were needed to introduce a nasal tracheal tube. Because of the limitation in mouth opening and the plated jaw, we anticipated a difficult intubation.

The patient declined awake fiberoptic intubation, so we planned to intubate the patient asleep. The surgical team were happy with an oral tube for removal of metal work. Our proposed management was: orotracheal intubation with a videolaryngoscope, if this failed, orotracheal intubation with a Berman airway and fiberoptic bronchoscope, and, if unsuccessful, insertion of a classic LMA.

Anaesthesia was induced with propofol target controlled infusion (Marsh) with a plasma concentration target of \( 7 \, \text{mg} \cdot \text{ml}^{-1} \). Once the patient was unconscious and bag-valve-mask ventilation was established, fentanyl (2 \( \mu \text{g} \cdot \text{kg}^{-1} \)) and rocuronium (0.6 \( \mu \text{g} \cdot \text{kg}^{-1} \)) were administered. The McGrath laryngoscope, which has an antero-posterior width of 15 mm wide, was easily introduced to obtain a Grade 1 view of the larynx. A Frova Airway Intubating Catheter (Cook) was then inserted but required a significant anterior bend in order to reach the larynx (Fig. 1). As a result, the preformed tip of the bougie was almost parallel to the vocal cords when viewed in the sagittal plane. Having just gone through the cords, it was difficult to advance the tip of the bougie. Pushing the proximal end caused it to bend even further hitting the inferior side of the cords instead of running down the trachea. At this point, the bougie was rotated 180°, so that the tip was facing posteriorly and was advanced without the characteristic ‘clicks’ felt from the tracheal rings. It was now sliding against the posterior wall of the trachea.

A 7.5 reinforced tracheal tube was inserted and the black marks could be easily seen at the level of the cords. Oxygen saturation was maintained above 98% at all times. Post-intubation, laryngoscopy was attempted with a Macintosh blade 3 and revealed a Grade 4 Cormack–Lehane view. The surgical procedure lasted around 1 h and the patient was extubated uneventfully. Due to its low profile of 15 mm and the continuous view of the cords, we think that the McGrath videolaryngoscope can be considered for an anticipated difficult airway caused by trismus.

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Retroperitoneal haematoma in a patient with continuous psoas compartment block and enoxaparin administration for total knee replacement

Editor—Psoas haematoma has been previously reported,1–3 but the overall incidence of this rare complication is not clear. We describe a retroperitoneal haematoma without lumbar neuropathy after continuous psoas compartment block (CPCB), in a 77-yr-old man who underwent total knee replacement (TKR) and was treated with enoxaparin for a deep venous thrombosis (DVT).

For the surgery, the anaesthetist performed an L2–3 spinal block injecting ropivacaine 5 mg ml\(^{-1}\) (2.5 ml) and 30 \( \mu \text{g} \) clonidine through the needle and...
the catheter, and an infusion of ropivacaine 2 mg ml\(^{-1}\) at 8 ml h\(^{-1}\) rate was begun for postoperative analgesia. The surgery was uneventful with the patient awake, using standard monitoring. The first dose of enoxaparin 4000 UI was given 10 h after perineural catheter placement. On the first postoperative day (POD), a Doppler study showed thrombosis of the right tibial posterior vein. Elastic-compressive stockings had been worn by the patient and enoxaparin 4000 UI was given twice a day. The perineural catheter was removed on the second POD, 12 h after the last enoxaparin dose, and the subsequent dose was administered 3 h after the catheter removal. On the fourth POD, the patient complained of left iliac fossa pain without sensory-motor deficit. The patient’s condition was stable and a computed tomography (CT) scan diagnosed a 15 × 12 cm haematoma of the left psoas muscle (Fig. 1). Laboratory exam: leucocyte count 14.3 \(\times 10^9\), erythrocyte 2.9 \(\times 10^{12}\), Hb 8.6 g dl\(^{-1}\), and Ht 26%. All the other biochemical measurements were within the normal range. The patient was continuously monitored, enoxaparin was discontinued, and antibiotic therapy was prescribed. By the fifth POD, the general condition was stable, the CT with contrast scan of abdomen and pelvis re-confirmed the haematoma, and a full blood count reported erythrocyte 2.15 \(\times 10^{12}\), Hb 6.4 g dl\(^{-1}\), and Ht 19%. Four units of concentrate red blood cells were transfused. Over the following days, the patient’s general condition was improving and psoas haematoma was progressively reducing. Enoxaparin 4000 UI once a day was recommenced on the 18th POD and a CT scan performed 2 weeks after hospital discharge showed almost complete resorption of the haematoma.

Other authors reported renal subcapsular\(^5\) or psoas haematoma\(^1,2\) after several attempts at placing a PCB block. Both Winnie and colleagues\(^4\) and Chayen and colleagues\(^6\) described needle insertion at fixed distance from iliac crest line and the vertebral column. Capdevila and colleagues\(^7\) proposed a point ‘1 cm cephalad from the point at the junction of the lateral third and medial two-thirds of a line between the spino column passing through the posterior superior iliac spine’. Since these landmarks take in consideration the anatomical dimension of the individual patient, they may be more precise and thus avoid multiple attempts at placement, but this hypothesis has not been studied. Although CPCB offers a more complete block of the thigh and knee,\(^8\) no clinical evidence on better analgesia is reported in comparison with continuous femoral nerve block after major knee surgery. We suggest that it be a more reasonable and less risky analgesia technique than CPCB after major knee surgery.

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Mivacurium in patients with myasthenia gravis undergoing video-assisted thoracoscopic thymectomy

Editor—Video-assisted thoracoscopic thymectomy is widely used in patients with myasthenia gravis (MG) as an option of minimally invasive surgery. Thoracoscopic approach provides reduced pain scores, early mobilization, and diminished length of stay.\(^1\) Different strategies have

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**Fig 1** Abdominal CT scan that diagnosed the psoas haematoma.