



Anaesthesia for maxillofacial surgery

Head and neck cancer accounts for 900,000 cases every year, with males significantly affected more than women ranging from 2:1 to 4:1 worldwide (1). Primary risk factors have not changed significantly—tobacco use, alcohol consumption, human papillomavirus (HPV) and Epstein-Barr virus (EBV) infection. Globally the incidence continues to rise, with some predictions up to a 30% increase annually in both developed and developing countries (2). Male incidence of oral and oropharyngeal cancer has declined in some countries/regions (Hong Kong 10.5%) whilst increasing in others (Japan 21.3%) (3). Five-year survival averages at 50% worldwide and there has been little change in mortality over the last decade, although this can vary across geographical location, tumour site and stage.

What remains clear is that most head and neck cancers are diagnosed at an advanced stage leading to particular challenges for anaesthesia. Judgement failure and lack of proper airway management plan are still significant causes of morbidity and even mortality (4). It is imperative anaesthetists use advanced knowledge, skills and techniques to improve outcome for these patients.

This series of articles have been written by anaesthetic clinicians experienced in head & neck anaesthesia focusing on a number of specific areas. Awake tracheal intubation is more frequently practiced than ever and needs to be in the armamentarium of all anaesthetists involved in the care of these patients. A variety of ventilation strategies can be utilised to allow a shared airway and optimise patient oxygenation. A backup plan must exist in case of failure of oxygenation and front of neck access must be implemented. Multiple extubation techniques can be used to allow smooth uneventful transition from positive pressure ventilation to awake spontaneous breathing. Enhanced recovery after surgery (ERAS) in head and neck surgery has been shown to reduce intensive care unit (ICU) admissions, shorter hospital stays, reduced opioid consumption and fewer overall complications in some centres (5).

How well these patients are managed by anaesthetists is difficult to measure, simply because successful intubation cannot be the sole indicator of anaesthetic care. The entire perioperative anaesthetic period needs to be managed well in order to avoid morbidity or mortality.

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