terior cervical fusion of C_{5-6} as an emergency procedure. For fear of moving the cervical spine and causing secondary neurological damage, it was decided to perform nasal fibreoptic intubation under general anaesthesia. After instilling nasal decongestant, anaesthesia was induced with halothane and 100% oxygen. On reaching an adequate depth of anaesthesia, a well lubricated 7.5 mm internal diameter (ID) nasal endotracheal tube (ETT) was passed via the nostril into the hypopharynx. A fibreoptic bronchoscope (FB) was passed via the ETT. On emerging from the ETT, the view was found to be obscured by blood (secondary to traumatic passage of ETT) despite repeated suctioning. It was decided to abandon nasal intubation and perform oral fibreoptic intubation assisted by a Berman airway. However, the slit in the Berman airway could not prevent the tip of the FB from soiling with blood and secretion. Multiple attempts failed to visualize the vocal cords. At this stage, our modified size #4 LMA (MLMA)[1,2] with a split along its shaft extending to the inflatable cuffed portion was inserted with ease and the cuff inflated. The FB with premounted 8 mm ID cuffed ETT was passed through the MLMA. With minimal manipulation the FB was guided towards the vocal cords. At this stage succinylcholine 50 mg *iv* was given and the trachea entered. The MLMA was now disengaged via its split surface and removed. The ETT was advanced over the FB into the trachea uneventfully.

Fibrescopy may be difficult when blood, vomitus, or secretions obscure the view. We observed that the Berman airway as a protective guide to FB was unsuitable for fibrescopy in such a situation. The edges of the slit in this airway are separated to prevent blood and secretion from soiling the tip of the FB. On the contrary, the split edges of the MLMA lie in close approximation to each other thereby providing a good protective sheath to the FB even in the presence of blood and secretion in the oral cavity.

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Myasthenia gravis and regional anaesthesia

To the Editor:

This case report shows how regional anaesthesia is not always free of complications in myasthenic patients.[1] A 65-yr-old, 87-kg woman was admitted for debridement of a palmar abscess. Myasthenia gravis (MG) had been diagnosed two years before, and for six months had been in stage IIB[2] and had an FVC of 950 ml. She received pyridostigmine 600 mg and prednisone 70 mg om *po*. Regional anaesthesia was proposed and a right-axillary brachial plexus block was carried out with the use of a neurostimulator and 38 ml mepivacaine 1,5% were injected. No sedation was administered. Forty-five minutes after the block, the patient suffered a respiratory weakness which required transitory assisted ventilation with face mask and was reversed with small doses of pyridostigmine up to 4 mg *iv*. Two hours after surgery, in the recovery room, and at the time of administration of cloxacillin (500 mg *iv*) the patient again suffered respiratory depression which did not recover with neostigmine 1 mg *iv* and required orotracheal intubation and mechanical ventilation. The patient was transferred to the ICU and was weaned from IPPV three days later. She was discharged after 25 days with recovery to MG stage IIB.

Several factors may have played a role. First, although ester local anaesthetics may affect neuromuscular transmission in patients receiving anticholinesterase therapy,[3] we used mepivacaine, an amide local anaesthetic without effect on neuromuscular transmission. Second, stress may have contributed to the MG crisis. She did not receive sedation because diazepam *iv* is not advisable in patients with limited respiratory reserve.[3] Third, antibiotics are the best known drugs involved in the development of a myasthenic crisis. However, cloxacillin has not yet been specifically implicated. Postoperative mechanical ventilation may be required in myasthenic patients and the risk factors have been well described.[5] However, none were found in the reported case. Therefore, preoperative evaluation

is important in MG, and even though regional anaesthesia is performed, the need for postoperative mechanical ventilation should always be borne in mind. In addition, factors not related to the anaesthetic technique, such as stress and medications, should always be taken into consideration.

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