

Our aim is to compare the efficacy and safety profile of drugs escitalopram and alprazolam as preoperative medication.

Methodology/Description: Forty patients aged between 18 and 60, scheduled for elective craniotomy surgery were included in this comparative study. Patients were randomly allocated into two groups of 20 each. Patients received tab. 5 mg escitalopram in Group E and tab. 0.5 mg alprazolam in Group A orally, 8 hours and 2 hours prior to surgery. Assessment of efficacy variables: anxiety, hemodynamic variables, sedation, postoperative pain, and anterograde amnesia. Anxiety was assessed using Amsterdam Preoperative Anxiety and Information Scale (APAIS). Pain was assessed using Visual Analog Scale (VAS).

Results: It was found that there was a significant difference in mean anxiety levels pre- and postoperative periods in both groups. Immediately before taking to operation theater, that is, 2 hours after drug administration, 5 patients in Group E were more anxious as compared with nine patients in Group A. Patients in Group E were more sedated in the postoperative period with better anterograde amnesia. There was no significant difference in pain scores in both the groups.

Conclusion: The inference drawn by the present study is that orally administered escitalopram produced superior anxiolysis, sedation, and anterograde amnesia compared with orally administered alprazolam.

Keywords: alprazolam, escitalopram, anterograde amnesia

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A052 Anesthetic Techniques for Awake Craniotomy: A Retrospective Review

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Introduction: Awake craniotomy facilitates excision of brain tumors near the eloquent area and requires an awake, cooperative patient. Aim was to review the management for the awake craniotomy patients, perioperative complications, and compare the hemodynamics, neurological monitoring, and complications observed with intravenous infusions, that is, propofol and dexmedetomidine.

Methodology/Description: We retrospectively reviewed the charts of 51 patients who underwent awake craniotomy for tumor excision over past 6 years. Anesthesia management mainly the IV drug infusions and scalp block techniques, perioperative complications, and postoperative course was noted.

Results: Anesthesia was by propofol and dexmedetomidine infusion with scalp block. Hemodynamics were

maintained better with dexmedetomidine infusion; only one had severe bradycardia which resolved with atropine. Propofol-induced desaturation was seen transiently in one patient for which jaw thrust was sufficient. Scalp block was either with bupivacaine 0.25% or inj. ropivacaine 0.2%. None of the patients required the conversion to general anesthesia. Brain bulge was seen only in one patient for which mannitol was administered. Three (5.8%) patients had intraoperative seizures with less incidence in propofol. Forty-two patients had positive localization on cortical stimulation, 23.5% had motor deficits, and 5.8% had aphasia intraoperatively. In one patient, there was propofol-induced neurological deficit which disappeared after stopping the infusion.

Conclusion: MAC with fentanyl, propofol, and dexmedetomidine is the technique of choice in our institute. Patients receiving dexmedetomidine had better hemodynamics but higher incidence of seizures. Propofol can help in the unmasking of the neurological deficits. Mapping of motor and language areas can alert the surgeon for proximity to the eloquent cortex and hence aid in careful tumor resection.

Keywords: awake craniotomy, propofol, hemodynamics

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A053 Comparison of Pressure-Controlled with Volume Controlled-Ventilation in Prone Position in Spine Surgery Patients

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Introduction: Pressure-controlled ventilation (PCV) in comparison to volume-controlled ventilation (VCV) in prone position has shown improvement in lung mechanics in a few studies using frames. However, the effect of ventilation modes on airway pressures and cardiac output in prone position on bolsters which is commonly used in various centers to perform dorsolumbar spine surgery has not been studied. We thus aimed to compare the effect of PCV versus VCV in prone position on lung mechanics, oxygenation, and hemodynamics.

Methodology/Description: Sixty ASA grade I and II patients between age 18 and 65 years, BMI < 30 kg/m² scheduled for lower dorsal, or lumbar spine surgery in prone position on chest rolls were allocated to receive mechanical ventilation using either PCV ($n = 30$) or VCV ($n = 30$) mode. We measured these variables 15 minutes after induction (T0), 30 minutes after prone position (T30), and at the end of surgery (Teos). Primary outcome variable was mean airway