

compliance. Postdecompression the patient received staged step down intensive care in the CCU, high dependency unit (HDU), and neurosurgery wards and culminated in the discharge of a functional patient with very little neurological sequelae.

**Conclusion:** A high index of suspicion and a close watch on the anesthesia monitor goes a long way in detecting the occurrence of and ameliorating the effects of VAE during the intraoperative period in neurosurgical patients. Though rare, the embolic event has the potential to cause ischemic injury to the brain which, though commonly arterial, can also lead to an insidious venous infarct.

**Keywords:** venous air embolism, venous infarct, decompressive hemicraniectomy

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#### A021 Incidental Detection of Takayasu Arteritis Presenting as Cerebral Aneurysm with SAH: A Case Report

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**Introduction:** Twenty percent of Takayasu arteritis cases present with central nervous system (CNS) involvement. When CNS disease is present, it typically manifests as cerebral ischemia or stroke. There are rare reports of intracranial aneurysms in adults with Takayasu arteritis. We report the anesthetic management of a patient with Takayasu arteritis with cerebral aneurysm with subarachnoid hemorrhage (SAH) grade 1.

**Methodology/Description:** A 16-year-old female patient weighing 42 kg posted for emergency craniotomy and clipping for ruptured left internal carotid artery (ICA) communicating segment and ICA bifurcation aneurysm with SAH grade 1. Patient presented with sudden severe headache with vomiting. Preoperatively right upper limb NIBP was persistently above 220/110 mm Hg, so lower limb NIBP reading was noted suspecting coarctation of aorta, which was significantly lower (90/60 mm Hg). On auscultation, grade 2 pansystolic murmur was heard in aortic area. Cardiology consultation was taken before proceeding for emergency clipping with the goal of maintaining cerebral hemodynamics and oxygenation, reducing ICP and maintenance of lower limb perfusion to avoid spinal cord ischemia. Intraoperatively, patient's blood pressure was managed with vasodilators and case went uneventful. Postoperatively patient underwent CTA thorax and was diagnosed with Takayasu arteritis grade 4. Patient was discharged with Glasgow Coma Scale (GCS) of E4M6VT with right hemiplegia (MCA territory infarct).

**Conclusion:** Coarctation of aorta or Takayasu arteritis should be suspected in patients with multiple intracranial aneurysms. The goal of anesthesia should be focused on minimizing hemodynamic changes to prevent cerebral ischemia and adequate tissue perfusion to prevent peripheral ischemia.

**Keywords:** Takayasu arteritis, cerebral aneurysm, SAH

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#### A022 ILMA-Guided Flexible Bronchoscopic Intubation Is Associated with Reduced Cervical Spine Motion when Compared to Video Laryngoscopic Intubation

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**Introduction:** The study of cervical spine mechanics during airway interventions is a gradually evolving realm of scientific study in an attempt to limit cervical spine movement during endotracheal intubation. In a similar pursuit, we compared the cervical spine motion during orotracheal intubation using intubating laryngeal mask airway (ILMA)-guided flexible bronchoscopy with intubation aided by video laryngoscope.

**Methodology:** Forty consenting patients without any history of known cervical spine abnormalities posted for elective neuroradiological procedures in the angiography suite were enrolled in the randomized crossover trial. All patients were randomized to both ILMA-guided flexible bronchoscopic and video laryngoscopic-guided intubation. The cervical spine motion was examined using continuous cinefluoroscopy at the following regions: occipital bone, C1, C2, C3, C4, C5 vertebra, the occiput-C1, C1-C2, C2-C3, and C4-C5 junction. The combined craniocervical motion from occiput to C5 between the two intubation techniques was the primary outcome of the study.

**Results:** Analysis of combined craniocervical movement from occiput to C5 revealed lesser movement (62% less) by the ILMA flexible bronchoscopy-guided technique as compared with video laryngoscopy-guided intubation (17.55 ± 14.23 vs. 28.95 ± 11.58 degrees,  $p < 0.001$ ). The ILMA flexible bronchoscopy-guided technique produced significantly lesser movement as compared with the video laryngoscopy at the occiput-C1 (9.75 ± 8.59 vs. 15.00 ± 10.48 degrees,