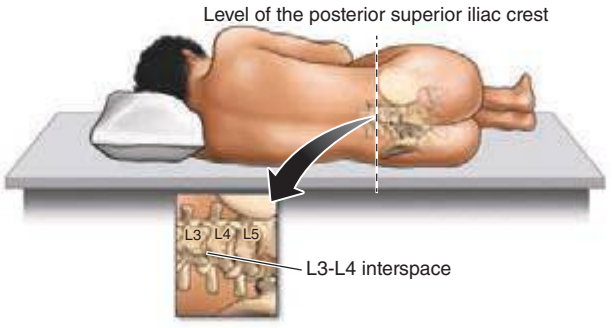

FIGURE 443e-1 Proper positioning of a patient in the lateral decubitus position. Note that the shoulders and hips are in a vertical plane; the torso is perpendicular to the bed. *(From RP Simon et al [eds]: Clinical Neurology, 7th ed. New York, McGraw-Hill, 2009.)*

Topical anesthesia can be achieved by the application of a lidocaine-based cream. Lidocaine 4% is effective when applied 30 min prior to the procedure; lidocaine/prilocaine requires 60–120 min. The cream should be applied in a thick layer so that it completely covers the skin; an occlusive dressing is used to keep the cream in place.

POSITIONING

Proper positioning of the patient is essential. The procedure should be performed on a firm surface; if the procedure is to be performed at the bedside, the patient should be positioned at the edge of the bed and not in the middle. The patient is asked to lie on his or her side, facing away from the examiner, and to "roll up into a ball." The neck is gently anteflexed and the thighs pulled up toward the abdomen; the shoulders and pelvis should be vertically aligned without forward or backward tilt **(Fig. 443e-1)**. The spinal cord terminates at approximately the L1 vertebral level in 94% of individuals. In the remaining 6%, the conus extends to the L2–L3 interspace. LP is therefore performed at or below the L3–L4 interspace. A useful anatomic guide is a line drawn between the posterior superior iliac crests, which corresponds closely to the level of the L3–L4 interspace. The interspace is chosen following gentle palpation to identify the spinous processes at each lumbar level.

An alternative to the lateral recumbent position is the seated position. The patient sits at the side of the bed, with feet supported on a chair. The patient is instructed to curl forward, trying to touch the nose to the umbilicus. It is important that the patient not simply lean forward onto a bedside tabletop, as this is not an optimal position for opening up the spinous processes. LP is sometimes more easily performed in obese patients if they are sitting. A disadvantage of the seated position is that measurement of opening pressure is not accurate. In situations in which LP is difficult using palpable spinal landmarks, bedside ultrasound to guide needle placement may be used. In some particularly difficult situations, a computed tomography (CT)-guided needle placement may be necessary.

TECHNIQUE

Once the desired site for needle insertion has been identified, the examiner should put on sterile gloves. A mask is worn if the clinician will be injecting material into the spinal or epidural space to prevent droplet spread of oral flora during the procedure. After cleansing the skin with povidone-iodine or similar disinfectant, the area is draped with a sterile cloth; the needle insertion site is blotted dry using a sterile gauze pad. Proper local disinfection reduces the risk of introducing skin bacteria into the SAS or other sites. Local anesthetic, typically 1% lidocaine, 3–5 mL total, is injected into the subcutaneous tissue; in nonemergency situations, a topical anesthetic cream can be applied (see above). When time permits, pain associated with the injection of lidocaine can be minimized by slow, serial injections, each one progressively deeper than the last, over a period of ~5 min. Approximately 0.5–1 mL of lidocaine is injected at a time; the needle is not usually withdrawn between injections. A pause of ~15 s between injections helps to minimize the pain of the subsequent injection. The goal is to inject each mini-bolus of anesthetic into an area of skin that has become numb from the preceding injection. Approximately 5–10 mini-boluses are injected, using a total of ~5 mL of lidocaine.

If possible, the LP should be delayed for 10–15 min following the completion of the injection of anesthetic; this significantly decreases and can even eliminate pain from the procedure. Even a delay of 5 min will help to reduce pain.

The LP needle (typically 20- to 22-gauge) is inserted in the midline, midway between two spinous processes, and slowly advanced. The bevel of the needle should be maintained in a horizontal position, parallel to the direction of the dural fibers and with the flat portion of the bevel pointed upward; this minimizes injury to the fibers as the dura is penetrated. When LP is performed in patients who are sitting, the bevel should be maintained in the vertical position. In most adults, the needle is advanced 4–5 cm (1–2 in.) before the SAS is reached; the examiner usually recognizes entry as a sudden release of resistance, a "pop." If no fluid appears despite apparently correct needle placement, then the needle may be rotated 90°–180°. If there is still no fluid, the stylet is reinserted and the needle is advanced slightly. Some examiners halt needle advancement periodically to remove the stylet and check for flow of cerebrospinal fluid (CSF). If the needle cannot be advanced because it hits bone, if the patient experiences sharp radiating pain down one leg, or if no fluid appears ("dry tap"), the needle is partially withdrawn and reinserted at a different angle. If on the second attempt the needle still hits bone (indicating lack of success in introducing it between the spinous processes), then the needle should be completely withdrawn and the patient should be repositioned. The second attempt is sometimes more successful if the patient straightens the spine completely prior to repositioning. The needle can then be reinserted at the same level or at an adjacent one.

Once the SAS is reached, a manometer is attached to the needle and the opening pressure measured. The examiner should look for normal oscillations in CSF pressure associated with pulse and respirations. The upper limit of normal opening pressure with the patient supine is 180 mmH_2O in adults but may be as high as 200–250 mmH_2O in obese adults.

CSF is allowed to drip into collection tubes; it should not be withdrawn with a syringe. Depending on the clinical indication, fluid is obtained for studies including: (1) cell count with differential; (2) protein and glucose concentrations; (3) culture (bacterial, fungal, mycobacterial, viral); (4) smears (e.g., Gram's and acid-fast stained smears); (5) antigen tests (e.g., latex agglutination); (6) polymerase chain reaction (PCR) amplification of DNA or RNA of microorganisms (e.g., herpes simplex virus, enteroviruses); (7) antibody levels against microorganisms; (8) immunoelectrophoresis for determination of γ-globulin level and oligoclonal banding; and (9) cytology. Although 15 mL of CSF is sufficient to obtain all of the listed studies, the yield of fungal and mycobacterial cultures and cytology increases when larger volumes are sampled. In general 20–30 mL may be safely removed from adults.

A bloody tap due to penetration of a meningeal vessel (a "traumatic tap") may result in confusion with subarachnoid hemorrhage (SAH). In these situations a specimen of CSF should be centrifuged immediately after it is obtained; clear supernatant following CSF centrifugation supports the diagnosis of a bloody tap, whereas xanthochromic supernatant suggests SAH. In general, bloody CSF due to the penetration of a meningeal vessel clears gradually in successive tubes, whereas blood due to SAH does not. In addition to SAH, xanthochromic CSF may also be present in patients with liver disease and when the CSF protein concentration is markedly elevated (>1.5–2 g/L [150–200 mg/dL]).

Prior to removing the LP needle, the stylet is reinserted to avoid the possibility of entrapment of a nerve root in the dura as the needle is being withdrawn; entrapment could result in a dural CSF leak, causing headache. Some practitioners question the safety of this maneuver, with its potential risk of causing a needle-stick injury to the examiner. Injury is unlikely, however, given the flexibility of the small-diameter stylet, which tends to bend, rather than penetrate, on contact. Following LP,