

with atlantoaxial instability. We present the management of a patient with the above disorder who underwent multilevel posterior spinal decompression and instrumentation.

Case Description: A 19-year-old male known case of spondyloepiphyseal dysplasia presented with spastic paraparesis and bowel-bladder incontinence. Patient had short stature, exostotic limb, and joint swellings with fixed-flexion deformities. There was multilevel platyspondyly with reduced canal diameters of cervical and dorsal spine. Airway assessment revealed reduced mouth opening and neck extension, and inability to bite upper lip. General anesthesia was induced and laryngoscopy was attempted with videolaryngoscope. However, no part of glottis could be visualized. No further attempts were taken, proseal LMA was inserted. Surgical tracheostomy was done. Patient was positioned in prone and surgery proceeded. Intraoperative course was uneventful. Following completion of surgery, residual neuromuscular blockade was reversed. However, patient developed significant swelling and redness over left forearm due to impaired venous drainage at the level of exostosis elbow joint.

Conclusion: Patients with spondyloepiphyseal dysplasia pose multiple perioperative concerns due to difficult airway, cervical spine instability, restrictive respiratory impairment, and problematic positioning. Meticulous planning and careful management of these concerns will help in providing good perioperative care to these patients.

A030 Pneumothorax: Do not Always Blame the Central Line

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Background: Central venous cannulation is often held responsible for iatrogenic pneumothorax. We present a case where faulty PEEP valve was found to be responsible for the occurrence of pneumothorax.

Case Description: A 50-year-old male, with no known comorbidities, was posted for excision of left vestibular schwannoma. Preoperative investigations were normal. On the day of surgery, the patient was wheeled into the theater and standard monitors were attached. Anesthesia was induced with fentanyl, propofol, and rocuronium. After bag-mask ventilation for 3 minutes, airway was secured with an 8.0-mm endotracheal tube. Chest auscultation revealed bilateral rhonchi with a Shark-fin appearance on capnography; airway pressure was 40 cm H₂O. A diagnosis of bronchospasm was made and was treated by deepening the plane of anesthesia and administration of salbutamol and hydrocortisone. A right subclavian vein cannulation was done, at second attempt. The patient was positioned right lateral position, immediately after which the airway pressure was increased to 37 cm H₂O. Hence, he was reverted back to supine position, but the airway pressure remained persistently elevated. Despite no application of PEEP, it was noted in the monitor

of a PEEP value of 12 to 15 cm H₂O. Ventilation was then performed manually with bag, but the bellows continued to move. At this point, the hemodynamic parameters worsened. A provisional diagnosis of right pneumothorax was made and needle thoracostomy was done followed by placement of an ICD. The hemodynamic parameters improved and airway pressures settled.

Conclusion: Although central venous cannulation is often implicated in iatrogenic pneumothorax, we should look for other possibilities with an open mind. In our case, a diagnosis of pneumothorax was made presumably due to more than one attempt during subclavian vein cannulation. However, further analysis suggested a faulty PEEP valve to be responsible for it.

A031 Perioperative Management of Cerebral Aneurysmal Clipping: A Neuroanesthetic Consideration of Sickle Cell Disease

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Background: Over 30 million people worldwide have sickle cell disease (SCD). Various surgical procedures in SCD have been associated with relatively increased risks of vaso-occlusive crisis, acute chest syndrome, heart failure, cerebrovascular accident, and acute kidney injury.

Case Description: A young adult female was admitted with history of headache and posted for clipping of right MCA saccular aneurysm. Preoperative assessment included 2D echo to rule out any cardiac dysfunction along with routine investigations. All possible crisis triggering factors were reviewed. Blood transfusion was started along with surgery, patient was well managed in intraoperative and postoperative period keeping high suspicion for vasospasm and possible triggering factors.

Conclusion: Use of preoperative blood transfusions should be selective and individualized based on the baseline hemoglobin, surgical procedure and anticipated volume of blood loss. Intra- and postoperative management should focus on minimizing pain, hypoxia, hypothermia, acidosis, and intravascular volume depletion.

A032 Anesthetic Management of an Adult Male with Fontan Physiology for Thoracic Arachnoid Cyst Excision: A Case Report

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Background: Patients with successful corrections for congenital cardiac anomalies present into adulthood with complex cardiac physiology. Here, we report the successful management of an adult with tricuspid atresia, post-Fontan surgery who underwent excision of a thoracic arachnoid cyst with intraoperative motor evoked potential (MEP) monitoring.