

**Table 2: Intubation score**

Criteria	Evaluation	Score	Group D n (%)	Group PF n (%)	P	Mann-Whitney U-test/P
Anesthesia quality	Asleep, deep sedation	2	19 (100)	20 (100)	1.000	136.000/0.039*
	Slight, resistance	0	0	0		
Vocal cords relaxation	No	0	0	0	0.064	
	In part, middle	1	3 (15.8)	0 (0)		
	Relaxed, open	2	16 (84.2)	20 (100)		
ETT tolerance	Bad, disturbing: Cough, swallowing	0	0	0	0.047*	
	Middle; coughing or swallowing not disturbing the procedure	2	7 (36.8)	2 (10)		
	Good, no coughing or swallowing	4	12 (63.2)	18 (90)		

ETT: Endotracheal tube

Fentanyl combination provided better AFOI condition than dexmedetomidine with shorter intubating time, better intubation score and post-operative profile with SAYGO technique. Both BIS and observer's assessment of awareness/sedation OAA/S are reliable indicators of sedation. Blinded could not be possible and small sample size were the limiting factors.

#### ISNACC-S-25

**A retrospective analysis of pre-operative management of patients presenting for awake craniotomy: Sree Chitra Tirunal Institute for Medical Sciences and Technology experience**

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**Introduction:** Awake craniotomy is performed when the lesions (usually tumour/seizure) are located close to the functional areas of the brain. However, awake craniotomy can pose challenges to the entire team of anaesthesiologist, surgeons and patients as well. We have retrospectively evaluated our experience in the management of these patients. **Materials and Methods:** Institutional Ethics Committee approval and patient consent waiver were obtained. Anaesthetic charts of all the patients who underwent the awake craniotomy in our institute from 2000 to August 2015 were analysed. **Results:** A total of 45 patients underwent awake craniotomy in the above period. The mean age of the patients was 33.4 years, male:female was 29:16. Initial presentation was seizure in 22 patients, speech disturbance in 11, sensory

in 4 and motor symptoms in 14. Premedication consisted of T diazepam (17), clonidine (16), pethidine (3) and haloperidol (9). One patient had airway obstruction and as converted to general anaesthesia. Rest of the patients underwent successful awake craniotomy. Scalp block was administered in 35, laryngeal mask airway was used in 3 (asleep awake asleep) technique. For maintenance anaesthesia, propofol with fentanyl infusion was given in 34 patients, dexmedetomidine in 3, midazolam in 2 and each pethidine and haloperidol in 2 patients. Intro complications were high end-tidal carbon dioxide (EtCO<sub>2</sub>) in 6, tachycardia in 10 patients, hypertension in 25 patients, bradycardia in 5, hypotension in 6 patients. Pre-operative seizures occurred in 10 patients, brain bulge in 3 patients and intraoperative pain in 5 patients. **Conclusion:** Awake craniotomy is a challenging situation. Our experience showed that propofol with fentanyl infusion combined with scalp block was popular. However, in patients with dexmedetomidine, haemodynamic problems were less compared to propofol fentanyl group but the numbers were small to make a useful comparison.

#### ISNACC-S-26

**Cerebral vascular effects of loading dose of dexmedetomidine: Transcranial colour Doppler study**

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**Background:** Dexmedetomidine has been widely used in critical care settings because of its property of maintaining stable haemodynamics and inducing conscious sedation.