

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 O₂ 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.

Table 2 Postoperative parameters

Most common complication	Fever (central origin)
No. of seizure-free patients	9 (60%); transient seizure in rest 6 (40%) patients
Mean duration of MV days	1.5 days
Mean duration of ICU stay	6 days
Mean duration of hospital stay	39.7 ± 21.90 days
Motor power at discharge	Improved in 5 patients as compared with preop, worsened in 5 patients, remained the same in 4 patients
GCS—motor score at discharge	14 patients had M6 score at discharge; 1 deteriorated from M6 to M4

Abbreviations: GCS, Glasgow coma scale; ICU, intensive care unit; MV, mechanical ventilation.

A0010 Perioperative Anesthetic Management of a Patient with Chin-on-Chest Deformity Presenting for Reconstructive Spine Surgery: A Case Report

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Background: Ankylosing spondylitis (AS) can present significant challenges to the anesthetist due to potential difficult airway, cardiorespiratory complications, osteoporotic bones, and increased risk of venous thromboembolism.

Case Description: A 33-year-old woman (50 kg/152 cm) presented with extreme fixed flexion deformity of neck as a sequela of AS and was scheduled for corrective surgery. Sensory and motor functions were intact. On airway examination, mouth opening was found to be 3 cm wide. Evaluation of Mallampati and other airway scorings were not possible. Midline neck structures including trachea were not accessible. Other complicated issues were inability to gargle, lack of landmarks for airway blocks, left-sided deviated nasal septum, and no scope for surgical airway. As a result of anticipated difficult airway, preoperative mock drills were performed. We planned awake fiberoptic intubation (FOI) through the right nostril. On the day of surgery, her airway was prepared using xylometazoline nasal drop, 10% lignocaine spray (orally) and 4% lignocaine nebulization. Awake nasal FOI was performed successfully using “spray as you go” (SAYGO) technique. Induction of anesthesia was achieved with fentanyl (150 µg) and propofol (100 mg). Rocuronium (50 mg) was used during induction. Anesthesia was maintained with O₂:air along with infusions of propofol and fentanyl. No muscle relaxant was administered further in view of motor evoked potentials (MEPs) monitoring. Maintenance of ventilation, circulation, temperature, and DVT prophylaxis were done accordingly. Corrective surgery was done uneventfully with a blood loss of 1,200 mL. The patient was electively

ventilated after the surgery and extubated successfully on second postoperative day. She was discharged on the 14th postoperative day without any neurological deficit.

Conclusions: Ankylosing spondylitis and consequent fixed flexion neck deformity bring forth tremendous anesthetic challenges. In this context, the role of preoperative planning, anticipation of complications, and preparedness to deal with complications may not be over-emphasized.

A0011 Efficacy of Targeted Epidural Blood Patch Treatment for Spontaneous Intracranial Hypotension: A Retrospective Study

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Background: Spontaneous intracranial hypotension (SIH) is characterized by an orthostatic headache due to CSF leak from dural tear at the spinal level. An epidural blood patch is performed for patients who fail to respond to conservative treatment. In this retrospective study, we wanted to study the efficacy of targeted epidural blood patch (EBP) in terms of the outcome at 3 months.

Materials and Methods: We retrospectively analyzed the charts of patients who received EBP for intracranial hypotension from 2013 to 2018. Age, sex, clinical presentation, site of the leak, site of EBP administration, amount of autologous blood injected, an alternative to blood for EBP, whether it was done awake, under sedation or general anesthesia (GA), number of times EBP was performed, duration of hospital stays, and its clinical and radiological recovery at 3 months were collected.

Results: A total of 16 patients received EBP, of whom 15 received autologous blood and 1 fibrin glue. There were 10 male and 6 female patients. The average age was 39 ± 15 years. An orthostatic headache was the main clinical presentation in 14 (87.5%). The diagnosis was confirmed and the leak site was identified by MRI. There were 20 leak sites detected in 16 patients, of whom 2 patients had cervical, 4 had upper thoracic (<T6), 7 had lower thoracic (T6–T12), and 3 had lumbar level leaks. Of the 19 injections, 1 was given at lower cervical and 5 -upper thoracic, 8 -lower thoracic, and 5 at the lumbar level. In 14 out of 16 patients, EBP was given either at the site or one level above or below the level of the leak (targeted), and 2 were given at lumbar level (non-targeted). Fifteen injections were performed in the awake state, two under GA, and two under propofol sedation. Two patients (2/16) received EBP twice, 5 days after the first injection. The average amount of blood injected was 27 mL. Upper thoracic leaks received less blood (20 mL) as compared with other sites. Duration of hospital stay was 5.5 (3–10) days. At 3 months of follow-up, all patients had complete clinical and radiological improvement.

Conclusions: Targeted EBP injection gives complete recovery; both clinically and radiologically. There were no complications of the EBP recorded at 3 months.