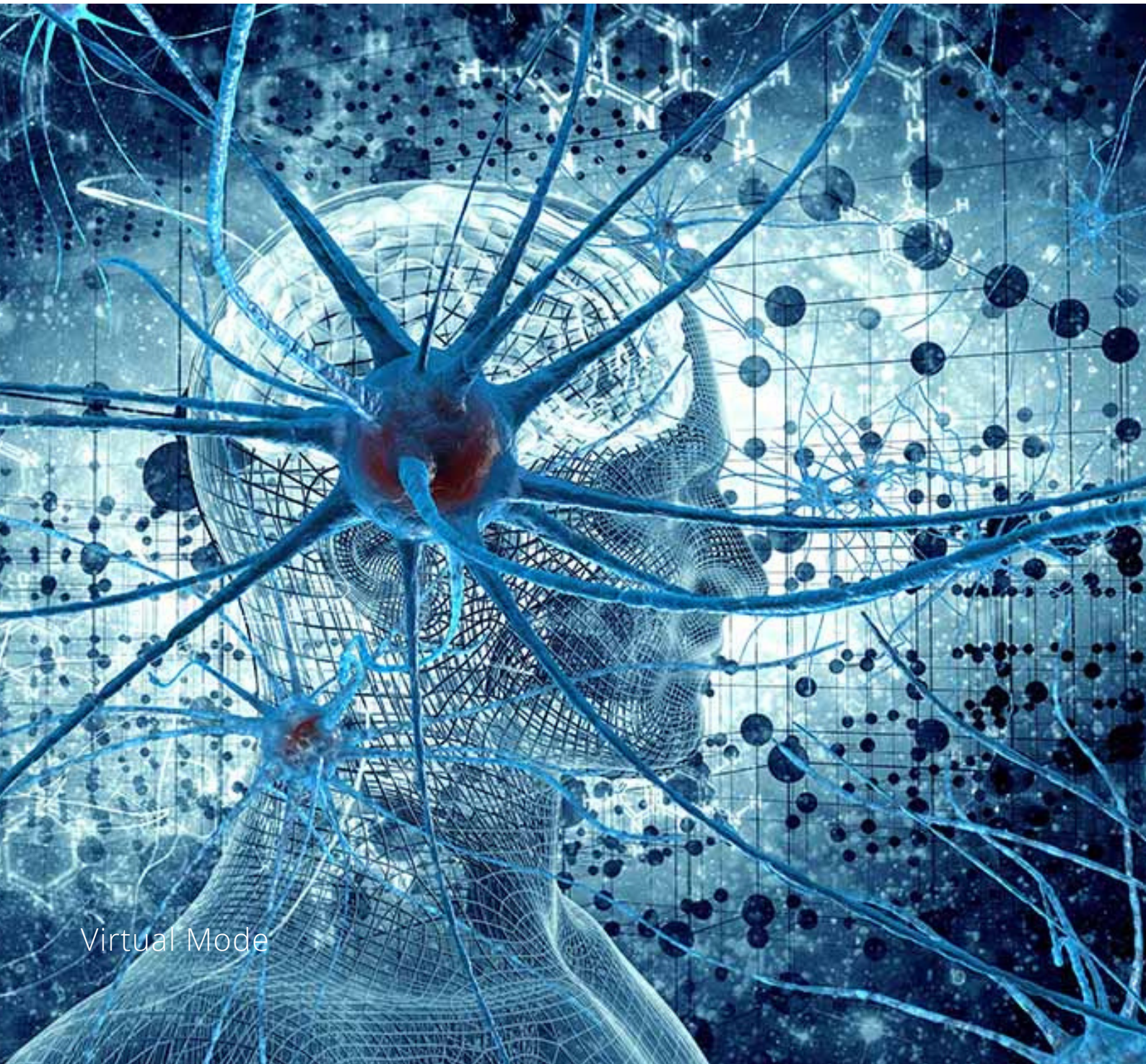


SYNAPSE

JAN, 2022



Virtual Mode



*The official newsletter of the
Indian society of Neuroanaesthesiology and
Critical care*

Secretariat Note

We thank all the ISNACC members for the opportunity given to us to run the office for a period 4 years .



