Ohio cuffed endotracheal tube previously moistened with sterile lubricant was insertedatraumatically at the first attempt with full cooperation of the patient. Anesthesia was immediately induced with thiopental, 250 mg, and maintained with N₂O–O₂ and succinylcholine infusion. Ventilation was controlled. Vital signs were stable throughout anesthesia and operation. Blood loss was minimal. At the end of the operation the patient initiated spontaneous ventilation. The trachea was extubated and she was returned to the intensive care unit, where she was given humidified oxygen by face mask for several hours. She was discharged from the hospital on the third postoperative day after an uncomplicated course.

**DISCUSSION**

This patient’s respiratory obstruction could have worsened had she been anesthetized and unable to maintain her airway. The tonsils and adenoids were necrotic, friable, and likely to bleed, making the risk of aspiration of blood and infected tissue considerable if the patient is unable to protect the airway. Tracheostomy could have been utilized to assure the airway, but it is associated with significant morbidity and, therefore, was avoided.

Nasotracheal intubation was avoided because the adenoid tissue was thought to be infected. Awake orotracheal intubation was chosen as the method of airway maintenance. This was facilitated by good rapport and enlistment of the patient’s cooperation, adequate premedication with droperidol, which does not depress ventilation, anesthetization of the posterior pharynx to inhibit the gag reflex, and utilization of a lubricated small endotracheal tube. The patient recalled no discomfort associated with intubation.

**REFERENCES**


**Bilateral Hypertrophy of the Coronoid Processes**

**JOSEPH SHURMAN, M.D.*

Limitation of motion of the mandible caused by abnormalities of the coronoid processes is rare. Enlargement of the coronoid processes is most frequently the result of osteochondroma, although other causes may include exostosis, osteoma, hypertrophy, and hyperplasia. Since 1943, 27 cases of coronoid process enlargement, either unilateral or bilateral, have been reported. I was unable to find a report of this entity in the anesthesia literature. A case of bilateral coronoid process enlargement is presented. It is emphasized that the patient may not be aware that the ability to open the mouth is diminished. We were fortunate in that we recognized this problem prior to anesthesia.

**REPORT OF A CASE**

A healthy 44-year-old man was admitted to the oral surgery service with the complaint of increasing inability to open his mouth and pain when attempting to exceed his "normal opening." He related this to a facial injury two years prior to admission, although there had been no facial bone fractures at that time. Examination revealed that he could open his mouth 2.2 cm, a distance that he could not increase even when forced. There was no palpable deformity of the facial skeleton, especially none of the zygomatic arches. Roentgenograms revealed no evidence of previous facial bone injury, but did reveal bilateral hypertrophy of the coronoid processes of the mandible. Otherwise,
physical examination and laboratory studies disclosed no abnormality.\textsuperscript{1}

Surgical sectioning and excision of the coronoid processes were performed with the patient under general anesthesia. Atropine, 0.5 mg, was given intramuscularly as preoperative medication. Cocaine, 4 per cent, was applied topically in the right nasal orifice. Lidocaine, 4 per cent, was sprayed into the posterior pharynx. The lungs were oxygenated and diazepam, 10 mg, was given intravenously. After several attempts, a blind nasotracheal intubation was done successfully. At this time sodium thiopental was given, and anesthesia was maintained with halothane. At the conclusion of operation, and when consciousness had returned, the trachea was extubated.

Early postoperatively, there was no significant change in the size of the opening because of edema. Over the next few weeks, the patient was placed on a vigorous regimen of physical therapy and gradually became able to open his mouth 4 to 5 cm.

**DISCUSSION**

This case is reported to emphasize the importance of the anesthetist's examining the mouth preoperatively. If this is not done, the routine thiopental-succinylcholine induction could end in a catastrophe.\textsuperscript{4–6} In emergency operations, in particular, where the patient has a full stomach and has not been seen preoperatively, there is a tendency to rush, and one may forget to check the patient's ability to open his mouth. Patients with coronoid process enlargement are frequently not aware of their problem.\textsuperscript{1–3} This is especially true of patients with bilateral enlargement of the coronoid processes.

**REFERENCES**