

scalp block was given to all patients with 1% lignocaine and 0.25% bupivacaine. Conscious sedation with a titrated dose of dexmetomidine (0.2-1 µg/kg/hour) provided reversible sedation, mild analgesia, controlled hemodynamics (target SBP <140 mm Hg), a patent airway and spontaneous ventilation. After craniotomy, electrocortical mapping and stimulation was performed to map the eloquent areas, correlating these findings with preoperative fMRI. Functional electrographic mapping and stimulation testing was performed during resection of tumour, to reconfirm the location and check for any new neurological deficit development. Intraoperative seizures, if any, due to electrocortical stimulation, were treated with irrigation with cold saline, titrated doses of intravenous midazolam. All hemodynamic parameters, sedation levels (RASS), intraoperative complications, as well postoperative development of new neurological deficits were noted. All patients cooperated, tolerated and participated for this procedure. Intraoperative and postoperative neurological deficits were noted in none. **Conclusion:** An effective scalp block, combined with dexmetomidine conscious sedation is a safe and effective technique for awake craniotomy for functional testing with electrocorticography. An anticipation and appreciation of likely intraoperative events and interventions required is key. Interdisciplinary team work and collaboration between neurologist, neurosurgeon, neuroradiologist and the neuroanesthesiologist is mandatory for successful outcomes.

#### ISNACC-S-56

**Dangerous liaisons: Pituitary adenoma and aneurysm associations: A case report**

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**Introduction:** The earliest mention of the coexistence of anterior circulation aneurysms and pituitary adenomas dates back to 1959. The coexistence of pituitary adenomas with anterior circulation intracranial aneurysms raises the question as to whether a causal relationship exists. **Case Summary:** A 49-year-old woman presented to our institution with a progressive visual field defect, occasional diplopia and oligomenorrhoea. Neurological examination revealed bi-temporal hemianopia (Left > Right). Hormonal studies showed a slight elevation in prolactin levels. MRI showed well defined solid cystic lesion invading seller and suprasellar region with displacement of B/L optic nerve. CT scan showed a slightly hyperdense lesion in the sellar region and a partially eroded sellar floor. The patient underwent a radical surgical decompression of the sella and

excision of the tumour (prolactin-secreting adenoma) via a transnasal trans-sphenoidal endoscopic approach. Intraoperative controlled normo-tension (Target MAP of 60 mmHg) was maintained with SNP and Esmolol. Patient was extubated (GCS 15/15) and shifted to the ICU. Post operatively she experienced severe headache with vomiting. She underwent MRA and was found to have a ruptured ACOM aneurysm. Supratentorial intracranial aneurysm clipping was performed. Specific attention was given to prevent major hemodynamic changes during the entire surgery. Intraoperatively heart rate, transmural pressure gradient, central venous pressure, SPO<sub>2</sub>, endtidal carbon dioxide, temperature, urine output, blood sugar, arterial blood gas and electrolytes were monitored. The patient was extubated successfully (GCS 15/15) without emergent hemodynamic changes. Postoperatively, we continued SNP infusion to maintain normo-tension. **Conclusion:** The key to the success in managing these dual lesions is modulating the hemodynamic targets for the individual conditions. Excision of the pituitary adenoma perioperatively demands controlled normotension. However, the cerebral aneurysm clipping requires strict control of the TMP gradient intraoperatively till the clipping of the aneurysm followed by controlled hypertension post clipping.

#### ISNACC-S-57

**Catastrophic presentation of venous air embolism in supine position**

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**Introduction:** Air embolism is a common complication during neurosurgery especially in sitting position with incidence of clinically significant venous air embolism around 25-40% followed by prone position. Risk of air embolism is usually neglected in supine position because of very low incidence. We report a case of massive air embolism in supine position during decompressive craniotomy for MCA territory infarct. **Case Summary:** 60 year male patient weighing 70 kg presented for decompressive craniotomy for MCA territory infarct. Patient was known hypertensive since 10 years taking amlodipin 5 mg and presented with GTCS, headache, vomiting since 2 days. Preoperative investigations were within normal limits. Patient was induced with propofol, morphine and vecuronium. Patient developed massive venous air embolism after bone flap elevation which was detected by fall in EtCO<sub>2</sub> more than 2 mmHg within 3 minutes followed by haemodynamic instability. Surgeon was informed about the possibility of air embolism, N<sub>2</sub>O was shut off, patient was ventilated with 100%