

Are we responsible for the dizzy operating surgeon?

Sir,

A 50 kg, 25-year-old ASA I male patient, presented with hoarseness of voice. He was diagnosed to have vocal cord polyp and was posted for its laser excision. After attaching standard monitors in the operating room, anesthesia was induced with fentanyl, propofol, and tracheal intubation was facilitated by vecuronium with uncuffed (5 mm ID) laser orotracheal tube. Anesthesia was maintained with air/oxygen (FiO_2 0.5) and isoflurane approximately MAC 1-1.2. Intraoperative boluses of fentanyl and vecuronium were administered as required. The surgery commenced and proceeded smoothly. However, after 20 min, while performing surgery on the vocal cords, the operating surgeon complained of feeling dizzy. He was not able to concentrate on the procedure and thus stopped the surgery. After resting for some time in the adjoining room, he felt fine and restarted the surgery. However, he again complained of the same problem to us and stopped to operate. We then went to the surgeons end while trying to sort out the cause of dizziness. We smelled pungent odor near the face of the surgeon and thus suspected inhalational agent (isoflurane) to be a probable culprit. We immediately switched off the isoflurane vaporizer and changed over to propofol infusion. The surgeon resumed his surgery and could immediately make out the difference from previous episodes and there were no more 'dizzy' problems thereafter. Rest of the surgery was uneventful.

Surgeries around vocal cord and bronchoscopy procedures require the operating surgeons to be close to the face of the patient. In these situations, the anesthesia gases along

with inhalational agents leak outside from around the tube. Constant inhalation of gases while near the face of the patient can make the surgeon feel considerably dizzy.

The fact that the leaking of gases from around the uncuffed endotracheal tube causes contamination of operating room atmosphere is well-known.^[1] However, what has never been described before in literature is that in these surgeries, close proximity of the operating surgeons face to the leaking gases, makes him dizzy enough to incapacitate him to even operate.

Though, cuffed laser orotracheal tubes are available to us, we required to use a smaller laser OTT in this patient to facilitate surgery for which only the uncuffed laser tube was available. Non availability of proper sized cuffed laser tubes could be a problem in many countries. After this incidence, we have indigenized a novel method to prevent leakage of gases to outside from uncuffed laser tubes. We cut the proximal end of the portex orotracheal tube till the distal end of the cuff along with the pilot balloon and sleeve it on the laser tube so that the cuff prevents leakage of gases to outside [Figures 1 and 2]. The cuff is thereafter filled with saline.

We also suggest using propofol intermittent boluses or infusion, for surgeries in and around the vocal cord and in bronchoscopies, rather than using inhalation agents in situations, which cause significant leakage of gases to outside atmosphere.

These two simple measures make for less operating room contamination and keeps surgeons 'fresh' intra-operatively.



Figure 1: Proximal end of polyvinyl chloride endotracheal tube sleeved over proximal end of uncuffed laser tube



Figure 2: Sleeving of proximal end of PVC endotracheal tube over laser tube including endotracheal balloon and pilot tube

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