deviation to right side. She had high-grade fever with chills and productive cough 15 days back, which subsided after taking symptomatic treatment. She was hypothyroid on regular medication with thyroxine. On examination she was conscious, requiring O_2 support by facemask. Power bilateral lower limb was 4/5 and upper limb was 3/5, plantar were mute, sensation was intact with a decreased neck tone on admission. A provisional diagnosis of unilateral Bell's palsy was made, and she was started on oral prednisolone and valcivir. Nerve conduction velocity revealed de-myelinating neuropathy; a diagnosis of GBS was made and intravenous immunoglobulin was started. The patient had increasing difficulty in breathing and inability to vocalize, and hence, trachea was intubated next day. She recovered after 8 days, and trachea was extubated. Gradually, she regained power in upper limbs, improved further, and was discharged to home care 3 weeks later.

Conclusions: Patients with the PCB variant of GBS typically present with areflexia in the upper limbs while preserved power (or mildly affected) in the lower limbs. It indicates that PCB represents a localized subtype of GBS. Very often patients presenting with PCB are initially misdiagnosed as having brainstem stroke, myasthenia gravis, or botulism, which can be excluded from clinical history and examination. This case highlights the fact that GBS should be considered as a differential in all cases of isolated multiple cranial palsies for early intervention.

A008 Effect of Preemptive Midazolam on Post-Electroconvulsive Therapy Headache, Myalgia, Nausea, and Vomiting

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Background: Electroconvulsive therapy (ECT) is a controlled electrical stimulus that affects central nervous system and leads to convulsion. As every other medical procedure, ECT has some side effects like headache, myalgia, nausea and vomiting. Patients undergoing ECT receive different anesthetic drugs and some drugs like midazolam and atropine to reduce side effects.

Results: Sixteen men (42.1%) and 22 women (57.9%) were studied. The incidence of headache ($p < 0.001$), myalgia ($p = 0.014$), and vomiting ($p = 0.011$) was significantly higher in witness group. The incidence of coughing and laryngospasm was not significantly different between the two groups ($p > 0.050$).

Conclusions: Midazolam can reduce convulsion time, but in most cases, convulsions last more than 25 seconds, which is in therapeutic range. So, it cannot affect the therapeutic value of ECT. Preemptive midazolam reduces post-ECT headache, myalgia, and nausea.

A009 Perioperative Anesthetic Management in Rasmussen's Encephalitis: A Retrospective Analysis

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Background: Rasmussen's encephalitis (RE) is a rare syndrome characterized by intractable seizures, progressive neurological and cognitive deficits associated with unilateral hemispheric atrophy. Antiepileptic drugs (AEDs) have limited effect on seizure control. Hemispherectomy of the affected hemisphere has shown encouraging results. However, anesthetic management of RE has never been reported before.

Materials and Methods: Data of all patients who had undergone hemispherectomy in the neurosurgery operation theater from a period of January 1, 2015 to September 30, 2018 were collected. Preoperative, intraoperative and postoperative data were collected.

Results: A total of 15 patients had undergone endoscopic hemispherectomy (M/F 7/8, mean age 12 years). Predominantly, right hemispheric involvement was seen ($n = 12$). Contralateral seventh nerve palsy (upper motor neuron type) was seen in four patients. Six patients had associated cognitive dysfunction, of whom three patients had a history of delayed development of milestones. Six patients had associated hypothyroidism. Intra- and postoperative parameters are summarized in (►**Tables 1** and **2**), respectively.

Conclusions: Various perioperative considerations in RE includes difficulty in assessment of patients with neurological and cognitive dysfunction, associated hypothyroidism, effect of multiple AEDs on anesthetic drugs, difficult extubation, and management of postoperative medical complications. Moreover, majority of patients are children, and demands understanding pediatric cerebral physiology and various perioperative anesthetic considerations.

Table 1 Intraoperative parameters

ASA class I/II/III	9/5/1
Induction of anesthesia (IV/inhalational)	13/2
Maintenance of anesthesia (balanced)	15
Mean fluid intake	2,270 mL (61 mL/kg)
Mean blood loss	365 mL
Most common complication	Bradycardia
Mean duration of surgery	315 minutes
Mean duration of anesthesia	375 minutes
Number (%) of extubation at the end of surgery	6/15 (40%)

Abbreviations: ASA, American Society of Anesthesiologists; IV, intravenous.