

The probable explanation is that with increased muscle tone, voluntary movement and increased body temperature there was increased perfusion of skeletal muscle with re-uptake by the blood of sufentanil and increased plasma concentration. Stimulation during emergence and transfer to the recovery room may antagonise the ventilatory depressant effects of residual low-dose sufentanil and respiratory depression may only become evident when the patient is relatively unstimulated in the postoperative period.

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Airway assessment in obstetrical patients

To the Editor:

After reading Dr. McIntyre's article on difficult tracheal intubation,¹ I would like to emphasize that any anaesthetist dealing with pregnant patients should assess their airway with the patient *recumbent*. In this position, large pendulous breasts will often rise up to rest under the chin and thus make both constant cricothyroid pressure and tracheal intubation difficult, if not impossible. Taping the breasts out of the way and/or use of a short handled (Datta)

laryngoscope or a laryngoscope with a "polio blade" may facilitate intubation.

Obstetrical emergencies often require anaesthetizing a patient who has recently ingested a full meal. The risk of encountering a difficult or failed intubation as well as pulmonary aspiration of excessively acid gastric material is much greater in the pregnant patient.^{2,3} Careful preoperative airway assessment may help to prevent these potential disasters.

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REPLY

One purpose of the article was to emphasise the value of a careful preanaesthesia examination regarding potential difficulties of tracheal intubation. From this viewpoint the problems that may be presented by the pregnant patient do not differ substantially from certain others such as the very obese person. As for the position in which the patient is examined, Dr. Ross's point is well taken and it is reasonable to state that any patient should be examined in the position in which intubation will be attempted. Other matters she mentions, though vitally important, fall within the realm of selection of anaesthesia conditions and state of consciousness under which intubation is done rather than the technique of intubation.

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Facial nerve paralysis following mask anaesthesia

To the Editor:

The incidence of facial nerve palsy following mask anaesthesia is rare. Azar and Lear¹ and Glauber² in 1986, described three patients who developed sensory and motor nerve dysfunction of the face, following mask

anaesthesia. A total of 14 cases has been reported in the past 50 years. We wish to report three further cases, as we believe there may have been many unreported cases.

Case 1

A 19-year-old, healthy male underwent a circumcision under general anaesthesia with a mask. No head harness or oral airway were used. The intraoperative and postoperative courses were unremarkable. The patient developed right-sided lower lip numbness which lasted for ten days, followed by complete recovery. There was no loss of motor function.

Case 2

A 48-year-old healthy female underwent general anaesthesia for a breast biopsy. A mask and oral airway were used, but no head strap. The procedure lasted 45 minutes. The intraoperative and postoperative courses were uneventful. The next day she complained of perioral numbness with weakness of the left side of her face. There was complete recovery within four weeks.

Case 3

A 58-year-old healthy male had mask anaesthesia for cystoscopy and excision of a hydrocoele. An oral airway was used, but no head strap. The procedure lasted one hour and 45 minutes. There were no intraoperative or postoperative problems. The patient complained on the second postoperative day that his lips were numb and he was unable to move the left side of his lower lip. A neurologist diagnosed facial neuropraxia affecting the mandibular branch of the facial nerve, probably secondary to compression by the face mask. Complete neurological recovery occurred within three months.

Our case reports suggest that sensory and motor deficits of the face may occur more commonly than indicated by the literature.¹⁻³ The facial nerve, after leaving the skull via the stylomastoid foramen, becomes superficial to the mandibular ramus and enters the parotid gland where it divides into its branches. The temporal and zygomatic branches run downward over or behind the ramus of the mandible where pressure may cause injury. Three anatomical variations are described.³ First, the trunk may give off its branches at varying levels in relation to the parotid gland. Second, the nerve may lie superficial rather than deep to the gland and thus the buccal branch may be injured by mask anaesthesia or use of head harness. Third, the mandibular branch sometimes runs in a lower position than usual and in this situation bends around the edge of the angle of the jaw.⁴ Pressure behind the mandible to relieve respiratory obstruction may injure the mandibular branch.

Numbness of the lower lip can be produced by pressure

exerted via the mask directly on the mental nerves bilaterally, as they pass through the mental foramina of the mandible. An oral airway may compress the inferior alveolar nerve as the nerve enters the mandibular foramen on the inner aspect of the mandibular ramus. Transient numbness of the lips and inner mouth may also occur for several hours following a mask anaesthetic if the oral airway had been lubricated with local anaesthetic.

The clinical management of these patients should consist of reassurance that they will recover completely and, while the sensory loss is present, they should be advised to avoid trauma and burns to the lips and face until the recovery of normal sensation. Recovery usually occurs within a few days to a few months.^{1-3,5}

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Pseudo-embolie Drum-Cartridge Catheter

Monsieur l'éditeur en chef,

Nous aimerions attirer votre attention sur l'utilisation du cathéter pour voie centrale Drum-Cartridge® Catheter (Abbott Ireland Ltd.). Vous remarquerez sur l'emballage du Drum-Cartridge® Catheter (Figure) la dimension suivante: 71 cm. Après vérification de dix cathéters, nous observons que ceux-ci varient entre 71 cm à 73 cm. Lorsque vous retirez un Drum-Cartridge Catheter d'un patient, comment pouvez-vous être assuré qu'il ne manque pas 2 cm de ce cathéter, et que celui-ci n'a pas provoqué d'embolie pulmonaire? Nous proposons d'ajouter