

with pacemaker in situ and anaesthetic implications are crucial. We report a successful anaesthetic management of a patient with pacemaker for frontal lobe tumor excision under general anaesthesia. **Case Summary:** 64 year old female with complaints of headache and irrelevant speech since 2 weeks, diagnosed to have frontal lobe tumor. Patient had history of syncope 5 years back and was diagnosed to have complete heart block. Thus a permanent pacemaker with VVI synchronised mode with heart rate 70/min was placed. On examination patient was moderately built, drowsy, heart rate was 68/min and rest vitals were within normal limits. Blood investigations were within normal limits. ECG showed pacemaker spikes just before QRS complexes and LVH. 2D Echo showed pacemaker lead in right ventricle and rest findings were normal. Patient accepted for surgery under ASA grade III with appropriate consent. Preoperatively central line was secured. Facility for temporary pacing and pacemaker technician were kept ready. Pacemaker settings were programmed from VVI mode to VVO mode. Patient was premedicated and induced with inj. thiopentone and inj. rocuronium, intubated and ventilated. Intraoperative vitals were maintained within normal limits. At the end of surgery patient was drowsy but maintained SpO₂ 100%. ET tube was kept in situ and patient was put on CPAP mode. VVO mode reprogrammed to VVI mode. Patient shifted to surgical ICU, all investigations were within normal limits. Patient was extubated in SICU 6 hours postoperatively. **Conclusion:** Neurosurgical patient with permanent pacemaker poses a real challenge to an anaesthetist. Thorough pre-op evaluation and team work of anaesthetists, physician and surgeon resulted in successful outcome.

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Evaluation of prognostic factors of outcome in severe traumatic brain injury patients following decompressive craniectomy

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Introduction: Severe traumatic brain injury (TBI) is leading cause of death and disability globally. Decompressive craniectomy (DC) is done to treat severe brain edema. We conducted a study to determine predictive factors for prognosis of DC at the time of cranioplasty. We correlated the admission variables, CT scan findings and timing of d/c, hospital stay with functional outcome. **Methods:** The functional outcome was noted prospectively and retrospective admission data was obtained from hospital records. All consenting

patients (15-65 yrs) posted for cranioplasty following DC due to severe TBI were enrolled. The data including Marshall grading, admission Glasgow coma score (GCS), mean arterial pressure (MAP), time of DC, duration of hospital stay, hospital readmission and GCS at discharge. The functional outcome at the time of cranioplasty was measured by Glasgow Outcome Score (GOSE) questionnaire. GOSE 5-8 were classified as good outcome and GOSE 1-4 were classified as poor outcome. **Results:** A total 85 patients (71 male and 14 female) were enrolled. The mean age was 33.42 yrs. Only 36% patients had a good outcome (GOSE 5-8). There was no significant association between age, sex, marshall grading, duration between d/c and cranioplasty, hospital readmission, GCS at admission with outcome. In univariate analysis tracheostomy, duration of hospital stay, MAP, timing of DC and GCS at discharge were predictors of outcome. On multivariate analysis tracheostomy was found to be independent predictor of outcome. **Discussion:** Significant disability is seen among the survivors of DC. Admission variables do not predict outcome. Larger sample size is required.

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Non-neurosurgical complications in traumatic neurosurgical ICU patients: A prospective observational study

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Introduction: Recognising and treating non-neurological complications occurring in neurotrauma patients during ICU stay is equally challenging. Primary aim: To estimate various non-neurological complications in neurotrauma patients. Secondary aim: To see the effect of these complications on ICU stay, disability and mortality. **Methods:** Prospective observational study at neurotrauma ICU of level 1 trauma center, AIIMS, New Delhi. 200 neurotrauma patients consisting of Traumatic Brain Injury (TBI) and/or Cervical spine injury (CSI) were enrolled. Period of study: From admission to discharge from ICU or demise. Inclusion criteria: Age >16 years, Severe TBI (GCS≤8), CSI requiring mechanical ventilation. **Results:** Non-neurological complications were frequent in neurotrauma ICU patients. We observed respiratory complications to be of highest occurrence (60.5%). Other complications in decreasing order included dyselectrolytemia (40%), cardiovascular (33.5%), coagulopathy (32%), sepsis (24%), abdominal (16.5%) and AKI (3.5%). Presence of systemic