Unilateral weakness of a limb has also been noted.³ Hyperventilation has only been mentioned as a factor to note when reporting seizures⁴ but not as a side effect. We wish to highlight this case because the initial presenting problem of a "hyperventilating patient in recovery" may be caused not only by anxiety or pain but may need more serious consideration, especially in day case anaesthesia.

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Leak reduction with the LMA

To the Editor:

Isserles and Rozenberg describe a simple technique for reducing leak with the laryngeal mask airway (LMA) which involves flexion of the neck.¹ A further method is to apply gentle pressure to the front and/or sides of the neck with the palm of the hand. By squeezing the periglottic tissues more firmly around the LMA cuff, the efficacy of the seal is increased and leak is reduced. Provided the glottis is open and in approximate alignment with the LMA bowl there will usually be an increase in ventilatory capability. In addition, once the neck pressure is removed, the LMA cuff is occasionally found to have moulded around the larynx and the leak terminated.

The pressure should be applied gradually and gently over the thyroid region (where the cuff is often seen to bulge forward on inflation), whilst assessing the impact of the manoeuvre on leak. Care must be taken as excessive external neck pressure could lead to displacement of the LMA, airway obstruction or compression of vessels to the head and neck. It must be remembered that low inspiratory flow rates should still be employed to obtain the most effective ventilation with the LMA.

We have used the external pressure manoeuvre in 20 paralysed patients in whom ventilation through the LMA was inadequate due to leak and found that mean (range) leak pressures increased by 8 (5-15) cm H₂O. Interestingly, during the developmental stage of the LMA, Brain described a device which was applied pressure to the anterior neck to improve the efficacy of seal.² Indeed, we have found that an alternative to the using manual pressure may be to place two sandbags on either side of the neck to obliterate leak.

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Spinal ketamine anaesthesia for hemithyroidectomy

To the Editor:

A 22-yr-old, 150 cm, 50 kg woman, ASA I and known asthmatic, presented with adenoma of thyroid, size 10 cm × 6 cm, for hemithyroidectomy. Pulmonary function tests revealed a mild obstructive pattern. A joint decision was taken to administer spinal ketamine and her written informed consent was obtained. Surgeons were aware of the intact cough and swallowing reflexes under spinal ketamine and that the maximum anaesthetic effect of 100 mg would last for 45 to 60 min.

No premedication was given except antiasthmatics. She was placed in left lateral position with the table in the neutral position. Two ml, 100 mg autoclaved, preservative-free ketamine hydrochloride with density of 0.9869 were administered at L₂-L₃ using a 23 G needle over <5 sec. A spinal microcatheter was placed for topping up if the surgery were prolonged.

The patient attained an unrousable state with eyes closed after seven minutes. She was positioned to leave a portion above the chin free to facilitate intubation if required. Movement of the swelling due to the swallowing reflex did not disturb the surgery which was completed in 45 min. The patient did not move or cough. Respiratory monitoring was within normal limits. The patient responded to verbal commands at the end of the surgery and the movement of the vocal cords was normal. Recovery was smooth and uneventful. There was no awareness and analgesia lasted for three hours. Oral fluids were permitted two hours after surgery.

In conclusion spinal ketamine was found to be an effective and efficient mode of anaesthesia. It may be indicated in circumstances, as in this case, if patients presenting with asthma where unnecessary airway instrumentation is not desired.

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