As we say adieu we Congratulate the new office bearers of the society as they assume office to take the society to greater heights in academics , research and practice of Neuroanaesthesiology and Critical care .

Our special thanks to the newer and younger faces of the society whose support we immensely enjoyed and encouraged us to reach newer frontiers .

Special regards to all members who put up their hands to take responsibility and voice opinion to divulge into newer dimensions .

With Regards



Dr Ponniah
Vanamoorthy
SECRETARY

Dr Prasanna
Bidkar
TREASURER



"Some of us think holding on makes us strong, but sometimes it is letting go."

www.isnacc.org

THANK
YOU



NIDHI PANDA

Dear ISNACC members,

I am overwhelmed for the opportunity to serve as the President of the prestigious society: Indian society of Neuroanaesthesiology and Critical Care (ISNACC).

I am thankful to the founder members of the society who with all their efforts and unending dedication established this prestigious society in 1999. The society is growing steadily since then and reached up to 833 marks now. They have prepared a strong foundation in the form of bylaw which has helped in the smooth running of this society for the last 23 years, though few modifications have been done time to time as per the requirement.

The society has contributed a lot in improving perioperative care and intensive care of neurosurgical and neurological patients in India. The level of care provided by us is at par with that of International standard. The society has developed collaboration with multiple International societies for exchange of knowledge in the field of Neuroscience. Our society is helping young anaesthesiologists to train in the field of Neuroanaesthesia (NA) and Neurocritical care (NCC). Various classroom programs have been initiated under the aegis of ISNACC to improve knowledge of the students doing DM, DNB, PDF courses in NA and NCC.

Society encourages research in the field of neuroanaesthesia and neurocritical care by providing research grant to the Neuro-anesthesiologists interested in good quality clinical research in the field of Neuroscience. Our society provides travel grant to the students for presenting their research work at International forums.



FROM THE PRESIDENT DESK

Neurocritical Care Society of India (NCSI) has been established (in 2019) under the aegis of ISNACC to improve the knowledge in the field of Neurocritical Care. Acute Neuro Care program was planned, established and carried out by ISNACC in various cities of India to create awareness about proper care of patients with acute neurological emergencies.

During beginning of COVID 19 pandemic, our society has prepared and published "Position statement and advisory for the practice of NA and NCC, to help all the neuro-anaesthesiologists and Neuro-intensivists of the country to manage these cases during COVID 19 pandemic.

I am proud of ISNACC which is the flag bearer of the Neuroanaesthesia and Neurocritical Care subspecialties of our country and placed itself as a strong society at the International forums. We, the past office bearers of the society are feeling very happy to handover our charges to the newly selected office bearers of the society. I am very confident about the future of this society and its growth as the responsibility has been handed over to a very experienced and dynamic team comprising Dr Rajashree Deopujari as the President, Dr Virendra Jain as Preside elect, Dr Indranil Ghosh as Vice President, Dr Girija Rath as General secretary, Dr Gyanender P Singh as Treasurer and other EC members.

I wish them all the best, to bring the society to the greater heights. I wish that increasing membership of the society from all the regions of the country should be given importance. All the neuroanaesthesia and neurocritical classes for DM, DNB, PDF and PDCC students should be conducted under the umbrella of the society, so that maximum benefit can be provided to the students pursuing neuroanaesthesia and neurocritical care courses with no overlapping of class timings or topics, so that maximum important topics can be covered for the benefit of the students. We can also improve quality of research by doing multicentric studies including national and international academic centers.

At the end I thank all the office bearers who worked with me and made it possible to keep the standard of the society high as expected by the founder members of the society. My special regards to Dr Venkatesh (Past President) for his timely advice and to the dynamic duo Dr V Ponniah and Dr P Bidkar for increasing the standard of the society to a higher level by their progressive ideas and dedicated efforts.

