tumours, Foramen magnum decompression with fusion, skull base tumours with endoscopic approach, and brainstem lesions. Exclusion – Epilepsy, awake craniotomy, intracranial shunts and cardiac pacemakers. As a protocol muscle relaxant was restricted to Intubation and anaesthesia maintained by benzodiazepine + opioid + propofol infusions, inhalational desflurane minimum alveolar concentration <1, oxygen and nitrous oxide. Train of four was demonstrated after which EP recordings were started. Depth of anaesthesia measured with bispectral index (BIS) monitor. D**iscussion:** In spine cases, somatosensory evoked potential (SSEP), motor evoked potential all limbs and sphincter were monitored. In cranial cases, SSEP, lower cranial nerves, facial nerve (direct stimulation) brainstem auditory evoked potential were monitored. In our series of 100 cases, spine SOL were 37, dethering of cord were 10. Cranial: CP angle approach were 41 cases, Foramen magnum decompression = 3, brainstem lesions = 8, skull base endoscopic transclival approach = 1. Mean time to demonstrate tetralogy of fallot after use of relaxant was 42 min. BIS was maintained between 40 and 45. All patients were within physiological limits (blood pressure, temp, haemoglobin, fluid intake/output and arterial blood gases). **Conclusion:** EP monitoring is a physiological module; hence, the pharmacologically induced anaesthesia technique is a challenge to demonstrate EPs successfully. From a wide choice of anaesthetic agents available, anaesthesia technique was modified and applied with successful recordings of evoked potentials intraoperatively in our series.

ISNACC-C-01

Thiopentone the most effective drug in status epilepticus

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Background: Intractable status epilepticus not responding to convectional pharmacotherapy is a medical emergency. Deeper suppression of cortical activity documented electrocerebral silence and titrable length of time during which such electrocerebral silence can be maintained made thiopentone the ideal drug for initial management of status epilepticus. A long lasting anti epileptic drug regimen can be established during thiopentone induced burst suppression; which then can be tapered and discontinued with minimal chances of recurrence. **Case Summary:** We report a case of viral encephalitis in coma with status epilepticus who was also a known case of Duchene muscular dystrophy. He was also on ventilatory support. When all other antiepileptic drugs were ineffective, thiopentone sodium infusion was started and the seizures were controlled. **Conclusion:** Thiopentone sodium is the oldest drug; yet, it is the most effective treatment in status epilepticus in Intensive Care Unit setting with mechanical ventilation. It reduces the relapse rate and avoids long-term morbidity and mortality with life-threatening emergency. We were successfully able to manage this case with thiopentone infusion.

ISNACC-C-02

Scalp block for drainage of cerebral abscess in a patient with tetralogy of fallot

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Background: Tetralogy of fallot (TOF) is the most common cyanotic congenital heart defect. Such patients are prone to frequent brain abscesses and account for 13–70% of all brain abscesses. The anaesthetic concerns in such patients are to maintain the systemic vascular resistance, reduce the pulmonary vascular resistance and prevent hyper cyanotic episodes intra-operatively. **Case Summary:** A 21-year-old male was admitted in the Department of Neurosurgery at Sir JJ Group of Hospitals, Mumbai with chief complains of headache, vomiting since 2 months and multiple episodes of abnormal body movements since 2 days. The patient was a known case of TOF. On examination, the patient was conscious, oriented with a Glasgow coma scale of 15/15 and was vitally stable with central cyanosis, clubbing and a pan-systolic murmur. Doppler was suggestive of a ventricular septal defect of size 0.7 cm with left to right flow. Computed tomography brain revealed a large space occupying lesion (approxmately 4.2 cm × 5.4 cm × 5.9 cm in size) in left temporal and left parietal region with a midline shift of approximately 13 mm toward right.

The patient was taken in the operation theatre, an 18-gauge intravenous line and appropriate monitors were attached. The patient was given a prophylactic dose of antibiotic, was pre-medicated with injection glycopyrollate, injection ondansetron, injection midazolam with 100% oxygen, was sedated using injection fentanyl and injection ketamine. After

confirming adequate analgesia scalp block was given. Anaesthesia was maintained with injection fentanyl and 100% O_2 via oxygen mask.

Conclusion: Intravenous sedation along with scalp block resulted in a good outcome for this patient, thereby avoiding general anaesthesia and its side effects.

ISNACC-C-03

Perioperative management of a patient with cushing disease undergoing transsphenoidal resection of pituitary tumours

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Pituitary tumours are frequently encountered and comprise of around 20% of primary brain tumours undergoing intracranial operations. Most of them are non-functional, adrenocorticotropic hormone secreting tumours causing Cushing disease are quite few. They are managed medically most of the time, very few require surgical intervention. The perioperative management of these patients is quite challenging due to multisystem involvement. We hereby describe the successful management of a 56-year-old female patient having body mass index = 42 kg/m^2 who had typical features of Cushing disease. Difficult airway was anticipated (MPG-III, short neck, large tongue). Diabetes and hypertension were other comorbities. Other perioperative concerns were positioning, intravenous cannulation, ventilation, haemodynamic stability, extubation and post-operative pain. Careful understanding of the neuroendocrine manifestations and judicious and meticulous planning leads to successful management of the patient.

ISNACC-C-04

Transforaminal injection in scoliotic spine: A challenge in interventional pain practice

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Background: Transforaminal epidural steroid injection is common non-surgical modality of managing lumbosacral radiculopathy. The potential advantage of transforaminal route for epidural steroid injection is the targeted delivery of the drug to the site of pathology, presumably onto an inflamed nerve root. Congenital scoliosis due to hemi-lumbar vertebra with severe radicular pain is uncommon. **Case Summary:** A young male with congenital scoliosis due to L3 hemi-vertebra presented with a 2-month history of severe back pain radiating to right lower limb. Pain was not relieved by rest or by analgesic medications. The orthopaedicians referred the patient to our pain clinic as one of the last resorts before contemplating surgical correction of the scoliosis for a transforaminal steroid injection. After obtaining due consent from the patient, a right L2–L4 transforaminal steroid injection was done under fluoroscopy guidance with 40 mg of triamcinalone. The patient had good pain relief immediately following injection and continues to be pain free with 4 months follow-up. Altered spine anatomy due to hemi-vertebra and scoliosis presented a challenge in recognising the structures under fluoroscopy for performing the injection. The spine rotated due scoliosis, suitable adjustments in the fluoroscope had to be made to appreciate the anatomy for a successful injection. **Conclusion:** Transforaminal epidural injection is a challenge for the interventional pain practitioner in patients with scoliotic spine presenting with radiculopathy.

ISNACC-C-05

Venous air embolism during craniosynostosis repair – Anaesthetic management: A case report

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Background: Craniosynostosis refers to a condition where one or more cranial sutures fuse prematurely leading to focal or global growth delay of the skull. One in 2000 live births may be affected. Surgical intervention should be performed as early as possible to prevent further progression of deformity and potential complications associated with increased ICT. Intraoperative death is primarily a consequence of massive blood loss. Anaesthetic considerations include associated congenital syndromes, difficult airway, invasive monitoring, raised ICT, considerable blood loss, massive transfusion, venous air embolism (VAE), positional injuries.