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Introduction: Cervical meningocele (MMC) is an extremely uncommon congenital spinal anomaly with incidence of 3-5% among spina bifida cystica. These babies also have associated multiple congenital anomalies. Anaesthesia for MMC poses a challenge to anaesthesiologist as one has to deal with infants, difficulty with positioning, airway problems and prone ventilation. **Case Summary:** A 3 month old female child, weighing 3 kg, came with complaint of swelling at the back of neck (3x4 cm) diagnosed as cervical meningocele with hydrocephalus. Patient also had complete cleft palate, imperforate anus and spina bifida. Patient was posted for MMC repair surgery. Patient was brought to the OT and baseline vitals were noted. Premedication in the form of inj glycopyrolate for anti-secretory effect and Inj ondansetron for anti-emetic effect was given. Induction was done with Inj thiopentone supplemented with inhalation induction with sevoflurane. To get ideal position for intubation the head was supported by an assistant to avoid pressure over swelling. The cleft in the palate was packed with a gauze piece. Intubation was done with endotracheal tube no 4. Air entry was confirmed and then inj atracurium was given for muscle relaxation. Throat was packed and tube was tied with a roller gauze. Patient was then given prone position and pressure points covered by soft gamzy rolls. Surgery lasted 2 hours. At the end, patient was reversed with inj neostigmine and inj glycopyrolate. Recovery was uneventful and patient was shifted to PICU for further management. **Conclusion:** Paediatric patients are prone for anaesthetic complications. Early repair of MMC is crucial to prevent sequale. Anaesthetic management in this case focuses on difficult airway management, positioning, fluid management and maintenance of temperature. The case is presented for its rarity and its successful management.

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Comparative study of postoperative pain following general anaesthesia with isoflurane and sevoflurane in spine surgery

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Introduction: Analgesic requirement following spine surgery is not addressed exhaustively, thus offering immense scope for continued research. Volatile anaesthetics have a biphasic effect on pain sensitivity;

they increase sensitivity to pain at low concentrations, and relieve pain at higher concentrations. This study was conducted to compare the differences in post-operative pain severity, duration and analgesic requirements with isoflurane and sevoflurane based anaesthetic regimens in patients undergoing elective spine surgery. We hypothesized that "General anaesthetics administered to provide anaesthesia will not affect postoperative pain and analgesic requirements independently, when analgesics are given in similar doses in the pre- and intra-operative periods." **Methods:** This was a prospective, observational study involving a total of 100 patients randomized into two groups - Group S (n = 50), who were maintained on sevoflurane and Group I (n = 50), who were maintained on isoflurane. Severity of pain of all patients was assessed preoperatively and upto 72 hours after extubation or till discharge using VAS scale and compared. **Results:** The mean preoperative VAS was comparable between the two groups (4.08 and 4.04, $p = 0.889$) as well as upto 4 hours postoperatively. Beyond 4 hours up to 72 hours, the mean VAS was higher in Group S, the difference being statistically significant ($p < 0.05$ at all times). The mean VAS scores were 5.76, 5.68, 4.28, 2.44, 1.52 in Group I and 6.56, 6.56, 5.36, 4.24, 3.96 in Group S at 6, 8, 24, 48, 72 hours respectively. 17 patients in Group I and 34 patients in Group S needed tramadol in addition to diclofenac postoperatively. **Conclusion:** Patients anaesthetised with isoflurane for elective spine surgery have significantly less pain and are pain-free earlier as compared to those anaesthetised with sevoflurane.

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A case series of 5 "awake" craniotomies with intraoperative electrocortical mapping

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Introduction: "Awake" craniotomy is standard for resection of intracranial tumours located near the eloquent areas of the cortex however functional mapping and stimulation in an awake patient is recent. **Case Summary:** We report a case series of 5 patients that underwent an "awake" craniotomy for resection of tumours in eloquent areas of the cortex. All patients were clinically evaluated, airway assessed, counselled, a rapport developed and optimised preoperatively. Functional MRI was done with activation mapped for finger, lip and tongue movement, word generation and counting paradigms. In the operation theatre, pre-oxygenation via nasal cannula was commenced and SpO₂, EtCO₂, NIBP, EKG, BIS monitoring initiated. A