Indian Journal of Anaesthesia | Vol. 54 | Issue 3 | May-Jun 2010

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The clinical diagnosis can be readily made in cases with positive family history of an insidious onset of chorea, dementia and emotional symptoms. We share our experience of managing such a rare case in our day-to-day practice.

A 44-year-old, 70 kg, female, mother of two, with dysfunctional uterine bleeding was posted for endometrial ablation. The patient was apparently fine prior to 10 years, when she noticed increased blinking of eyes and some facial movements, which gradually spread and involved her whole body since the last three to four years. The movements were more in the extremities and patient could not sit still in one place. The movements were less during sleep. She would do most of her household work. This patient with normal vitals and a normal cardiorespiratory system had apparently normal higher functions.

As the procedure was restricted to the uterus we decided to conduct neuraxial blockade. The patient was prepared for the procedure after explaining the details. Oral diazepam 5 mg and IV ondensetron were administered 45 minutes prior. Continuous arm movements made securing of the IV line a difficult task; it was then doubly fixed and fluids infused. The monitors were firmly attached. Her continuous body movements made it difficult for us to give her the required position for spinal anaesthesia. She was made to sit at the edge of the operating table with her legs hanging down and two OT attendants holding her firmly to make lumbar puncture possible. We could get dural puncture at the very first instant, with a 25 gauge needle. 2.8 ml of heavy bupivacaine was then injected to achieve analgesia up to the T8 level. The procedure lasted 50 minutes. Oxygen was administered and no sedative or hypnotic was given. Vitals were stable throughout and no vasopressors were used. She continued to have movements of both her arms and head throughout the procedure, but not of the lower extremities. In the recovery room, she gradually regained the sensations in the anaesthetised parts and within three-and-a-half hours the preoperative movements appeared in the lower limbs. She had an uneventful hospital stay till her discharge on the fourth postoperative day.

There are few case reports published describing the anaesthetic management of patients with Huntington's chorea. Major concerns in management are potential difficult airway, sleep apnoea, risk of aspiration and altered reactions to various drugs. For general anaesthesia, propofol, short-acting neuromuscular agents, nitrous oxide, sevoflurane combined with an opioid and droperidol are safe. Although reported experience with regional analgesia is sparse, spinal anaesthesia has been successfully administered. Reviewed literature showed a higher possibility of complications with general anaesthesia; hence we opted for a neuraxial blockade. The movements of lower limbs slowly reappeared once the effect of the drug wore off. This could be explained, as the pathology in HD lies in the brain and all the pathways are blocked when the neuraxial block is achieved.

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mechanically ventilated patients but are expensive,[1] provide a possible source of contamination[2] and require adjustments in minute ventilation during delivery.[3]

In contrast drugs administration by MDI is easier, faster and provides cost-effective drug delivery. But the direct delivery of the drug into the circuit with MDI is difficult and may be inefficient.

Syringe actuated MDI have been described in past but they may be associated with loss of drug because of impaction on the syringe and catheter walls and mucosal injury due to impact of propellant on the tracheal mucosa.[4]

We describe a simple, indigenous, cheap device which can be used to deliver bronchodilator drugs to the tracheobronchial tree in intubated patients in circuit without leaks [Figure 1]. The nozzle of MDI is removed, smoothened and drilled into a standard right angle connector and fixed with a screw. This assembly is then sterilized before use. The distal end of this angle connector is attached to corrugated catheter mount for flexibility and ease of use. The patient end can be connected to the ETT when required.

This device is easy to use and saves times so, can be handy in emergency situations. We are keeping this device on our emergency trolley and can deliver the bronchodilator drugs to the patients in few seconds with simple sequence pick - attach and deliver.

This device has been successfully used by us - on many occasions to save patients life intraoperatively and in intubated ICU patients.

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**Letters to Editor**

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**Boneless occiput and awake fibreoptic intubation in lateral position**

DOI: 10.4103/0019-5049.65355

Sir,

Tracheal intubation with a patient in a lateral position is not a routine procedure. The use of a laryngeal mask airway (LMA) has been suggested for difficult airway situations with a patient in a lateral position.\[1\] Tracheal intubation using fibreoptic bronchoscope remains an alternative. However, awake fibreoptic intubation with a patient placed lateral has never been described. Nathanson and colleagues suggested such a concept in a manikin.\[2\]

An 18-year-old male with operated 'suboccipital intra-diploic subarachnoid cyst' [Figure 1] was scheduled for ventriculo-peritoneal shunt (VP) surgery. He underwent two different surgeries under general anaesthesia (GA), 10 days prior. In the first procedure, craniotomy and de-roofing of the suboccipital cyst was carried out. Four days later, the patient developed intra-diploic pseudomeningoele with the sub-galeal collection of CSF for which a sub-galeo-peritoneal shunt was inserted. In both the occasions, the airway was secured Figure 1: Indigenous device for in circuit delivery of bronchodilator drugs through MDI. (a) Metered dose inhaler (b) Right angle connector (c) Corrugated catheter mount (d) Nozzle of MDI.