Case Summary: A 11-month-old, 10 kg female baby presented with deformity of head. She had no other positive findings in the history or physical examination. Investigations were within normal limits. Suturectomy was done under general anaesthesia with controlled ventilation with intravenous induction and maintenance was done with oxygen, N₂O, sevoflurane and muscle relaxants. Peripheral venous access included two 22-gauge cannulae in left upper and lower limbs. Central venous access was secured with 5 Fr central venous catheter (CVC) in the right internal jugular vein. Intra-arterial blood pressure was monitored using left femoral artery catheter. Intraoperatively, there was a sudden fall in end-tidal carbon dioxide (EtCO₂), SpO₂ levels decreased and sudden hypotension developed raising the suspicion of VAE. Immediately, the surgeon was asked to stop the surgery and the surgical field was flooded with saline. Sevoflurane and N₂O were cut down, and baby was ventilated with 100% oxygen. Around 30 ml of frothy blood was aspirated from the CVC. Later, EtCO₂ slowly increased and SpO₂ also improved. Surgery was continued. Blood loss was replaced. Baby was ventilated for 24 h post-operative and extubated successfully in the Intensive Care Unit on second post-operative day.

Conclusion: VAE is a dreaded complication which might arise intraoperatively in surgeries where the surgical field has many open venous channels. Careful and vigilant monitoring is very essential.

ISNACC-C-06

Cardiogenic subarachnoid bleed: A case report

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Background: Ruptured mycotic aneurysms account for approximately 5% of the neurologic complications of infective endocarditis. Rarely, a ruptured mycotic aneurysm can be the first manifestation of infective endocarditis and is associated with an 80% mortality rate. A case of subarachnoid haemorrhage (SAH) with infective endocarditis undergoing successful multidisciplinary management is reported. **Case Summary:** A 41-year-old male presented with sudden onset vomiting, followed by loss of consciousness. Soon after admission, patient developed severe respiratory distress and bilateral coarse crepitations on auscultation. Electrocardiogram showed sinus tachycardia with features of left ventricular hypertrophy. He was immediately intubated and put on mechanical ventilation. Urgent chest X-ray showed features of pulmonary oedema and was administered diuretics. Computed tomography (CT) scan showed SAH and intraventricular hemorrhage. Simultaneous CT angio demonstrated left posterior cerebral artery aneurysm

Figure 1

Figure 2

[Figure 1]. Echocardiography revealed severe aortic regurgitation along with vegetation on the aortic cusps [Figure 2]. Diagnosis of infective endocarditis was made provisionally and started on appropriate antibiotics after sending blood for culture. Once stabilised, he was taken up for definitive treatment. Cerebral angiogram revealed a mycotic aneurysm of posterior cerebral artery which was embolised. He improved over the next few days and was discharged being neurologically intact. One month after discharge, he underwent aortic valve replacement and thus attained complete recovery. **Conclusion:** The overall prevalence of haemorrhage in central nervous system involvement of infective endocarditis is 3–7%. However, SAH or subdural haematoma is rare. The incidence of clinically diagnosed intracranial mycotic aneurysms in patients with infective endocarditis is approximately 2%. When aneurysms form, the most likely mechanism is bacterially induced weakening. Our case report depicts successful management of a rare but fatal disorder through interdisciplinary collaboration.

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Post-operative complication after stereotactic biopsy

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Cancer involving the central nervous system ranks second as the most common malignancy seen in infancy through adolescence. Stereotactic biopsy for histopathological diagnosis has become a standard component of the neurosurgical armamentarium. Post-operative care for this procedure has its own challenges. We report a case of a 9-year-old female patient with history of deviation of the face to the left side for 3 years, minimal drooling of saliva and weakness of the right