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 6th 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