JAI ISNACC, JAI HIND

Regards
Dr Nidhi Panda



THANK
YOU

Npanda



Message of Editor-in-Chief

First issue of Journal of Neuroanesthesiology and Critical Care (JNACC) saw the light of day in year 2014 with the collective efforts of entire neuroanesthesia fraternity. Since then it has not looked back. Now the journal is in its 9th year of publication. JNACC is the only other journal in the medical literature dedicated to Neuroanesthesia and Neurocritical care. Following a humble beginning it has achieved many milestones like, indexing with Directory of Open Access Journals, Emerging Source Citation Indexing and SCOPUS beside, Google Scholar. It is being published regularly with three issues in a year. Its popularity can be gauged from the number of manuscripts which the journal is receiving from all over the world. I am indebted to the researchers for considering JNACC to showcase their research. I am equally grateful to the executive editor, Prof Girija Prasad Rath, various associate editors, the reviewers and the publishers. I have a humble request to all the members, seniors as well as juniors, to work in tandem with one another to propel the journal to the pinnacle of glory.



PARMOD KUMAR BITHAL

I am very confident that it is doable with the active cooperation of all of you.

Wishing all the ISNACC members a very safe and happy new year 2022

Parmod Kumar Bithal



ISNACC GOVERNING COUNCIL

MEET THE NEW OFFICE BEARERS



Congratulations!



President

2022



RAJSHREE DEOPUJARI



SECRETARIAT

Neurosciences Centre,
6th Floor, Room No. 9
AIIMS, New Delhi 110029

info@isnacc.org

Congratulations!



Past-President

2022



NIDHI B PANDA

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Congratulations!



President-Elect
2022



VIRENDRA JAIN



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Vice-President
2022



INDRANIL GHOSH

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Editor-in-Chief



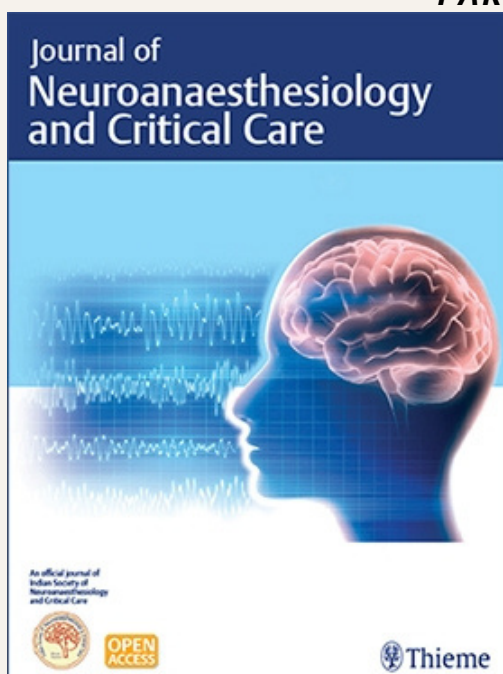
PARMOD BITHAL



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GIRIJA PRASAD RATH
SECRETARY



2022-2024



GYANINDER PAL SINGH
TREASURER



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KESHAV GOYAL (NEW DELHI)



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Congratulations!



*Organising Secretary
ISNACC 2023*

Padmaja Durga



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ISNACC 2020



ISNACC 2020 - CHENNAI



Creating Benchmark

Trend to Future

An exemplary trend setter

SIGNIFICANT
financial contribution
in the history of
ISNACC



V I R T U A L M O D E

I S N A C C 2 0 2 1 w a s t h e b e g i n n i n g
o f n e w e r a o f v i r t u a l o n l i n e
c o n f e r e n c e



