In response to unanticipated cannot intubate situation due to difficult mouth opening

Sir,

We read with the interest case report "Unanticipated cannot intubate situation due to difficult mouth opening" by Akasapu *et al.*[1] published in January-March 2015 issue 1 volume 31. We have some queries regarding the management of this case: The use of 100 mg of rocuronium in an ASA grade IV E patient can be confounding. Furthermore authors should have attempted bag mask ventilation (BMV) without sellick's maneuver after their first attempt of BMV with sellick's maneuver failed.[2] Also it would have been prudent to consider cricothyroidotomy in a patient who is rapidly desaturating.

We also encountered a similar case of unanticipated cannot intubate situation in a 64-year-old and 50 kg, ASA I female, posted for right radical parotidectomy with posterior segmental mandibulectomy with free anterolateral thigh flap reconstruction. Her airway examination was normal with the mouth opening of 3 cm and mallampatti class I with a full range of neck movements. Airway plan was to secure the nasotracheal tube. Anesthesia was induced with propofol 120 mg and fentanyl 100 μg. Rocuronium of 50 mg was given for neuromuscular blockade after confirmation of BMV. After 3 min of BMV, an attempt to open the mouth for laryngoscopy was failed, teeth were firmly approximated. BMV was continued for another minute. Sevoflurane 2% with oxygen was used during BMV at the fresh gas flow of 2 l/min. Another attempt to open the mouth was also failed. Masseter muscles spasm and temporomandibular joint dislocation were ruled out by the surgeons. The surgeon tried to open the mouth with the help of mouth gag but failed again. We decided to intubate the trachea with the help of fiber optic bronchoscope (FOB) through nasal route and continued BMV till FOB arrived. We successfully managed this stressful situation with FOB.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Access this article online	
Quick Response Code:	Website: www.joacp.org
	DOI: 10.4103/0970-9185.175725

How to cite this article: Thota RS, Purohit R, Solanki SL. In response to unanticipated cannot intubate situation due to difficult mouth opening. J Anaesthesiol Clin Pharmacol 2016;32:125.