CORRESPONDENCE

Anesthetic management in Melkersson Rosenthal Syndrome

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Sir,

Melkersson-Rosenthal syndrome (MRS) is a rare, noncaseating granulomatous disorder of unknown etiology and undefined diagnostic criteria. Patients with MRS may have potential difficult airway and laryngeal complications. Here we discuss anesthetic management in a case of Melkersson Rosenthal Syndrome who underwent check curettage under spinal anesthesia.

A 35 years female, primigravida, a known case of MRS and bronchial asthma, was scheduled for check curettage in view of missed abortion. She was on tab. prednisolone 35 mg OD. Clinical parameters within normal limits. She had orofacial edema and a fissured tongue. Patient was shifted to OR after obtaining informed and written high risk consent. Spinal anesthesia was chosen to avoid complications of general anesthesia. Preloading was done with 500 ml of ringer lactate. Supplementary oxygen was given at 4lit/min. Patient was kept warm by using warm IV fluids, warm blankets and also the temperature of the OR was kept constant. Patient remained hemodynamically stable throughout surgery. She was shifted to PACU for postoperative monitoring. MRS is a rare pathological entity of unidentified pathogenesis and equivocal diagnostic criteria,[1] All three classical signs of orofacial edema, facial nerve palsy and fissured tongue,[2] as described by Melkersson and Rosenthal, are not frequently encountered and many patients remain misdiagnosed or undiagnosed for years due to indefinite syndrome subclassification. The annual incidence of MSR ranges between 0.2 and 0.3 in 100000 among various published studies,[3-5] but the rarity of the disease in conjunction with the difficulty in diagnosis makes these estimations quite precarious. Although there is no consensus in therapeutic approach, corticosteroids are generally accepted as the mainstay in MRS management.[3 6,7]

Basic principle in the management of MRS with asthmatic patient is to avoid all factors that may stimulate an allergic reaction. Anesthetic drugs known to trigger urticaria should be avoided in these patients. Anesthesia and surgery commonly cause disruptions of the thermoregulatory process. During surgery, a patient can lose heat through convection, radiation, and conduction. Body and operating room temperatures, which may trigger allergic reactions, were kept constant during the perioperative period by using warm blankets and warm intravenous fluids. Mucosal lesions in the nasopharyngeal airway should be examined if intubation is planned. Anesthesiologists must be aware of MRS as a cause of problematic airway management and regional anesthesia should be preferred to minimize the risk of laryngeal edema. Regional anesthesia avoided the manipulation of the airway, providing a proper sensitive block throughout the surgery with no perioperative complications.

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