ISNACC 2021



**Apart from the scientific
extravaganza substantial
financial benefit of upto
7.8 lakhs was gained in a
short period**

REPORT OF ISNACC 2021

Keeping in mind the safety of the participants owing to the ongoing COVID-19 pandemic, ISNACC 2021 was conducted on a virtual platform from 24th-26th January 2021 by the members of ISNACC. Even though the international borders were sealed due to pandemic, the participation of the international faculties and delegates was overwhelming. Nearly 400 delegates attended the conference. The major attractions for the residents were various informative workshops, PG symposium, PBLDs, and the quiz moderated Shobhana Rajan and Dr. Tumul Chaudhary. There were more than 60 poster presentation in various categories. For the first time Prof. VK Grover award was introduced. The highlights of conference were the didactic lectures, panel discussions, orations, and video presentations.

Day 1 commenced with a welcome address by the ISNACC secretary, Dr. Ponniah. The first session shed light on the nuances of the relationship between carbon dioxide and steno occlusive disease, management of cerebral vasospasm and acute kidney injury in neurosurgery. The second session of scientific talks resumed after the inaugural ceremony. The faculties shared their experiences with jugular venous oximetry, NIRS guided therapeutic interventions, and choice of anaesthetic agents in head injury. The third session of the day was dedicated to debate about anaesthetic agents being neuroprotective or neurotoxic, and whether intraoperative goal directed fluid therapy was the road to adopt or not.





ISNACC 2021

The SNACC panel was our greatest attraction. This year's theme was "harnessing technological innovations for patient safety in neuroanaesthesia". This was followed by brain storming sessions on cerebral autoregulation guided therapy to improve outcomes in sepsis, and lectures on processed EEG and states of consciousness. Dr. Deepak Sharma spoke about his inspiring work on a simulation based TCD innovation to improve patient safety.

Followed by video presentations on pupillometry and USG assessment of DVT. The post lunch session commenced with an insightful talk on telemedicine in neuroanaesthesia. Following that the pros and cons of using prognostic calculators in neuroanaesthesia, and a panel discussion on multimodality monitoring in traumatic brain injury.

The next session many renowned faculties Dr. Basil Matta, Dr. Martin Smith, and Dr. Wade Smith delivered engaging talks on lessons learnt from the COVID pandemic with respect to monitoring the brain and optimising sedation and oxygenation, pitfalls of incorporating perioperative research into clinical practice, and the role of neurointensivists in the management of large vessel stroke. The next sessions enlightened us on significant research in the field of perioperative neuroscience in the year 2020, fluid therapy with inimitable ease.

The prestigious Dr. Harivir Singh oration was delivered by Dr. Andrew Kofke. He deliberated on the layered and complex subject of intracranial hypertension at length and opened new horizons for us.



Day 2 commenced with the PG symposium. The second sessions highlighted perioperative management of direct anticoagulants in neurosurgeries, the impact of anaesthetic agents on survival of brain cancer patients, the myriad neurological complications of COVID-19, the prevailing concepts of perfusion pressure breakthrough after surgery for AVM, and TEG.



ISNACC 2021

22nd Annual Conference of The Indian Society of Neuroanesthesiology

The fourth session of the day started talk on optimisation of intraoperative electrocorticography. Followed by the anaesthetic management of patients with prior stroke for non-neurological surgery, and perioperative risk stratification in neurosurgical patients. The next session included airway challenges in acromegalics, brain death certification, and perioperative management of endoscopic neurosurgical procedures. The post lunch session commenced with trips and tricks of cerebral protection during aneurysm surgery followed by management of an intraoperative “angry” brain, and intraoperative evoked potential monitoring in a neonate scheduled for MMC repair. The next session was a medley of interesting and contentious subjects including the feasibility of thromboprophylaxis in neurosurgical patients, the perioperative challenges in management of a newborn with vein of Galen malformation, and hemodynamic monitoring in neurosurgery in sitting position. The next session commenced with weaning strategies in tetraplegics, cogitations on anaesthesia and cognitive outcomes in the elderly, and the choice of vasopressors use in neurosurgical patients. The following session started with the use of TCD in neurocritical care, the strengths and limitations of big data research in clinical neurosciences, and differences in outcomes of emergent neurosurgical procedures when performed at day as against those performed at night. The prestigious Dr. Malati oration was delivered by Dr. David Menon, who highlighted rational approaches to management of a traumatic brain injury in a brilliant, well rounded session. The penultimate scientific session of the day included the lecture on use of intravenous anaesthetics in the management of refractory and super refractory status epilepticus, and neural inertia during anaesthesia.

