



REVISTA BRASILEIRA DE ANESTESIOLOGIA

Official Publication of the Brazilian Society of Anesthesiology
www.sba.com.br



LETTERS TO THE EDITOR

Thoracic epidural anesthesia in a geriatric patient with cardiac risk: a case report

Dear Editor,

With increasing life quality, older population increase fastly. Cardiac and respiratory disorders and autonomic dysfunction seem to occur more frequently in older people.¹ Unfortunately this circumstance limits choosing anesthetic methods for these patients. Epidural anesthesia or analgesia can decrease the potential complications due to general anesthesia such as prolonged ventilation, myocardial depression and prolonged ileus.² Fifth cot resection was planned to a 83 years old man with 168cm height and 68kg weight due to the chest wall hydatic cysts. His past medical history revealed that he had high degree heart insufficiency, epilepsy, dyspnea and a pacemaker for five years. He had cholecystectomy and inguinal hernia repair surgeries done 20 years and 10 years ago respectively. He was oriented, cooperative and hemodynamically stable. Physical examination revealed basal rales and rhonchi. The ejection fraction was assessed as 33% by echocardiography. He was evaluated as ASA III.

Cardiac treatment was given him according to cardiologist suggestion preoperatively and epidural anesthesia was planned for surgery. No premedication was given before arrival to the operating room. After routine monitoring, peripheral intravenous access was provided and preloading of isotonic solution was given. Epidural catheter was inserted between T4 and T5 intervertebral spaces with a loss of resistance method at sitting position. The catheter tip was set forward to 3cm cephalad and the test dosage of 3mL 2% Lidocaine was applied. Then, 7mL 5% levobupivacaine and 50mcg fentanyl were added. Ten minutes later from the application of epidural anesthesia adequate sensorial blockage level was provided between T3 and T8 spaces. Surgical procedure was performed with standard technique at lateral decubitus position. 4lt/min oxygen was given with a face mask. During surgery, his blood pressures were between 154/94 and 97/54mmHg, heart rates were 65–108min⁻¹

and saturations were 89–96%. Approximately 15 min after epidural anesthesia, his blood pressure was recorded as 76/45mmHg; therefore 5mg Efedrin was applied intravenously.

Simultaneously evaluated sensorial blockage level was T4. Patient has no additional sedation and analgesia requirements during the surgery which lasted 45 min. He had no respiratory distress intra- and post-operatively. For epidural analgesia 3 mL 5% bupivacaine + 50 mcg fentanyl mixture was applied through the epidural catheter three hours after surgery. Epidural catheter was drawn 24 h later. The patient was discharged with stable vital signs four day after surgery. High thoracic anesthesia (T1–T5) decreases sympathetic tone; however dysrhythmia risk is reduced by blocking cardiac accelerator fibers during cardiac surgery.³ Niimi et al. reported that high thoracic epidural anesthesia decreased cardiac output but did not affect left ventricular ejection fraction and diastolic filling function.⁴ Rodgers et al. reported that perioperative cardiac complications were less in patients undergoing surgical operations with regional anesthesia.⁵

We applied successful high thoracic epidural anesthesia to our high-risk patient with arrhythmia and low ejection fraction undergoing cot resection.

Conflicts of interest

The authors declare no conflicts of interest.

References

1. Marik PE. Management of the critically ill geriatric patient. *Crit Care Med.* 2006;34:176–82.
2. Arık H, Erhan OL, Beştaş A, et al. The effect of a single or fractional dose of local anesthetic on hemodynamics in epidural anesthesia evaluated according to ejection fraction. *Turk J Geriatr.* 2012;15:439–44.
3. Clemente A, Carli F. The physiological effects of thoracic epidural anesthesia and analgesia on the cardiovascular, respiratory and gastrointestinal systems. *Minerva Anesthesiol.* 2008;74:549–63.

4. Niimi Y, Ichinose F, Saegusa H, et al. Echocardiographic evaluation of global left ventricular function during high thoracic epidural anesthesia. *J Clin Anesth.* 1997;9:118–24.
5. Rodgers A, Walker N, Schug S, et al. Reduction of postoperative mortality and morbidity with epidural or spinal anaesthesia: results from overview of randomised trials. *BMJ.* 2000;16:321.

