



**Figure 1** (a) Narrow orifice of tube connector (left) as compared to other tube of same size (right), (b) Occlusion of tube connector lumen at the distal end by a plastic meniscus.

connector allowed only a small portion of the gases to flow through and resulted in high airway pressure during ventilation. The substitution of tube connector with another same-sized ETT connector led to marked improvement in ventilatory parameters. These cases show that the ETT connector defects should be kept in mind during differential diagnosis of airway obstruction and further highlight the significance of inspection and testing of the ETT prior to use. They also emphasize on the checking of tube connector externally as well as internally for any physical defects to avoid such complications.

### Conflict of interest

No conflicts of interest declared.

Neerja Bharti  
Indu Bala  
Kiran Sharma

Department of Anesthesia and Intensive Care,  
Post Graduate Institute of Medical Education and Research  
(PGIMER), Chandigarh, India  
Email: bhartineerja@yahoo.com

doi:10.1111/j.1460-9592.2011.03793.x

### References

- 1 Szekely SM, Webb RK, Williamson JA *et al*. The Australian Incident Monitoring Study: Problems related to the endotracheal tube: an analysis of 2000 incident reports. *Anaesth Intensive Care* 1993; **21**: 6116.
- 2 Reddy KD, Naraghi M, Adriani J. Complications from unrecognized defects in endotracheal tubes. *South Med J* 1978; **71**: 783–788.
- 3 Sofi K, El-Gammal K. Endotracheal tube defects: hidden causes of airway obstruction. *Saudi J Anaesth* 2010; **4**: 108–110.
- 4 Hajimohammadi F, Taheri A, Eghtesadi-Araghi P. Obstruction of endotracheal tube: a manufacturing error. *Middle East J Anaesthesiol* 2009; **20**: 303–305.
- 5 Heitz JW, Franze VP. Inopportune breakage of the endotracheal tube T-connector. *Can J Anaesth* 2007; **54**: 958.

## Current state of malignant hyperthermia in China mainland: a less optimistic reality

SIR—Malignant hyperthermia (MH) is a rare life-threatening condition which was first recognized by Denborough and Lovell (1) in Australia in 1960. Since then, it has been found to occur worldwide including in China, the most populous country in the world. In recent years,

with MH-susceptible gene discovered in Chinese patients (2,3) and increasing cases of MH reported, the traditional concept that Chinese people are rarely at risk of MH is unable to be justified. However, the current state of MH in China mainland is far from

optimistic, in terms of underestimation of the incidence, poor diagnostic tests and lack of specific treatment.

First, the incidence of MH has long been underestimated. Because there is not a national MH data base, case reports published on journals have been the exclusive resource for estimating the incidence of MH in China mainland, and the estimation was that 34 cases and 21 cases occurred during the year 1974–2004 (4) and the year 2004–2008 (5), respectively. However, case reports only represent part of the real number of MH because underreporting is common. Building a national data base to bring together MH data may be a choice to obtain a relatively true incidence of MH.

Second, MH patients are almost diagnosed on the basis of clinical manifestations, without specific laboratory tests to confirm them. Only one medical center in China mainland offers laboratory confirmation tests (2). However, the effect that one medical center can take seems to be rather limited when considering this country has the largest population and the third area in the world. Therefore, quite a number of MH-suspected individuals did not receive right treatment because of uncertain diagnoses.

Third, there is no specific treatment for MH. The only known antidote to MH, dantrolene, is still not

available in Chinese market, although it has been widely used for decades in western countries. Almost Chinese MH individuals were treated without dantrolene and this may contribute to a high mortality rate up to 73.5% (4), even though this rate has been reduced to < 10% in western countries.

We appeal that more attention should be paid to the reality of MH in China mainland. A national data base should be established to reevaluate the incidence of MH. Furthermore, efforts should be made to enable specific laboratory tests more accessible to Chinese patients, and dantrolene should be available in Chinese market.

### Conflict of interest

No conflicts of interest declared.

Changsheng Huang, Wonsik Ahn & Qulian Guo  
 Department of Anesthesiology,  
 Xiangya Hospital, Central South University,  
 Changsha, PR, China  
 Email: guoqulian@yahoo.cn

doi:10.1111/j.1460-9592.2011.03774.x

### References

- Denborough MA, Lovell RRH. Anaesthetic deaths in a family. *Lancet* 1960; **276**: 45.
- Xu ZH, Luo AL, Guo XY *et al.* Malignant hyperthermia in China. *Anesth Analg* 2006; **103**: 983–985.
- Wang YL, Luo AL, Tan G *et al.* Clinical features and diagnosis for Chinese cases with malignant hyperthermia: a case cluster from 2005 to 2007. *Chin Med J* 2010; **123**: 1241–1245.
- Wang YL, Guo XY, Luo AL. Analysis of literature reports on malignant hyperthermia in mainland China. *Chin J Anesthesiol (Chin)* 2006; **26**: 107–109.
- Yang Z, Wu XQ, Huang Z *et al.* Retrospective analysis of malignant hyperthermia. *Clin Med (Chin)* 2010; **30**: 8–11.

## Bilateral ultrasound-guided axillary plexus anesthesia in a child with dystrophic epidermolysis bullosa

### Introduction

We report the management of a severely affected toddler with recessive dystrophic epidermolysis bullosa (RDEB), requiring surgery of both hands, with bilateral ultrasound-guided plexus brachialis block and analgesedation.

Recessive dystrophic epidermolysis bullosa is a severe mechanobullous disorder with neonatal onset. Minimal mechanical trauma causes separation of skin

or mucosa from the underlying tissue resulting in blistering, scarification, and consecutive mutilations (1).

Surgical procedures requiring anesthesia are frequently necessary in RDEB. Anesthesia is precarious, especially because of an often difficult airway with microstomia, fixation of tongue, and epiglottis. Airway manipulation can result in additional blistering, bleeding, and scarring. Venous access can be elaborate.