by fibreoptic orotracheal intubation under GA. There was difficulty in mask ventilation during the second surgery, as the patient was placed lateral. Six days later, the sub-galeo-peritoneal shunt was blocked; hence, VP shunt insertion was planned. The patient had restricted extension of neck after the first surgery which comprised cranioplasty, and fixation of the suboccipital bone and cervical spine with a mini-plate and screw. The mouth opening was less than two fingers’ breadth with a mallampatti grade IV. The patient was nursed in a lateral position as the occipital part of the skull was boneless, and because of his comfort on the right side. There occurred bradycardia, whenever the patient was placed supine. Possibly, the external pressure was transmitted to the brainstem or intracranial pressure increased, resulting in haemodynamic disturbances. Hence, it was planned to intubate the trachea with the patient awake, using a fibreoptic bronchoscope in the right lateral position. The patient was very cooperative. The oropharyngeal airway was anaesthetized using 10% lignocaine spray. Fibreoptic intubation was attempted by a spray-as-you-go (SAYGO) technique, using a 2% lignocaine solution. Inspite of a difficult spatial orientation, the fiberscope was negotiated into the trachea. Intubation was successful, albeit, with difficulty in railroading the tracheal tube (Portex, Smiths Medical International Ltd., Kent, UK; size 8.0 I.D.). The total intubation time was 110 s. This was followed by the induction of anaesthesia with a standard technique. Rest of the surgical course was uneventful. At the end of the surgery, the trachea was extubated after reversal of the residual neuromuscular blockade.

Securing an airway in patients with anticipated difficult intubation is always a challenge. To carry out this manoeuvre in a lateral position seems to be more complicated, especially when the patient is awake. The left lateral position results in the deterioration of the laryngoscopic view in 35% of patients, without any improvement.

Anaesthetic trainees found tracheal intubation in the left lateral position more difficult than in supine. However, the left lateral position is preferred to the right for intubation as it prevents laryngeal structures from collapsing. Our patient was comfortable in the right lateral position; hence, intubation was performed in that position. The use of a large donut-shaped pillow could have kept the patient supine, but the problems of boneless occiput might not have been ruled out. Anaesthetizing the airway with a bilateral superior laryngeal nerve block, transtracheal injection of local anaesthetic is feasible, but, difficult to be carried out owing to improper position. Hence, the SAYGO technique was preferred. We feel that it is necessary to learn the art of awake fiberoptic intubation in patients placed lateral. This manoeuvre may be particularly useful while securing airways in neurosurgical patients with a large encephalocele and boneless occiput, as in this case.

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Indigenous neonatal facemask

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Sir,

This report is to highlight how an emergency situation let to the creation of an indigenous mask to overcome...
an emergency situation. Routinely, the Jackson–Rees modification of Ayre’s T-piece breathing circuit with a Rendell Baker Soucek mask\textsuperscript{[1,2]} is preferred for ventilation in neonatal anaesthesia, as this mask has a malleable edge to fit on the face with low dead space.\textsuperscript{[2]}

Following an unfortunate electric short-circuit in one of the paediatric emergency OT, we had to shift the paediatric surgical emergencies to another OT. At midnight, a 3-day-old neonate requiring emergency laparotomy was posted for surgery and as the preparation for anaesthetic induction took place, the neonatal face mask was found missing.

This piece of equipment seems to have been left inadvertently in the disabled OT. Since there was no replacement at that time of the night we created our own indigenous neonatal face mask from empty disposable PVC-made fluid bottle.

The upper part of the bottle (tapering part) was cut transversely [Figure 1a], keeping the diameter of the bottle such that it comfortably covered the nose and mouth of the baby. Now the cap of the bottle, through which the intravenous drip-set spike is inserted, was cut to fit the patient end of Jackson–Ree’s circuit with an angle piece (15 mm) [Figure 1b].

Cotton and an adhesive tape were fixed to the circumference of the ‘face mask’ to prevent injury to the face. We were thus able to ventilate the neonate and proceed with anaesthesia uneventfully.

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