Serdar Kokulu^{a,*}, Remziye Gül Sivaci^a, Gürhan Öz^b, Elif Doğan Baki^a, Hasan Şenay^a, Yüksel Ela^a

^a Department of Anesthesiology, Afyon Kocatepe University School of Medicine, Afyonkarahisar, Turkey

^b Department of Thoracic Surgery, Afyon Kocatepe University School of Medicine, Afyonkarahisar, Turkey

* Corresponding author.

E-mail: serdarkokulu@yahoo.com (S. Kokulu).

Available online 16 October 2013

<http://dx.doi.org/10.1016/j.bjane.2013.06.010>

Can positioning alter the success of endotracheal intubation in obese?

Dear Editor,

We read with great interest your article "Use of Simple Clinical Predictors on Preoperative Diagnosis of Difficult Endotracheal Intubation in Obese Patients" in which you have shown a significant correlation of Obstructive Sleep apnea (OSA) and difficult intubation (DI) in obese patients.¹

1. The position of the patient during laryngoscopy is an important factor determining the success of endotracheal intubation. In the present study, the authors have not specified the position of the obese patients while attempting laryngoscopy and endotracheal intubation. The use of ramped position has shown to improve the laryngoscopic view and intubation success rate in comparison to the standard sniffing position in obese patients.² Neligan et al. in their study showed that OSA does not form a risk predictor for DI in morbidly obese patients in ramped position.³
2. Contrary to the statement by the authors we feel, that the risk factors for difficult mask ventilation and DI are quite different. Modified Mallampatti, neck circumference, thyromental distance and restricted jaw mobility form risk factors for difficult intubation in obese patients.⁴ While increased body mass index (BMI) and history of OSA has been shown to have correlation with difficult mask ventilation.⁵

Therefore we feel that a mention of the positioning for endotracheal tube is an important aspect of this study, which can affect the results of the study.

Conflicts of interest

The author declares no conflicts of interest.

References

1. Magalhães E, Marques FO, Govêia CS, et al. Use of simple clinical predictors on preoperative diagnosis of difficult endotracheal intubation in obese patients. *Rev Bras Anesthesiol.* 2013;63:262–6.
2. Collins JS, Lemmens HJ, Brodsky JB, et al. Laryngoscopy and morbid obesity: a comparison of the "sniff" and "ramped" positions. *Obes Surg.* 2004;14:1171–5.
3. Neligan PJ, Porter S, Max B, et al. Obstructive sleep apnea is not a risk factor for difficult intubation in morbidly obese patients. *Anesth Analg.* 2009;109:1182–6.
4. Sheff SR, May MC, Carlisle SE, et al. Predictors of a difficult intubation in the bariatric patient: does preoperative body mass index matter? *Surg Obes Relat Dis.* 2013;9:344–9.
5. Langeron O, Masso E, Huraux C, et al. Prediction of difficult mask ventilation. *Anesthesiology.* 2000;92:1229–36.

Divya Jain

Department of Anaesthesiology and Intensive Care, Postgraduate Institute of Medical Education and Research, Chandigarh, India

E-mail: jaindivya77@rediffmail.com

Available online 7 November 2013

<http://dx.doi.org/10.1016/j.bjane.2013.07.010>

Palatoplasty in a patient with Seckel syndrome: an anesthetic challenge

Dear Editor,

Seckel syndrome first described in 1960,¹ is an autosomal recessive disorder found in consanguineous marriages² characterized by severe IUGR, postnatal growth retardation, mental retardation, beak like face and retrognathia. Its inci-

dence is less than 1 in 10,000 live births with 25% chances of recurrence in subsequent siblings.³ Nearly 60 cases have been reported till date with very few cases having being administered general anesthesia (GA). We report the first successful palatoplasty done under GA in a child with Seckel syndrome.

An eight-year-old male child with wide cleft palate presented with complaints of poor feeding, repeated upper respiratory infections and inability to verbalize clearly.