FIGURE Data (mean ± SD) are expressed as percentage of the control (in the absence of the drugs). * $P < 0.05$ vs control.

reduction of neutrophil function by rabeprazole. Thus, rabeprazole could be beneficial in non-septic patients with systemic inflammation or multiple organ failure. On the other hand, pirenzepine, omeprazole, and lansoprazole may not interfere with neutrophil function in infectious or septic patients. Further *in vivo* studies are required to assess the clinical effects of these gastric protectors on neutrophil function.

Katsuya Mikawa MD
Hirohiko Akamatsu MD
Kahoru Nishina MD
Yukie Niwa MD
Kobe, Japan

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Retropharyngeal neurofibroma presenting with severe kypho-scoliosis: respiratory obstruction in postoperative period

To the Editor:

Space occupying lesions in the retropharyngeal space are rare. Various masses have been described including angiomatoma,¹ ganglioneuroma,² malignant mesenchymoma,³ neuroblastoma⁴; the commonest are hematomas.⁵ The clinical presentation is varied but most had presenting symptoms of dyspnea and dysphagia. In this 27-yr-old patient the retropharyngeal neurofibroma presented with severe cervical kypho-scoliosis (Figures 1,2) and neurological symptoms of tingling and numbness in both arms but there were no

FIGURE 1 Plain radiograph of neck in lateral view showing extreme kyphosis.

FIGURE 2 MRI showing kypho-scoliosis of cervical spine with cord compression from front due to retropharyngeal space occupying lesion. Destruction of cervical vertebral bodies is evident. The larynx and trachea are only slightly displaced ventrally.

symptoms of dyspnea or dysphagia. After investigation the patient underwent excision of the tumour under general anesthesia with tracheal intubation. No problems occurred during visualization of laryngeal opening and tracheal intubation. The operation was with minimal blood loss and a 6 cm by 4 cm by 4 cm, smooth, hypovascular mass was removed. Following tracheal extubation, airway obstruction occurred in the immediate postoperative period and the severity of stridor continued to increase. Direct laryngoscopy revealed bilaterally moving vocal cords and no edema or injury around glottis. The patient was managed with tracheal re-intubation and supported ventilation. Extubation was again tried after 12 hr with no further airway problem. Lateral x-ray of neck after extubation demonstrated normally placed trachea. The postoperative airway obstruction was probably due to tracheal angulation and realignment in the vacant space created by excision of the tumour. With time, the space filled with serous exudate and realigned tissues, but it could not be anticipated or demonstrated with the tracheal tube *in situ*.

Prabhat Tewari MD
Chandra Kant Pandey MD
Isha Tyagi MS (ENT Surgery)
Lucknow, India

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Is a single vital capacity breath a suitable method for preoxygenation?

To the Editor:

In their recent paper,¹ Baraka *et al.* compared in ten adult patients the effect of preoxygenation by a single vital capacity breath (SVCB) with preoxygenation by three minutes of tidal volume breathing on mean arterial oxygen partial pressure (PaO₂). From the finding that PaO₂ was not different between the two groups, the authors conclude in their abstract that the single vital capacity breath technique "can rapidly provide adequate preoxygenation within 30 sec".

We agree that the study contributes interesting data. However, we feel that a problem arises from using solely PaO₂ as a marker of "adequate preoxygenation". In his recent paper in *Anesthesiology*, we can learn from the same author that "the time to desaturate is a more appropriate outcome measure for the efficiency of preoxygenation".² And he further explains that "the only reason that we perform preoxygenation maneuvers is to attempt to increase the oxygen body store and to prevent hemoglobin desaturation, and this is obviously a function of more than acute changes in PaO₂". Indeed, several studies have shown that the time to desaturation after a few vital capacity breaths is significantly shorter