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Safe use of mivacurium in oculopharyngeal muscular dystrophy

To the Editor:

Oculopharyngeal muscular dystrophy, a clinically distinct syndrome, is a late onset autosomal dominant disease characterized by progressive dysphagia and ptosis.[1,2] We present the anaesthetic management of such a patient using mivacurium, propofol, nitrous oxide and fentanyl.

A 55 yr old man was scheduled for resection of squamous cell carcinoma of the right maxillary sinus. After applying standard monitors including a peripheral nerve stimulator he was pre-oxygenated and anaesthesia was induced with 1 mg midazolam, 100 μg fentanyl and 150 mg propofol 150 mg and tracheal intubation was facilitated with 0.12 $mg \cdot kg^{-1}$ mivacurium. Anaesthesia was maintained with N_2O/O_2 and propofol infusion. Additional 2 mg mivacurium was given after 20 min. The neuromuscular block was reversed with 1.2 mg atropine and 15 mg edrophonium. Two months later the anaesthetic management was similar for maxillectomy. Mivacurium 0.2 $mg \cdot kg^{-1}$ facilitated intubation and its effective duration was 25 min. No reversal was necessary as he had good cough and sustained head lift. The trachea was extubated in OR in both procedures. There were no postoperative complications.

A similar case has been reported in whom vecuronium was used without complication. These patients may undergo therapeutic cricopharyngeal myotomy and ptosis correction frequently without surgical complications.[4,5] Anaesthetic considerations include the risk of aspiration and of underlying pulmonary function. Sensitivity to non-depolarizing muscle relaxants does not appear to occur and we believe that mivacurium can be safely used for patients in this condition.

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Abdominal distension during transurethral resection of a bladder tumour

To the Editor:

A healthy, 79 yr old woman presented for cystoscopy and transurethral resection of a large, friable bladder tumour. Anaesthesia was induced with propofol. Succinylcholine was administered to aid in the insertion of a #3 laryngeal mask airway (LMA). The LMA was easy to place, and the airway appeared patent. Anaesthesia was maintained with nitrous oxide, oxygen and isoflurane. The lungs were mechanically ventilated with a respiratory rate of eight and a tidal volume of 500 ml. Peak airway pressure was 28 cm water. After approximately 30 min of resection the surgeon became concerned about swelling of the abdomen. Removal of the drapes revealed a substantially distended abdomen. The surgeon ordered a cystogram to investigate the possibility of a ruptured bladder.

A nasogastric tube was passed with considerable difficulty and it was necessary to remove the LMA to allow the tube to pass. A substantial gush of air was released from the stomach, and the abdomen returned to its normal size. The cystogram showed no perforation of the bladder. Although gastric insufflation is a recognised complication of ventilation through an LMA[1,2] it is seldom so pronounced to make the surgeon suspect that the enlarged abdomen could be due to a surgical problem.

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