Kiran Jangra
Associate Professor
PGIMER, Chandigarh



The final day of the virtual conference began with another PG symposium session.

The second session of the day began with the perioperative considerations of advances in endovascular neurosurgeries, the hemodynamic targets before, during and after interventions for acute stroke, and the perioperative temperature management in neurosurgical patients. Dr. Kavita Sandhu delivered the prestigious **Dr. Gode oration** on lessons learnt and unlearnt in the neuroanaesthesiology practice in the last decade. It was a beautifully nuanced and enlightening session.

The next session was the pros and cons of opioid free anaesthesia and balanced anaesthesia and age old controversy about normal saline and balanced salt solutions in the setting of neurosurgeries. This was followed by a panel discussion on why and when an elective neurosurgery should be deferred. The post lunch session commenced with the evolving options for post-operative pain management in spine surgeries, targeted perfusion therapy in SCI, management of neurogenic shock beyond fluids, and the use of nitrous oxide in the practice of neuroanaesthesia. The next speakers enlightened the audience on the common problems associated with and how to troubleshoot them during intraoperative neuromonitoring and artificial intelligence in anaesthesia, and intensive care unit followed by videos on sitting position and optic nerve sheath diameter measurement. There after a panel discussion, featuring senior neuroanaesthesiologists from across the country, who deliberated on how the COVID-19 pandemic affected teaching and training in neuroanaesthesia. The final session of the day included an excellent talk on the use of volatile agents for sedation in ICU, cross talks between inflammation and coagulation in sepsis, and perspective on decompressive craniectomy. The valedictory ceremony announced the winners of the final round of the quiz and the winners in various categories of paper and poster presentations.

The conference proceeded seamlessly on virtual platform with mild hiccups in between, and was a great academic extravaganza for both novices and experienced neuroanaesthesiologists.



"ENVISAGE, INNOVATE, IMPLEMENT"
- The Art of Neuroanaesthesia and Neurointensive care



23rd Annual National Conference of
INDIAN SOCIETY OF NEUROANAESTHESIOLOGY
AND CRITICAL CARE

ISNACC 2022 - KOLKATA | 21st - 23rd Jan



ISNACC 2022 WAS



Organised By
Neuroanaesthesiologists of Bengal
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ISNACC2022

ICPNT

- International Council for Perioperative Neuroscience Training
- Based on CAST (committee on Advanced Specialty Training) a Neurosurgery society
- Overseen by SNACC
- International Option
- Not reliant on government support

ISNACC 2022 - KOLKATA
22nd Jan 2022 - Day 3 Hall B

"ENVISAGE, INNOVATE, IMPLEMENT"
- The Art of Neuroanaesthesia and Neurointensive care

ISNACC 2022 - KOLKATA
23rd Jan 2022 - Day 3 Hall A

Dr. Srihita M
Topic: Awake craniotomy in skull base surgery

ISNACC 2022 KOLKATA • 4/12

OUTLINE

- Definitions
- Pathophysiology
- Rationale for aggressive treatment- why?
- Prognosis
- Treatment options
- Role of Neuro-anesthetist/Intensivist
- Summary

