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Morbid obesity is considered one of the anaesthetic problems met with. Many methods are used for its measurement, the body mass index **(BMI)** is considered the best .It has manyu aetiological factors beside the mere positive caloric balance .

Many physiological and biochemical derangements are associated with morbid obesity. The most important are the respiratory and cardiovascular deteriorations as well as liver functions, lipid and carbohydrate metabolism. Many systemic diseases are present in association with morbid obesity ,the most important are coronary artery diseases, hypertension and diabetes mellitus.

Most anaesthetic agents are metabolized indifferent way if compared with the lean counterparts. For example inhalational anaesthetic agents are metabolized to a great extent and toxicity hazards are may be more. Thiopentone and muscle relaxants have also metabolic considerations as regards their doses.

Great care should be taken in the preoperative assessment; careful history, clinical examination and investigations should be paid more towards cardiovascular diseases, pulmonary functions and pulmonary diseases as well as endocrinal abnormality

including thyroid functions and diabetes mellitus. History about drugs intake in morbid obesity isalso important

Premedication must not be heavy. Antacids and antisialogogue are important, oral route is preferred.

Anaesthetic management in the morbidly obese patients must consider the problem of difficult intubation, gastric regurge and aspiration, difficult maintenance of airway, difficult vein puncture and the problem of ventilation as well as the special care in the use of muscle relaxant and anaesthetic agents, also the problem of transportation to and from the operating room. Spinal and epidural analgesia could be used but there are certain precautions and difficulties, the later is good for postoperative pain relief. General anaesthesia is better as regard ventilation which should be controlled and oxygen percentage should not be less than 40%. Induction is intravenous after preoxygenation. Monitoring of vital sings is very important.

In the postoperative period, oxygen supplementation in semisitting position is essential together with measures to avoid deep venous thrombosis and pulmonary embolism including early ambulation is very important.