Horner’s Syndrome (HS) is characterized by a triad of miosis, ipsilateral ptosis and facial anhydrosis as a result of a lesion occurring at any given point of the oculosympathetic pathway between the hypothalamus and the eye¹. Although rare, there are, however, a few reports of this syndrome occurring in the sequence of the internal jugular vein catheterization². We report a case of HS postoperatively following IJV catheterization in a child.

**DESCRIPTION OF THE CASE**

Boy, 4 years old, 19 kg, admitted for a cardiac septoplasty under general anesthesia due to a partial AV septal defect. ASA 3

Monitorization: ASA standards + invasive arterial blood pressure + Central venous pressure + BIS®.

**INDUCTION**

- Positioning:
  - Trendelenburg tilt
  - Without head rotation
  - Rolled towel placed under his shoulders
  - 24 gauge needle
  - Seldinger technique
  - Medial approach

- General balanced anesthesia

**MAINTENANCE AND EMERGENCE**

- 2 attempts were undertaken
- Inadvertently puncturing the carotid artery
- Immediately followed by direct compression.

- Same positioning and approach
- Cannulated on a first attempt

**HOSPITAL STAY**

- Recovery room
- Discharge

- Pediatric Neurology consult,
- Head and neck CT and carotid Doppler ultrasound
- Normal

**COMMENTS AND DISCUSSION**

The proximity between the cervical sympathetic pathway and the internal jugular vein may predispose it to lesions, either by direct needle trauma or owing to pressure exerted by an expanding local hematoma resultant from an inadvertent carotid artery puncture¹. In what it relates to the present clinical case, the findings, particularly the sudden onset, point to the HS being a result of the ipsilateral jugular vein catheterization, underlining that an ultrasound-guided puncture was not ensued due to a momentary lack of availability². This case report, therefore, emphasizes the importance of ultrasound monitoring and guidance of central venous cannulation.

**REFERENCES**

1. Journal of Clinical Anesthesia 2008; 20: 304-06