ISNACC 2022 - KOLKATA
21st Jan 2022 - Day 1 Hall A



COVID-19 AND NEUROANAESTHESIA

A TRAINEE PERSPECTIVE

BY NIDHI SINGH



DR. NIDHI SINGH
SENIOR RESIDENT
NEUROANAESTHESIA
DEPARTMENT OF ANAESTHESIA AND
INTENSIVE CARE
PGIMER, CHANDIGARH, INDIA

The COVID-19 pandemic has hit our lives as residents in unprecedented ways. Learning in fields like Neuroanaesthesia where we learn “on and with” patient have been profoundly affected. Residency is a peculiar phase in doctors’ life—they being young, staying away from home, with lower work experience and high load of work commitments. With the pandemic all-around and the anxiety and confusion in the masses, the work demands at the hospitals have increased causing psychological stress and fear of getting infection.

In April and May last year, on one side were deserted streets, quiet cities, closed malls, vacant eating places, and on other side were bustling covid wards with hue and cry all over. The huge number of patients who poured into hospitals strained on the limited means and resources in Indian hospitals. With major chunk of neurosurgical cases being emergency or semi-emergency, it was difficult to decide which ones to operate and which ones to postpone.

As DM residents we were already struggling with the long duties hours, research work and academics – overworked and burnt-out -- and then the pandemic banged to make things worse. With alternate days off, duties felt good in the beginning but we rapidly realised how covid had disrupted almost every domain of our lives.

We worked amidst the news of our batchmate's husband getting critical, a friend's father succumbing to the deadly virus, a colleagues' whole family including an infant and parents getting admitted to the covid facility, a friend giving MCH exams online from Covid ICU while being on Venturi mask. A long day at work would make us so exhausted that a trivial cough would cause anxiety about we ourselves getting infected. For each of our friends who fell ill or was put in quarantine, an additional burden was placed on the fellow colleagues. Walking and working in PPEs is no longer seen in movies—we are living this life every-day. While on Covid duties, urging conscious patients to lie prone or lateral as much as possible, to have their oxygen devices on even if it was uncomfortable, reassuring them that things will be fine when we knew too deep in our hearts that they are deteriorating and are going to die soon, has not been easy.

Thinking that this dying patient is of our age only, knowing that the breathless father is the only bread-winner for his young wife and an infant and trying to stop ruminating and keep working without emotions has been disturbing. It has been difficult to move a patient off the ventilator or to refuse an ICU bed due to limited resources.

Our training as Neuroanaesthesia residents has received a setback. The considerable decline in patients presenting to hospital for non-urgent cases, suspension of elective OTs and limited physical case presentations has adversely affected the clinical work experience. Our surgical counterparts have had less free-hands, having performed less surgeries. The final year batches who are expected to acquire certain skills and competency before working independently are especially affected. We have decreased experience of managing specific elective cases and procedures such as patient of DBS, awake craniotomies, neuromonitoring and awake fiberoptic intubation. There are added concerns of keeping ourselves up to date about the pandemic, ways to safeguard against it and information of safe donning and doffing.

Examinations have been another challenge during the medical learning process. While postponement of exams caused confusion and distress amongst seniors, the junior batches who joined the hospital had to face a dramatic increase in physical, emotional and social workload overnight making them doubt their choice. With most experienced physician doing major procedures, the learning opportunities have decreased. The detailed routine preoperative check-ups in pre-anaesthesia clinic prior to surgery have been stopped but that has meant getting more unoptimized cases done, which is stressful for us as well as the patient. For emergency cases where there was not enough time to rule out Covid-19 infection, we were instructed to get cases like mechanical thrombectomy for stroke, EDH evacuation etc. done "with full protection" but this was easier said than done.



Academics and research work too have suffered a set-back. Online teaching and assessment and virtual learning tools were the only and quite reasonable alternatives to traditional teaching. It allows us to undertake the learning in our own times i.e. even after a night duty from the comfort of home. Most of our faculties which earlier could not physically attend the classes due to demands of OTs could now connect online. However, distractions in during online classes due to attending classes through unspecific locations is also concerning. Also many practical classes like those of neuroanatomy, ECHO, TEE, TCD, BLS, ACLS etc. were conducted online making understanding of concepts difficult. Transition from routine to online classes has made us realise that there is no substitute for clinical and hands-on experiences.

