

have been caused by aseptic meningitis, and microhemorrhage and fibrinogenic components might have been causes of CSF circulation disorder and absorption disorder in the subarachnoid space. This situation may have then led to delayed hydrocephalus. This is a rare case of delayed hydrocephalus after CSF leakage following spine tumor surgery.

A020 Asleep–Awake–Asleep Technique with Endotracheal General Anesthesia in a Patient of Hemiballismus for Pallidotomy: A Unique Challenge

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Background: Hemiballismus is a relatively rare movement disorder. It is usually caused by a lesion that involves the contralateral subthalamic nucleus (STN). Stereotactic pallidotomy is the procedure of choice in the treatment of medically intractable hemiballismus.

Case Description: A 24-year-old female with history of left thalamic and midbrain cavernoma having right sided hemiballistic movements with right sided weakness, underwent craniotomy and excision of cavernoma under general anesthesia in February 2019. Patient got symptomatic relief from hemiballismus for 2 months, again developed hemiballismus of increased severity in spite of pharmacological treatment. Hence, it was decided to go for surgical treatment in form of left pallidotomy. After all preoperative workup, patient was given general anesthesia with standard doses of inducing agent propofol and muscle relaxant atracurium and maintained on sevoflurane. Patient was then taken to MRI and CT scan for mapping of globus pallidus. Patient was shifted to operating room and left sided burr hole was completed under anesthesia. Stereotactically, left-sided pallidus was identified. Wakeup test was done and patient was asked to follow the commands for checking effects of left pallidotomy. After confirming benefits with help of neurologist, permanent pallidotomy was done. Effects of pallidotomy rechecked and patient was taken under general anesthesia again, shifted to MRI for confirmation of lesion of pallidotomy. Patient was then reversed and extubated in operating room.

Conclusion: Pallidotomy presents unique challenge to attending anesthesiologist. Anesthesia was given by asleep–awake–asleep technique. Dexmedetomidine and narcotic based anesthesia was the technique of choice.

A021 Airway Management in Children with Noma Sequelae Undergoing Craniomaxillofacial Reconstructive Surgery

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Background: Noma (cancrum oris) is an exclusive disease of childhood characterized by ulcerative necrosis of

the maxillofacial structures, affecting up to 1,40,000 children annually. It is fatal in 80 to 90% of cases in the acute setting. Survivors are left with disfiguring maxillofacial deformations that make airway manipulation for reconstructive surgery very challenging.

Materials and Methods: Sixteen patients with chronic sequelae of noma, underwent maxillofacial reconstructive surgery at the Noma Hospital for Children, Sokoto, Nigeria. The procedures were done by Medicines Sans Frontiers (OCA) mission. The Each patient posed significant airway challenges due to anatomic malformations, trismus, and restricted neck movements. Lack of preoperative imaging and limited resources added to the challenge. We were able to surmount these with the use of a three-tier hierarchical plan: plan A (intended airway management strategy), plan B (secondary management strategy), and plan C (surgical access to the trachea).

Results: Preoperative workup included measuring thyromental, sternomental, and inters incisor distances, neck movements, and mouth opening. Of the 16 patients in this series, 14 were intubated using plan A. Two required deployment of plan B and none required plan C. We predominantly used fiber optic and nasal intubation for these patients.

Conclusions: Maxillofacial reconstructive surgery for Noma poses a huge challenge to the anesthesiologists, especially in children. Adequate planning, screening, and assessment of the airway with primary, secondary, and back-up plans are crucial. With this strategy in place “cannot intubate, cannot ventilate” situations can be handled during an emergency. Psychological and nutritional rehabilitation is essential prior to surgery.

A022 Hematuria during Lumbar Spine Surgery in Prone Position: A Perioperative Challenge

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Background: Hematuria in patients undergoing surgery in prone position is a perioperative diagnostic challenge, making it difficult to find the source of bleeding in this position. Gross hematuria during this period adds to the surgical blood loss, contributing to morbidity, and mortality. We present a case of intraoperative hematuria during lumbar spine surgery in prone position which was investigated postoperatively.

Case Description: A 35-year-old female patient of ASA class 1 suffered a fall from fourth floor of construction building with impact on her feet. Radiological assessment at the time of admission revealed L1 burst fracture. Transforaminal lumbar fixation was planned on fourth day following injury. Patient was induced and positioned prone. Thirty minutes after commencement of surgery, sudden onset of frank hematuria was noted which continued over 10 minutes, amounting to approximately 400 mL. Surgery was stopped. Following urosurgical consultation, catheter was