Spinal cord stimulation is a well-established and effective treatment for a variety of chronic, intractable pain syndromes, with 27,000 stimulators being implanted annually in the USA alone. Known complications are equipment failure, pain in the region of hardware implantation, infection, and rarely haematomas and spinal cord injury, which necessitate timely, targeted interventions. The true incidence of these complications, however, is not known, although a retrospective analysis using a manufacturer and user facility device experience (MAUDE) database reports the incidence of epidural haematoma as about 0.19%. Subsequent paraparesis after haematoma can prove devastating to the patient as it may, in fact, leave the patient with permanent residual neurological deficit.

In conclusion, lead migration is the likely cause of epidural haematoma, not the needle trauma. In particular, the MRI showed a ‘thin spread’ epidural haematoma. This may explain the spontaneous resolution of the patient’s symptoms, as the haematoma spread along the spine, relieving pressure and preventing compression to any single isolated area.

**Declaration of interest**

None declared.

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**Use of retromolar intubation in paediatric maxillofacial trauma**

Editor—We would like to present the usefulness of retromolar tracheal intubation for airway management in paediatric maxillofacial trauma. A shared narrow operative field, that is, the oral cavity, in these cases necessitates good cooperation between the surgeon and the anaesthetist. The use of retromolar intubation can be a good alternative in airway management for these patients aged <15 yr old (before narrowing of this space by the eruption of the permanent second molar). The room for the placement of the retromolar tube is basically limited by the eruption status of the last molar teeth.

After approval by the ethics committee and informed written consent from the parents, retromolar tracheal intubation was performed in 48 selected paediatric patients with...
faciomaxillary trauma undergoing surgical open reduction and internal fixation under general anaesthesia. The adequacy of retromolar area for this tracheal tube accommodation was evaluated before operation by asking the awake patient to close his or her mouth slowly while an alternative tracheal tube was placed in the retromolar space. All patients were subjected to the same anaesthetic protocol for general anaesthesia and placement of accurately sized armoured oral tracheal intubation was done. After checking the airway pressure, oxygen saturation and bilateral equal air entry; the tube was then placed distal to the last upper molar in the retromolar space and trial of maximum intercuspation was attempted. The tube then was secured in the retromolar space by transdental wiring around the present upper posterior last tooth. Airway pressure, arterial oxygen saturation (\(S_pO_2\)), and bilateral air entry then were checked again before embarking on surgery and the ease of intraoperative centric occlusion with maxillomandibular fixation was evaluated. Data were analysed by using SPSS software using t and \(\chi^2\) tests and \(P<0.05\) was considered significant.

Retromolar intubation was done without difficulties or complications on 48 patients (nine females and 39 males), aged between 4 and 15 yr. The placement and fixation of the flexometallic tracheal tube in the retromolar space was handy without inconveniences. There were no significant differences in airway pressure, \(S_pO_2\), and bilateral air entry with teeth in centric occlusion. It allowed a reliable airway and an unobstructed surgical access to the nose and to the oral cavity with the ease of maximum dental intercuspation (Fig. 1). Intraoperative and postoperative periods went smoothly; all patients’ relatives accepted the procedure and were happy with the avoidance of tracheostomy or submandibular intubation.

Retromolar positioning of the tracheal tube is a satisfactory non-invasive alternative technique for maintaining the airway in paediatric patients with maxillofacial trauma undergoing maxillomandibular fixation without obscuring the operating surgical area to the surgeon or compromising the safety and patency of the children’s airways to the anaesthetist.

Declaration of interest
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