section, drawn from the literature underpinning this case, is presented in Table 6, and a summary of the key supporting studies is provided in Table 7. In our patient, satisfactory surgical anaesthesia was achieved rapidly without significant haemodynamic compromise; only one small dose of intravenous ephedrine was required, and no episode of bradycardia occurred, an incidence favourable relative to published data on side effects of spinal anaesthesia in general [16].

Table 6. Comparative Overview: Thoracic versus Conventional Lumbar Spinal Anaesthesia for Caesarean Section

Feature	Thoracic Spinal Anaesthesia (T9–T11)	Conventional Lumbar Spinal Anaesthesia (L3–L5)
Rationale for use	Alternative when lumbar access is contraindicated or unavailable	Standard first-line neuraxial technique
Anatomical basis	Spinal cord lies anteriorly; posterior CSF space ≈5–8 mm at T10 permits safe needle placement	Performed below the conus medullaris (≈L1–L2); wide subarachnoid space
Sympathetic blockade	More segmental / limited	Extensive; higher incidence of hypotension
Haemodynamic stability	Comparatively better; lower vasopressor requirement	Higher incidence of hypotension requiring vasopressors
Reported neurological risk	Low in experienced hands; historical (largely theoretical) concern for cord injury	Well-established safety record
Extent of clinical experience	Limited; predominantly case reports and case series	Extensive; standard of care worldwide
Typical indications	Skin infection/lesion over lumbar site, prior failed lumbar approach, select upper-abdominal surgery	Routine elective/emergency caesarean section
Operator expertise required	High — detailed knowledge of thoracic anatomy essential	Standard obstetric anaesthesia training sufficient

Table 7. Summary of Key Supporting Literature

Author (Year)	Study Type	Key Relevant Finding	Ref.
Van Zundert et al. (2006)	Case report	Segmental thoracic spinal anaesthesia used successfully for cholecystectomy in a patient with severe lung disease, demonstrating limited sympathetic spread	6
Van Zundert et al. (2007)	Case report	First description of segmental thoracic spinal anaesthesia for caesarean section, with satisfactory block quality and haemodynamic stability	7
Imbelloni et al. (2010)	Anatomical / MRI study	Demonstrated a measurable posterior CSF space between dura and spinal cord at T10,	5

		supporting the anatomical safety of thoracic puncture	
Imbelloni & Gouveia (2011)	Systematic review	Reviewed thoracic spinal anaesthesia case series; reported a low incidence of neurological complications with experienced operators	4
Hebl (2006)	Review	Emphasised the importance of strict aseptic technique in regional anaesthesia, including precautions near skin lesions	10
Chestnut et al. (2020)	Textbook	Outlined core principles of obstetric anaesthesia, including risks of general anaesthesia and management of spinal-induced hypotension	2

The addition of intrathecal fentanyl enhanced analgesic quality and allowed the use of a relatively small dose of hyperbaric bupivacaine. Intrathecal opioids have been shown to improve block characteristics and reduce local anaesthetic requirements while maintaining maternal haemodynamic stability [2].

Neurological injury remains the greatest theoretical concern associated with thoracic spinal anaesthesia. However, numerous case series have reported an extremely low incidence of neurological complications when the procedure is performed by experienced anaesthesiologists with meticulous attention to anatomy and technique [4], and current practice advisories on neurological complications of regional anaesthesia support close postoperative neurological surveillance rather than avoidance of the technique altogether [12]. In the present case, no postoperative neurological deficit, paraesthesia, post-dural puncture headache, or infectious complication was observed, and the patient had an uneventful recovery with discharge on the third postoperative day.

The successful outcome observed in our patient highlights the importance of individualised anaesthetic planning and emphasises that thoracic spinal anaesthesia can serve as a useful alternative in selected obstetric patients when conventional lumbar neuraxial access is contraindicated. Nevertheless, this technique should only be undertaken by anaesthesiologists familiar with thoracic neuraxial anatomy and with immediate availability of facilities for conversion to general anaesthesia if required.

The present case also demonstrates that active dermatological disease over the lumbar region need not necessarily mandate general anaesthesia. Careful assessment, meticulous aseptic precautions, and a thorough understanding of thoracic spinal anatomy can facilitate successful neuraxial anaesthesia while preserving the advantages associated with regional techniques. Given that our patient also had an elevated body mass index (29.4 kg/m²), which can further obscure surface landmarks, preoperative point-of-care ultrasonography of the spine — already established as a useful adjunct for identifying neuraxial landmarks — may be a valuable addition for confirming interspace level and depth to the intrathecal space before thoracic puncture in future cases [20].

This case report is limited by its single-patient design, which precludes generalisable conclusions regarding the incidence of complications, and by the absence of long-term neurological follow-up beyond the immediate postpartum period. Larger case series and prospective studies are needed to define standardised patient-selection criteria and to establish the long-term safety profile of thoracic spinal anaesthesia in obstetric practice.

4. CONCLUSION

This case highlights the successful use of thoracic spinal anaesthesia for elective caesarean section in a patient with extensive active tinea corporis involving the thoracolumbar region. Conventional lumbar spinal anaesthesia was avoided because the intended puncture site was affected by active dermatophytosis. Lower thoracic subarachnoid block at the T10–T11 interspace provided rapid onset of surgical anaesthesia with excellent maternal and neonatal outcomes and without neurological or infective complications. Thoracic spinal anaesthesia may represent a valuable alternative neuraxial technique in carefully selected patients in whom lumbar puncture is undesirable. Thorough preoperative assessment, strict aseptic precautions, comprehensive knowledge of thoracic spinal anatomy, and vigilant perioperative monitoring are essential for ensuring patient safety and successful outcomes. Further prospective studies are required to establish standardised indications and to evaluate the long-term safety profile of thoracic spinal anaesthesia in obstetric practice.

Patient Perspective

The patient expressed satisfaction with remaining conscious and comfortable throughout the delivery of her child and valued the avoidance of general anaesthesia and its associated risks. She reported adequate postoperative pain relief with the multimodal analgesic regimen, which allowed early ambulation, uninterrupted maternal–neonatal bonding, and successful establishment of breastfeeding during her hospital stay.

Ethical Considerations and Patient Consent

This case report has been prepared with reference to the CARE (CAse REport) guidelines for the transparent and complete reporting of case reports. Written informed high-risk consent for the anaesthetic technique was obtained from the patient prior to the procedure, and separate written informed consent was obtained from the patient for publication of this case

report and the accompanying clinical photographs. A copy of the consent form is available for review by the Editor-in-Chief of this journal upon request.

Author Contributions

- Dr. Nancy Sharma – Patient management, data acquisition, and drafting of the manuscript.
- Dr. Bharathi B – Anaesthetic supervision, and critical review and editing of the manuscript.
- Dr. Latha Narayan – Conceptualisation, anaesthetic supervision, critical revision, and final approval of the manuscript.
- Dr.S.Alagendran – Correction, manuscript editing and final draft conceptualisation

All authors read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

Conflict of Interest

None declared.

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