

**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, N<sub>2</sub>O, 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 (EtCO<sub>2</sub>), SpO<sub>2</sub> 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 N<sub>2</sub>O were cut down, and baby was ventilated with 100% oxygen. Around 30 ml of frothy blood was aspirated from the CVC. Later, EtCO<sub>2</sub> slowly increased and SpO<sub>2</sub> 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

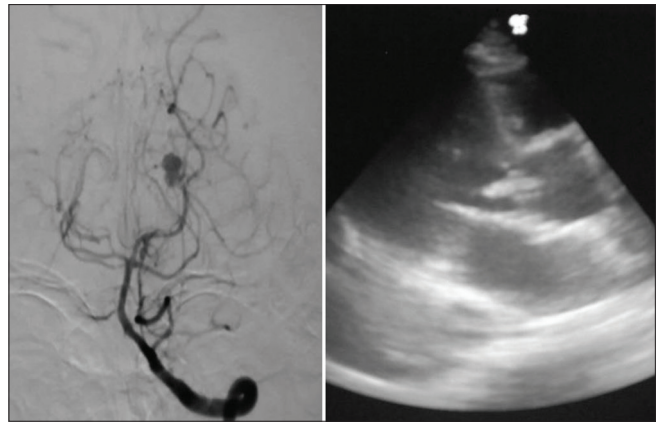


Figure 1

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.

#### ISNACC-C-07

##### 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

hand for 2.5 years, dysphagia for solids and liquids since 3 weeks. On examination, she had right fourth, sixth and eighth nerve palsy, with right lower motor neuron facial palsy (seventh) and right side paresis of SCM (eleventh). On investigation, she was found to have a well-defined enhancing lesion about 1.8 cm × 1.3 cm involving right side of medulla extending to pons. She was posted for stereotactic biopsy under general anaesthesia. The procedure was uneventful. The patient was reversed and extubated. Post-operatively she was unable to swallow secretions and cough adequately resulting in aspiration and laryngospasm/bronchospasm, for which she was reintubated and ventilated. She was extubated on the 6<sup>th</sup> day and discharged after 4 days. Stereotactic biopsy is a relatively safe procedure but studies have shown complications such as post-operative development of new cranial nerve palsies and worsening of existing deficits which could have occurred in our case. At discharge, although the existent cranial nerve palsies persisted, she was able to swallow and expel secretions as she did before surgery. Thus, it is imperative that we need to be updated about the post-operative complications of certain recently developed procedures and plan accordingly.

#### ISNACC-C-08

##### **Perioperative management of uncorrected D-transposition of great arteries with brain abscess: A case report**

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Transposition of great arteries (D-TGA) is the most common cyanotic congenital heart defect in neonate where aorta arises from right ventricle and pulmonary artery from left ventricle. Seizure, sudden cardiac arrest, haemodynamic instability, cyanotic spells, coagulation defects, electrolyte and acid-base imbalance are major complications in such patients. Mortality rate remains very high in these patients. Patients with cyanotic heart disease are prone to develop frequent brain abscess. Here, we want to report management of a patient having cyanotic heart disease (uncorrected D-TGA) presented with multiple episodes of seizures, high-grade fever and severe respiratory distress. Initially, we managed the patient in Intensive Care Unit (ICU) with ventilatory support and antibiotic coverage. After stabilisation, computed tomography brain was planned which revealed ring enhancing lesion in left temporal lobe causing mild mass effect and moderate surrounding oedema with abnormal leptomeningeal enhancement (S/O: Abscess? Tubercular?). Hence, we

took neurosurgical opinion then transferred the patient to operation theatre and planned for drainage of abscess. There was no abnormal intraoperative event. After operation, patient was shifted to ICU and gradually weaned from ventilator and extubation was done. Patient was shifted to ward and was advised for cardiosurgical opinion regarding cyanotic heart disease.

#### ISNACC-C-09

##### **Role of anaesthesiologist in neuroendovascular intervention**

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In recent years, the endovascular treatment of disease of intracranial and spinal vessels has become widely popular. Mostly these procedures are done under general anaesthesia. Hence, choosing an appropriate anaesthesia regimen and careful pre-intervention preparation are most important. The anaesthesiologist can modify and influence the post-intervention outcome. The working environment in digital subtraction angiography (DSA) lab. is quite different from regular OT. Long breathing circuit, long intravenous line and long infusion lines are required for smooth movement of DSA machine. Low ambient temperature is maintained as pre-request for DSA machine. Hence, it is vital to maintain body temperature of the patient by applying heating unit. In DSA lab. All the facilities should be there to address the routine as well as emergency procedures. Short-acting narcotics and muscle relaxants should be used to facilitate the intervention if required for neuroradiologist and anaesthesiologist. After the procedure, the patient should be monitored at least 24–48 h. Pre-interventional and post-interventional complications such as thermo-embolism or haemorrhage must be managed aggressively. The anaesthesiologist plays crucial role to improve the post-intervention outcome. Therefore, good communication, close interaction and cooperation between the anaesthesiologist and neuroradiologist is vital for successful management of these patients.

#### ISNACC-C-10

##### **An unusual cause of loss of brainstem reflexes-barbiturate infusion for status epilepticus**

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**Background:** High dosage barbiturate infusion is commonly used as last resort in patients with