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Reply

doi: 10.1017/S0265021507001214

EDITOR:

The intention of reporting this case was to warn anaesthetists of the potential difficulties with airway management where the orbital floor has been removed, and therefore stimulate debate. We are pleased that Drs Chethan and Rassam and also Dr Massimiliano and colleagues have entered this debate.

The patient did not initially have a prosthesis, simply a large dressing over the exenterated area. Concerning the preoperative evaluation, clearly in this case the ideal assessment would have been to carefully insert a fibreoptic scope under local anaesthesia into the orbital defect. It would then have been clear that the defect leads directly to the larynx and therefore that positive pressure ventilation via a facemask would not have been possible. Unfortunately this was not a practical option on the ophthalmic ward and, because of lack of accurate surgical information and a recent general anaesthetic in another hospital apparently without incident, was not considered. Limitation of mouth opening is a concern for the anaesthetist; however, it is not our practice to conduct an awake intubation unless the limitation is extreme. We would normally plan to use a McCoy laryngoscope with a bougie or consider the use of the Bullard laryngoscope, which can be used down to a mouth opening of 6 mm [1]. Awake fibreoptic intubation would be available but held in reserve.

It is often the case, and it was so for this gentleman, that such patients return for further surgery. As it happens, between submission of the letter and publication, further general anaesthesia was required on two occasions. As Chethan and Rassam suggested, we placed an intubating laryngeal mask (size 5), and ventilated through the mask following the induction of anaesthesia. Although placement and ventilation was straightforward, successful intubation through the intubating laryngeal mask airway (ILMA) proved impossible both without and with fibreoptic assistance. This was abandoned and nasotracheal fibreoptic intubation was again successful. In retrospect, the difficulty with the ILMA probably related to the patient's airway anatomy, in that he is tall with a long neck. Thus the ILMA, although adequately positioned for ventilation, was not positioned optimally for successful endotracheal intubation. Using the Aintree catheter with the classic LMA would almost certainly have failed for the same reason. A subsequent successful general anaesthetic was achieved with an awake fibreoptic intubation with the aid of a low-dose remifentanil infusion. Total intravenous anaesthesia with infusions of propofol and remifentanil was used for maintenance of anaesthesia in each case. The major advantage of this technique was that further doses of muscle relaxants were not required, thus ensuring complete recovery from neuromuscular blockade after several hours of surgery, and once both anaesthetic agents had worn off, the patient was fully co-operative for controlled extubation without the risk of residual anaesthesia or paralysis.

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Accepted for publication 1 June 2007 EJA 4547a
First published online 2 August 2007