A 39 year old woman ASA I, 75 Kg was admitted for laparoscopic cholecystectomy. Preoperative assessment of airway revealed no abnormalities with a Mallampati I score with a mouth opening of at least 30mm. She referred no previous operations. After sedating the patient with intravenous midazolam 2 mg, anesthesia was induced using 200 mg propofol and 50 mg of rocuronium bromide and fentanyl 5μg/Kg. Mask ventilation was easy and it was performed for 90 seconds with 10 L/min of oxygen and tracheal intubation was initiated. When manual pressure was applied to open the mouth, the opening decreased to about 15mm, making it impossible to insert a Macintosh 3 blade. Subsequently an Airtraq No 3 airway device was used but one attempt to intubate her was unsuccessful so an elastic gum bougie was used through the airtraq. A No 7 endotracheal tube was railroaded and the patient was successfully intubated. Immediately after intubation and 30 minutes later we measured again the mouth opening and it was still 15mm. Surgery was uneventful and anesthesia was maintained with desflurane 5% in 50% N₂O. After reversing the neuromuscular blockade using 4mg/kg sugammadex, she was extubated and the mouth opening returned to the preoperative value.

Discussion

Searching Pubmed we found case reports of limited mouth opening only associated with masticatory muscle tendon-aponeurosis hyperplasia (MMTAH), a disease characterized by limited mouth opening due to contracture of the masticatory muscles as a result of tendon hyperplasia and aponeuroses [2-4], in which the degree of mouth opening can markedly decrease after anesthesia induction [5]. During the preoperative interview of the patient she did not refer anything and her clinical examination both preoperative and postoperative did not reveal any signs of MMTAH.

References