

speculum insertion and had perioperative hemodynamic stability. There was reduction in anaesthetic, analgesic, muscle relaxant consumption in group D. Emergence time and extubation time was less, and there were fewer episodes of postoperative nausea and vomiting and shivering in group D. VAS was less and time for first analgesic was prolonged in patients of dexmedetomidine group. There were few incidences of side-effects like bradycardia and hypotension. **Conclusion:** We conclude that dexmedetomidine as anesthetic adjuvant is efficacious in attenuating nasal speculum response, provides intraoperative hemodynamic stability, decreases intraoperative anaesthetic requirement and hastens early recovery without any serious side-effects.

9. Miracle of a syringe attached to the pilot balloon of endotracheal tube during neurosurgical procedures

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Background: The use of cuff inflating syringe *in situ* results in preventing airway related complications during neurosurgical procedures in various positions. **Materials and Methods:** It is a prospective study including all neurological surgeries done under GA from 2000. The parameters noted were duration of anesthesia and a standard 10 ml of air is used to inflate the cuff to prevent air leak, the remaining amount of air in syringe is noted and the amount of air left *in situ* is noted at the end of procedure. **Results:** In 20% of patients there was an increase in air volume of which 5-10% increase was noted in 2 hrs, 20-25% in 2-4 hrs and up to 50% for surgeries lasting more than 5-6 hrs. We had 5 patients of which 3 patients who had air leak during posterior cervical surgeries and 2 patients had complete tube blockade at bevel end of the ET tube. **Conclusion:** Securing and maintaining the ET tube in long duration procedures and positions other than supine can be difficult as the patency of tube can be compromised also the added risk of using nitrous oxide which can diffuse into the cuff increasing its volume and pressure. Complications like tube blockade at bevel end, hoarseness, laryngeal edema, vocal cord edema, accidental extubation and ventilator malfunction can be prevented. The simple technique of leaving the cuff inflating syringe can help to avoid airway catastrophe as the airway is inaccessible during the procedure.

10. Anesthesia for carotid stenting: Our experience

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Background: Patients with carotid artery disease frequently have other co-morbidities especially cardiac disease. A new option of treatment, carotid artery stenting (CAS) shows lower risk of stroke and myocardial infarction but high incidence of hemodynamic changes during procedure. We reviewed the anesthetic management and complications during and after treatment of CAS. **Materials and Methods:** One hundred and fourteen patients who had CAS over a period of four years from 2009-2013 were reviewed. For conventional common femoral artery approach procedure was done under conscious sedation with midazolam and fentanyl. Oxygen was supplied with nasal prongs. The groin site was anesthetized with local infiltration of lidocaine. Monitoring include ECG, invasive BP, SpO₂. After femoral sheath insertion temporary pacemaker lead was placed and attached to the pacemaker. Prophylactic vagolytic agent atropine 0.6 mg IV was used prior to balloon inflation to block the baroreceptor response. Heparin was given before placement of carotid stent. **Result:** Most of the patients were ASA Grade 3. Common pre-procedure morbidities were Coronary Artery Disease, HT, DM and peripheral vascular disease along with neurological deficits. 12 patients had TIA, 10 with stroke and 1 patient had aphasia. One patient had femoral artery tear at the puncture site, which was secured by Perclose-intra arterial suture. **Conclusion:** Anesthesia for carotid intervention requires protection of the brain from ischemic insult. Attention to physiological factors influencing cerebral blood flow is mandatory. The anesthesiologist plays a crucial role in maintaining hemodynamic stability, adjusting anticoagulation and monitoring neurological status.

11. Comparison of hemodynamic responses to intubation: Flexible fiberoptic bronchoscope versus McCoy laryngoscope in presence of rigid cervical collar simulating cervical immobilization for traumatic cervical spine

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Background: Intubation is known to cause exaggerated hemodynamic response in form of tachycardia, hypertension and dysrhythmias. In cervical spine immobility or instability, intubation has to be performed using cervical immobilization to prevent