Awake anesthesia: is it valid for all thoracic surgical procedures?

Mohamed Fouad Ismail
Cardiothoracic Surgery Department, Faculty of Medicine, Mansoura University, Egypt

Received 28 July 2007; accepted 21 November 2007; Available online 31 December 2007

Keywords: Awake anesthesia; Thymectomy; Sympathectomy; Thoracoscopic surgery

I read with interest the article titled ‘Awake anaesthesia for major thoracic surgical procedures: an observational study’ [1], but I have some comments about it.

As the authors mentioned that when ‘the chest wall was opened, spontaneous collapse of the lung occurred.’ This is due to the effect of external pressure with the negative intrathoracic pressure. I agree with that but want to ask about the method mentioned for management of this case, as they proposed that a suction tube was introduced at the thoracic cavity causing re-expansion of the lung. Although this hypothesis is correct for thoracoscopic surgery, it is unacceptable for open thoracotomy as was done in 11 patients in this series. During lung resection we need to inflate and deflate the lung; how could it be available without the endotracheal intubation and positive PEEP?

There were two cases of pneumonectomy in that study, one of them was converted to general anesthesia because there was a lesion in the upper lobe. I want to ask about the details of the other case and how did you proceed for pneumonectomy with awake anesthesia?

There were other cases that were converted to general anesthesia. I want to explain how to convert a case of azygous vein injury to general anesthesia and not that case with right ventricular injury. Was the azygous injury as severe to that degree?

The use of midazolam 3–4 mg intramuscularly and fentanyl 50 mcg intravenously [1] as a premedication may render the patient into a sleep anesthesia with spontaneous breathing unless it was not used intraoperatively.

The authors also mentioned that: ‘another important finding in our study is that only 30% of patients required chest tube after major thoracic surgical procedures’ [1]. I found that there is no relation between the awake anesthesia and the using of postoperative chest tubes.

Finally I found this study to be a large one that included different scopes of the field. I think that individualization would be better in this case as to be performed for thymectomy, sympathectomy, thoracoscopic, ... etc.

Major resection is difficult to do with awake anesthesia as it needs a steady field, possibility for inflation and deflation of the lung, and difficult manipulations. Awake anesthesia can be done in restricted cases with contraindications for general anesthesia.

Reference