Intraoperative problem during surgery for Chiari malformation

To the Editor:

I read with interest the paper by Williams *et al.*¹ who discussed Chiari Type I malformation and postoperative respiratory failure. The authors note that the surgical procedure proceeded uneventfully. I recently provided anesthesia care for a similar case except that the procedure was not uneventful.

An obese but otherwise healthy anesthetized female was positioned in the prone position on bolsters and the head stabilized. She had had surgery for this condition 14 yr before but her symptoms had recurred, necessitating a revision.

The procedure was uneventful until the dura was incised to explore the fourth ventricle. Cerebrospinal fluid poured out and all monitors developed flat lines. No retractor was in place compressing the brain stem but some change had occurred to affect the vital centres. Atropine was administered immediately. A stretcher was prepared so that she could be turned supine. Fortunately, the heart rate returned after about a 20-sec interval. With a small dose of ephedrine the heart rate returned to normal and the blood pressure rose to acceptable levels. The patient was carefully monitored postoperatively and had no sequelae from the bout of asystole.

It was a valuable experience for the operating room staff because the first indication of a problem was the silence of the oximeter. There was no ECG, pulse oxymeter trace nor CO₂ trace, but only the flashing red light and alarm indicating asystole.

This case demonstrates again that surgery, especially involving the posterior fossa and areas around the brain stem, requires constant attention.

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Reference

- 1 Williams DL, Umedaly H, Martin IL, Boulton A
Chiari type I malformation and postoperative respiratory failure. *Can J Anesth* 2000; 47: 1220–3.

An aid to correct positioning of the ProSeal laryngeal mask

The ProSeal laryngeal mask airway (PLMA; Laryngeal Mask Company, Henley-on-Thames, UK) is a new device developed with a modified cuff intended to

FIGURE PLMA with the aspiration catheter protruding at the end of the drainage tube.

improve the seal, and a drainage tube designed to prevent aspiration by providing a bypass channel for regurgitated gastric content.^{1,2} Although not mandatory, the drainage tube also offers the opportunity to pass a gastric tube through it. The insertion of the gastric tube is generally easy and reliable if the PLMA is positioned properly.² We recently encountered a case in which an aspiration catheter could not be inserted, and corrected the problem with a simple manoeuvre. After inducing anesthesia and paralysis in a 74-yr-old female scheduled for elective laparoscopic cholecystectomy, a size 4 PLMA was inserted easily and provided a satisfactory airway with a seal over 30 cm H₂O in the anesthesia circuit. Surprisingly, the attempt to insert a lubricated size 14 F aspiration catheter met with strong resistance inside the drainage tube. The PLMA was removed and reinserted with equal ease, after verifying the patency of the drainage tube. Again, even if the PLMA provided an excellent airway, it proved impossible to pass the aspiration catheter. We then presumed that the tip of the PLMA, where the opening of the drainage tube is located, was somehow