

in patients awaiting heart transplantation normalizes haemodynamics, improves end-organ dysfunction and exercise tolerance, with a relatively low incidence of major adverse events Thoratec, a continuous flow device need to be anticoagulated with Coumadin. Complications related to this anticoagulation include amongst other bleeding, intracerebral haemorrhage which requires emergent evacuation. **Case Report:** A 27-year-old female with a left ventricular assist device presented for emergent frontotemporal craniectomy, evacuation of intracerebral haemorrhage, partial frontal lobectomy and external ventricular drain placement. Computed tomography scan demonstrated a large right frontal haemorrhage extending into the ventricular system, causing 1.5 cm of midline shift. She had required automatic implantable cardioverter-defibrillator (AICD) placement for recurrent polymorphic ventricular dysrhythmias and reduced EF (20%) in the past after failed ablation. Temporary paddles were placed, and a magnet was placed to deactivate the AICD. In the operating room, anaesthetic induction and intubation were uneventful. She was supported with vasopressors. There was significant blood loss which reduced flows in the left ventricular assist device (LVAD). This was corrected with volume resuscitation with packed cells, Fresh frozen plasma and cryoprecipitate. The primary goal was to prevent further neurologic insult. Thromboelastogram was done which revealed fibrinolysis, and so 1 g of tranexamic acid (TXA) was given. **Discussion:** In summary, the emergent nature of this procedure required rapid optimisation of cardiac, coagulation and neurologic systems in a patient with end-stage cardiac disease. These patients with LVAD require careful management of preload and afterload. Multiple agents to improve her coagulation status were used. TXA is reported to reduce the risk of death from traumatic bleeding but not in intracerebral bleeding. The use of prothrombin concentrate complex in intracerebral haemorrhage is being reviewed.

ISNACC-C-13

An unusual case of paraneoplastic neurological syndrome

S. V. Puppallwar, D. Turnbull

Department of Anaesthesia, Sheffield Teaching Hospitals, Sheffield, UK

Background: Paraneoplastic neurological syndromes (PNS) could be present in 3–5% of patients with small cell lung cancer (SCLC). Coexisting myasthenia gravis (MG) and Lambert–Eaton myasthenic syndrome (LEMS) have been reported in non-cancer patients. LEMS has been reported in 16–40% of paraneoplastic

cerebellar degeneration (PCD) cases associated with lung cancer. Reports of endobronchial ultrasound guided transbronchial needle aspiration (EBUS-TBNA) performed via tracheostomy tube are rare. We report a case initially presenting with symptoms of PNS that underwent EBUS-TBNA through tracheostomy tube for diagnosis of SCLC while still on ventilator support. **Case Summary:** A 75-year-old female was transferred to Sheffield Teaching Hospitals with history of difficulty in walking, leg weakness, respiratory distress, dysarthria and ataxia. Provisional diagnosis was MG, and she was put on pyridostigmine, intravenous IgG and steroids. Computed tomography chest showed a 33 mm suspicious lesion in right hilum. She eventually developed respiratory failure requiring intubation followed by tracheostomy. Due to slow respiratory wean, EBUS-TBNA was performed on Intensive Care Unit while the patient was still being ventilated through tracheostomy tube. Histology results showed that SCLC and chemotherapy with carboplatin and etoposide were started. The patient was successfully weaned off ventilator, decannulated and transferred to ward. Initial repetitive stimulation electromyography (EMG) and single fibre EMG were consistent with MG hence treatment continued for the same. Anti-AChR antibodies, anti-MuSK antibodies and paraneoplastic cerebellar antibody screen were negative. Repeat EMG results after discharge to ward were more in favour of LEMS. Voltage-gated calcium channel antibodies titres were high (254). Hence, patient was put on 3,4-diaminopyridine as well and finally discharged from the hospital. **Conclusion:** This case was unusual in that she had features suggestive of MG, LEMS and PCD and that she underwent EBUS-TBNA through tracheostomy tube while still on ventilator, leading to early diagnosis and chemotherapy.

ISNACC-C-14

Endoscopic skull base surgery-anaesthesia considerations

Pratima S. Kothare

Bombay Hospital and Medical Research Centre, Mumbai, Maharashtra, India

Background: Endoscopic skull base surgeries (ESBSs) present a special challenge to neuroanaesthesiologist for a safe outcome. Specialised endoscopic surgical techniques, equipment and advanced intraoperative monitoring require skill full anaesthesia management specially designed to the needs of minimally invasive fully ESBSs. The aim of anaesthesia is being a balanced technique with adequate depth to have an ideal surgical field, stable haemodynamics, smooth emergence

adds to an excellent outcome. **Summary:** Considering the wide scope of minimally invasive ESBS, there are various anaesthesia challenges encountered perioperatively – unanticipated difficult intubation, airway sharing with surgeon, need for a lax brain, hypotensive anaesthesia, associated metabolic and hormonal disturbances, temperature, etc, all need to be addressed intraoperatively. The aim of anaesthesia is being a balanced technique with adequate depth

to have an ideal surgical field, stable haemodynamic, smooth emergence adds to an excellent outcome. **Conclusion:** A wide spectrum of surgeries is performed by minimally invasive endoscopic approach which requires a customised plan of anaesthesia to provide optimum surgical conditions in a haemodynamically stable patient. Diligent intraoperative monitoring, lax brain, clear operating field and smooth emergence are fundamental in anaesthesia for ESBS.