Although previously described,¹⁻⁵ the cause of the alopecia is not well defined, but ischaemia from pressure by the head over a scalp vessel while the patient is unconscious has been suggested. Hypotension, prolonged anaesthesia and surgery, fixed head position, hard head rings, extended head position, non-pulsatile flow and hypothermia may all influence the incidence of this complication.

From our observations and literature review, we conclude that postoperative alopecia occurs in typical sites – vertex and occipital regions, at any age, in either sex and it may be temporary or permanent. There appears to be no relationship between the onset of hair loss and regrowth of hair. Although considered to be of minor importance, it may lead to psychological and cosmetic difficulties. Frequent changes in head positions should be made during and after surgery to avoid this complication.

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General anaesthesia of a bullous pemphigoid patient

To the Editor:

We report the first case of general anaesthesia in a patient with Bullous Pemphigoid (BP). A 75-yr-old man with BP and intestinal neoplasm was admitted for right hemicolectomy. The procedure was performed under general anaesthesia with tracheal intubation and neuromuscular blockade without untoward events.

Bullous Pemphigoid is a chronic autoimmune blistering skin disorder¹ characterized by the appearance of large, tense bullae on the skin and mucous membranes. Guidelines for the anaesthesia management of BP patients² include special attention to possible airway difficulties due to bullae in the oropharynx and the risk of inducing bulla formation by laryngoscopy. Awareness of the potential side effects and interactions of the drugs used for the treatment of BP is indicated. Mucocutaneous involvement, if extensive, may compromise fluid and electrolyte balance. Perioperative corticosteroids therapy may be indicated. No specific anaesthetic drug or

technique is indicated. There is controversy about the use of regional anaesthesia in patients with bullous skin diseases but local infiltration and regional anaesthesia should be avoided because of the risk of blistering at the injection site and of unnoticed trauma of skin in the anaesthetized region.² Uncomplicated spinal anaesthesia has been reported in BP.³ Ketamine anaesthesia with spontaneous ventilation has been advocated for epidermolysis bullosa,⁴ which is similar to BP in its tendency to blistering and sloughing as a result of even slight mechanical trauma. This affords minimal airway manipulation but is not applicable when muscle relaxation is needed. If intubation is essential, an elective procedure is preferable to a potentially traumatic emergency intubation. To minimize airway trauma, the laryngoscope and endotracheal tube should be well lubricated and, because the face mask may also cause blistering, it should be lubricated.

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Do you really want the surgeon to take care of the airway?

To the Editor:

We enjoyed the article by Devitt and Boulanger on “Lower airway injuries and anaesthesia.” In their article, they stated that patients with extrathoracic tracheal injuries presenting with complete or impending airway obstruction require urgent tracheostomy under local anaesthesia.¹ We disagree.

If tracheostomy is a good approach for definite airway control in some patients, we do not believe it is the initial airway of choice in the emergency situation. A tracheostomy is technically very difficult in a patient with severe respiratory distress, abnormal anatomy and where neck extension is inadvisable because of the possibility of associated injury to the cervical spine. In the emergency situation, the surgical airway most often performed is a cricothyroidotomy,² a procedure that may be very difficult in cases of penetrating trauma to the neck where the anatomy is distorted and visualization of structures may be impossible due to blood or oedema. In cases where there might be an extrathoracic tracheal injury, a cricothyroid-