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Introduction: Dilated cardiomyopathy is an uncommon yet life threatening complication in acromegalic patients. Anesthetic management can be a challenge in the event of poor preoperative optimization in the event of emergency surgery. **Case Summary:** A 33 year old female patient with visual field defects of the right eye since 6 months was diagnosed to have pituitary macro adenoma and posted for trans sphenoidal excision. The case was an emergency in view of progressive visual loss owing to pressure effects on the optic chiasma. On examination, vitals were stable albeit the presence of B/L basal crepitations. 2D Echo revealed dilated cardiomyopathy with EF = 18% and was started on ACE inhibitors, beta blockers, statins and diuretics 2 days prior surgery. Anesthesia was induced with inj etomidate 0.2 mg/kg, inj fentanyl 2 mcg/kg and inj rocuronium 1 mg/kg. Anaesthesia was maintained with nitrous oxide: Oxygen (50:50), sevoflurane and atracurium 0.25 mg/kg. Dobutamine infusion started at 5 mcg/kg/min, surgery proceeded uneventfully. Vitals were maintained throughout. After the surgery patient was reversed with inj neostigmine 0.05 mg/kg. However owing to poor neuromuscular tone and breathing the patient was electively ventilated for one day. This prolonged action of anesthetic drugs could be attributed to the low cardiac output status of the patient. **Conclusion:** Anesthetic management requires minimal use of anesthetics with minimal perturbations in hemodynamics. Adequate Preoperative optimization and ICU care could help in improving post operative outcomes in acromegaly patients with DCM.

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Acute hypotension as a manifestation of seizures intraoperatively

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Introduction: The most common hemodynamic change observed during seizures is sympathetic activation. But dysautonomia associated with seizures leading to hypotension is also a probability in such situations. **Case Summary:** We report an unusual manifestation of seizures as significant hypotension in a young lady who underwent a transcranial decompression of pituitary macroadenoma. The first episode occurred during the intraoperative period (fall in systolic blood pressure (BP) from 110 to 30 mm Hg) but the clinical manifestations were masked because of general anesthesia and muscle

relaxation. On the second occasion, a GTCS occurred in the intensive care unit with concomitant hypotension (systolic BP falling to 40 mm Hg). Both episodes required vasopressor support to restore BP to normal levels. **Conclusion:** Acute hypotension unexplainable by other causes can be a manifestation of seizure during anesthesia for neurosurgery. Hypotension caused by dysautonomia can produce cerebral hypoperfusion and prolong EEG suppression leading to a vicious cycle. So rapid identification of seizure as a cause for hypotension and its prompt control, can avoid further cerebral ischemia during neurosurgeries.

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Efficacy and safety of priming principle in propofol induction

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Introduction: Reduction in induction dose of Propofol may help in reducing adverse hemodynamic events and anaesthetic cost. In this study the 'priming principle' was used during induction with Propofol and dose requirements and hemodynamic changes were assessed. **Methods:** Eighty ASA I and II patients of both gender, aged between 18 to 55 years planned for elective surgical procedure under general anaesthesia were randomly allocated into equal numbers as two groups: Group P (Priming), Group NP (Non-priming). The calculated propofol dose was 2 mg/Kg. Inj Fentanyl 1 µg/Kg was given to all patients. Standard ASA monitoring and BIS were used. Group P received 20% of the calculated Propofol dose and after 2 minutes the remaining drug was given. In group NP bolus Propofol was given. In both groups propofol was administered at the rate of 30 mg in 10 seconds till loss of verbal response. Inj Suxamethonium 2 mg/Kg was used for intubation. Total dose of propofol, BIS values after propofol administration, hemodynamic parameters including heart rate, blood pressure were recorded before and after induction, 1 minute and 5 minutes after intubation. **Results:** Both groups were comparable in demographics and baseline hemodynamic parameters. The total dose of propofol was significantly less (39.8%) in Group P than Group NP (67.0 ± 17.9 mg; 111.3 ± 17.6 mg; p<0.01). The BIS values at end point were comparable. In group NP heart rate was significantly high and blood pressure values were low in all time points after induction. **Discussion:** The priming principle significantly reduced induction dose of Propofol with less incidence of hypotension. This principle can be useful where minimal hemodynamic fluctuations during induction is warranted.