

Correspondence

Rare complication after Stellate ganglion block

To the Editor:

A case is reported of suspected inadvertent subdural block following attempted stellate ganglion block (SGB). A 56-yr-old man was suffering from right shoulder and neck pain. He obtained a good degree of pain relief for three days with SGB. On one occasion, C6-SGB was performed with 6 ml mepivacaine 1%. The aspiration test was negative. Twenty minutes after SGB, he reported heaviness in the left leg, followed by the right leg and left hand. Hypoaesthesia was observed from C2 to T7, and below T12 levels by pin prick test. He could not move either leg or his left hand 50 min after SGB. When he eventually recovered from the motor block two hours after SGB, a 20 sec clonic, systemic convulsion (just like shivering or continued fasciculation) from his face to both legs was observed every 10 min. He could answer questions at all times. The convulsion was temporarily relieved by administration of 5 mg diazepam *iv* twice, then administration of 250 mg of phenytoin *iv* stopped the convulsion completely. After four hours, he recovered fully without any complications. Brain CT, electroencephalogram and cerebral angiography showed no abnormalities.

Subdural block is a very rare complication of SGB.¹ The clinical characteristics of subdural block are a negative aspiration test, delayed onset, widespread sensory block, variable motor blockade.² The MMPI test³ indicated neurosis. We consider that he had anxiety after sensory and motor paralysis because of subdural block following SGB, and hysteria lead to convulsions.⁴

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The LMA for the application of postoperative CPAP

To the Editor:

We have used the reinforced laryngeal mask airway (RLMA) for application of continuous positive airway pressure (CPAP) support in two patients suffering hypoxia during recovery from anaesthesia. Both were obese (92 kg, 112 kg) with mild sleep apnoea and required general anaesthesia for corrective surgery to their upper airway; septoplasty and uvulopalatoplasty respectively. Anaesthesia was induced with propofol, fentanyl and vecuronium. An RLMA was inserted and a 20° head-up position adopted. Intermittent positive pressure ventilation was satisfactory with peak airway pressures of 18 cm H₂O. Anaesthesia was maintained with N₂O/O₂/isoflurane. After an uneventful perioperative course neuromuscular blockade was reversed and spontaneous respiration allowed. Both patients became desaturated (SpO₂ < 88% and < 85%) in spite of receiving 15 L·min⁻¹ oxygen via a T-piece. Substitution with a Whisperflow system providing CPAP of 5 cm H₂O and 40% O₂ produced rapid, sustained improvement in saturation (SpO₂ 96% and 99%). The RLMAs were removed by the patients when awake.

Use of the RLMA for ENT surgery provides an unobstructed easily maintained airway protected from soiling perioperatively and, if left in situ, throughout the recovery period until full return of upper airway reflexes.¹⁻³ Recovery is less eventful than if an endotracheal tube were left in situ or exchanged for a Guedel airway.²⁻³ The RLMA also allows immediate application of CPAP as soon as spontaneous ventilation returns with

the advantages of improved gas exchange⁴ and reduced work of breathing.⁵ This combination may be of particular value in moderately obese, sleep apnoeic patients undergoing ENT procedures.

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Airway anaesthesia during fiberoptic endoscopy

To the Editor:

Fiberoptic intubation in conscious, sedated patients is not associated with significant haemodynamic alterations if adequate topical anaesthesia is employed. In the emergency setting, the use of translaryngeal and superior laryngeal blocks is generally contraindicated when the risk of aspiration of gastric contents is high. However, under most circumstances, adequate conditions for intubation can safely be established by restrained application of local anaesthetic (typically lidocaine 2–4%) directly on the pharyngeal/laryngeal mucosa, and vocal cords, *via* the working channel of the endoscope. Unfortunately, use of the operating channel for this purpose makes coincident suction of blood, mucus or secretions away from the endoscope tip more difficult. We have found that a standard 20 g epidural catheter can readily be threaded down the operating channel of the bronchoscope, to protrude 1–2 mm at the distal end and leaving a coil of 5–10 cm

at the control end; (threading is most easily effected by passing the catheter from the distal tip up to the operating controls, rather than vice versa). The presence of the catheter does not interfere with either retrograde suctioning, or antegrade oxygen flow, yet it facilitates measured application of topical anaesthetic from a syringe connected to the catheter via a standard epidural compression connection. The lone operator can readily inject local anaesthetic and apply intermittent suction (or continuous oxygen) without the confusion of multiple valves and stop-cocks, and without compromising the flexibility or utility of the flexible fiberoptic bronchoscope.

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Paradoxical vocal cord motion

To the Editor:

We were very interested to read the clinical report by Drs. Arndt and Voth on paradoxical vocal cord motion masquerading as pulmonary dysfunction in the recovery room.¹ As the authors point out, paradoxical vocal cord motion has been a great “masquerader” which has led not only to difficulties in diagnosis, but also to related errors in therapy.

For readers interested in the topic, the original description of this phenomenon in the anaesthesia literature, can be found in a previous volume of the *Canadian Journal of Anaesthesia*.²

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REPLY

Dr. Voth and I are also very interested in Dr. Tousignant's previous report on a functional stridor. We feel that these types of reports are very important in that it allows the anaesthetist to have some insight into the clinical aetiologies of postoperative stridor. Many times clinicians will intubate the trachea in patients with postoperative stridor in almost a reflex manner. These reports allow clinicians to have a differential diagnosis