Sir,

With an increasing population, smoking, and tobacco consumption, the actual burden of patients presenting for head and neck cancer surgery is on a rise, especially in the developing parts of the world. Patients operated for the primary cancers of head and neck usually require a reconstructive surgery like pectoralis major myocutaneous (PMMC) flap, with reported incidence of complications such as flap necrosis, fistula, wound dehiscence, hematoma, and infections ranging from 17% to 63% in the postoperative period.[1,2] Patients presenting for revision flap surgery with associated complications are on rise and they offer certain unique challenges to the anesthesiologists during the perioperative period.

We here report a successful management of a 40-year-old 60-kg male patient presenting for revision of PMMC flap because of flap necrosis and fistula, presenting at emergency dental department with difficulty in breathing and swallowing with ongoing bleeding from the suture site. The patient had undergone previous reconstructive PMMC flap surgery after resection of biopsy-proven squamous cell carcinoma of right alveobuccal complex 2 months back.

The patient presented to hospitals with complaint of low-grade fever with bleeding mixed with secretions from the suture site. The patient also had some difficulty in breathing due to the ongoing bleeding. The patient was on Ryle’s tube (RT) feed which he has stopped himself since 12 h.

On examination, the patient appears to be in some distress due to ongoing bleeding from flap site and difficulty in respiration, the patient was febrile with temperature of 99°F, Mallampati grading of the airway was not possible due to distorted landmarks and range of movement of neck was also restricted, small defect of size 2 cm × 2 cm was present at right mandibular area and was covered with gauge piece, and mouth opening of 3 cm was present. 14 Fr RT was fixed and passing through the left nostril [Figures 1 and 2].

Emergency surgical exploration with revision of PMMC graft was planned. Written and informed consent was taken. In view of difficult airway, the patient was explained about awake nasal fiberoptic intubation (FOB) and his cooperation was asked. A backup option for front of neck access for airway was also planned. A 18G intravenous (IV) access was secured and normal saline at 100 ml/h was started; 1 g of IV paracetamol was given stat. Routine standard American Society of Anesthesiologists monitoring was applied. Oxymetazoline 0.1% nasal drops was instilled into right nostril for vasoconstriction and injection glycopyrrolate 0.2 mg was given intramuscularly to minimize oropharyngeal secretions. To facilitate awake intubation and positioning, 1 μg/kg dexmedetomidine was administered over 10 min followed by 0.5 μg/kg/h infusion. A 7.5-mm flexometallic endotracheal tube was loaded over insertion cord up to control section and FOB was inserted through the nose. The bronchoscope was progressed and endotracheal tube was passed through carina using spray-as-you-go technique with 2% lidocaine for topical anesthesia. Once trace of end tidal CO2 was confirmed, the patient was induced with 80 mg of propofol and 6 mg of vecuronium. Maintenance was provided by O2 + N2O and sevoflurane 4%–6%. Intraoperative course of the patient was uneventful and tracheostomy was done at the end of surgery for better toileting and postoperative care. The patient was nursed in high dependency unit after the surgery and was shifted to postoperative ward on 2nd day.

With more and more patients undergoing reconstructive surgery after head and neck cancers, there is an increasing trend of patients coming for revision surgery for flap complications. Such patients are really tricky because...
of problems such as limited mouth opening, deformed airway, inability to classify the difficult airway, loss of bony landmarks, deranged anatomy, ongoing bleeding, secretions, infection, and anxiety. Thorough preoperative assessment and individualization of all cases is utmost important for better anesthetic management.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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