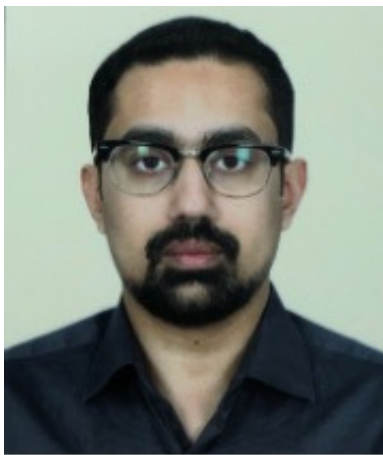
As they say, "Every cloud has a silver lining", Covid times have made us realise the importance of wholesome health and mindset and the importance of the family by our sides which we have always taken for granted. We have to be psychologically strong even after having enormous negative vibes around due to pandemic. Publications and studies don't get happiness if one is in ill-health. Witnessing this pandemic made us more aware of importance of sterility in hospitals, frequent disinfection of surfaces and the spread of infection. The general public realised the importance of frequent handwashing. These difficult times have paved the way for digital technologies which have come up in a big way to support teaching and learning. Till now the radiologist were heard working remote from hospital, but increased reliance on tele-OPDs, virtual intensive care, remote monitoring, online cross-consultations is being placed these days. In near future, who knows "work from home" may be possible for doctors as well! But it will never happen and should not happen for the residents and trainees. During this impactful pandemic affecting public health at large, there have also been moments of greater level of satisfaction at work and deeper feeling of purpose. It was an opportunity to learn something new on pandemic preparedness, management, and coping skills as a healthcare professional.

Covid-19 has strained the healthcare system and we are already pushing ourselves to the limit. The way to ease out things include communication with friends and family members, physical exercise, meditation and relaxation techniques, eating healthy food, good sleep, having some hobby and opting to stay away from negative news. Years down the line we may be proudly telling to our future generations how we steered through our residency with covid around. With hopes that the things will get better soon, my respect and endless gratitude goes out to all my fellow colleagues who are pushing themselves to their limits to meet the extraordinary demands of healthcare despite personal risk.



WHATS NEW ?

PUBLICATIONS IN NEUROANAESTHESIA



Neuroanaesthesia, as a field, has come a long way since its inception but the central nervous system still remains a mystery in many aspects. Optimal management of patients with neurological insults still remains challenging. High quality research has been at the forefront of addressing questions related to our understanding of the disease process and optimal management of neurologically impaired patients. In this section, we try to further our understanding into the diagnosis and management of such patients with a few recent research papers delving into pertinent questions of the time.

Optimal Hemodynamic Parameters for Brain-injured Patients in the Clinical Setting: A Narrative Review of the Evidence

Kan Ma, John F. Bebawy

J Neurosurg Anesthesiol 2021;00:000-000. DOI: 10.1097/ANA.0000000000000752

in their review article, titled 'Optimal Hemodynamic Parameters for Brain-injured Patients in the Clinical Setting: A Narrative Review of the Evidence', try to address an important question with regard to optimal blood pressure (BP) management in patients with neurological insults. Several evidence based guidelines for optimal BP management are available for various neurological conditions, however, none have been able to definitively establish the ideal BP targets. BP management has to be weighed with regard to maintenance of optimal cerebral perfusion pressure against the risk of hemorrhagic conversion/vasogenic edema in conditions like traumatic brain injury, spontaneous intracerebral hemorrhage, aneurysmal subarachnoid hemorrhage and acute ischemic stroke. Moreover, individual variation in the limits of autoregulation and the variable degree of impairment of autoregulation in brain injured patients make BP management challenging. This article is a comprehensive review that sheds more light with regard to optimal BP management in brain injured patients.

WHATS NEW ?

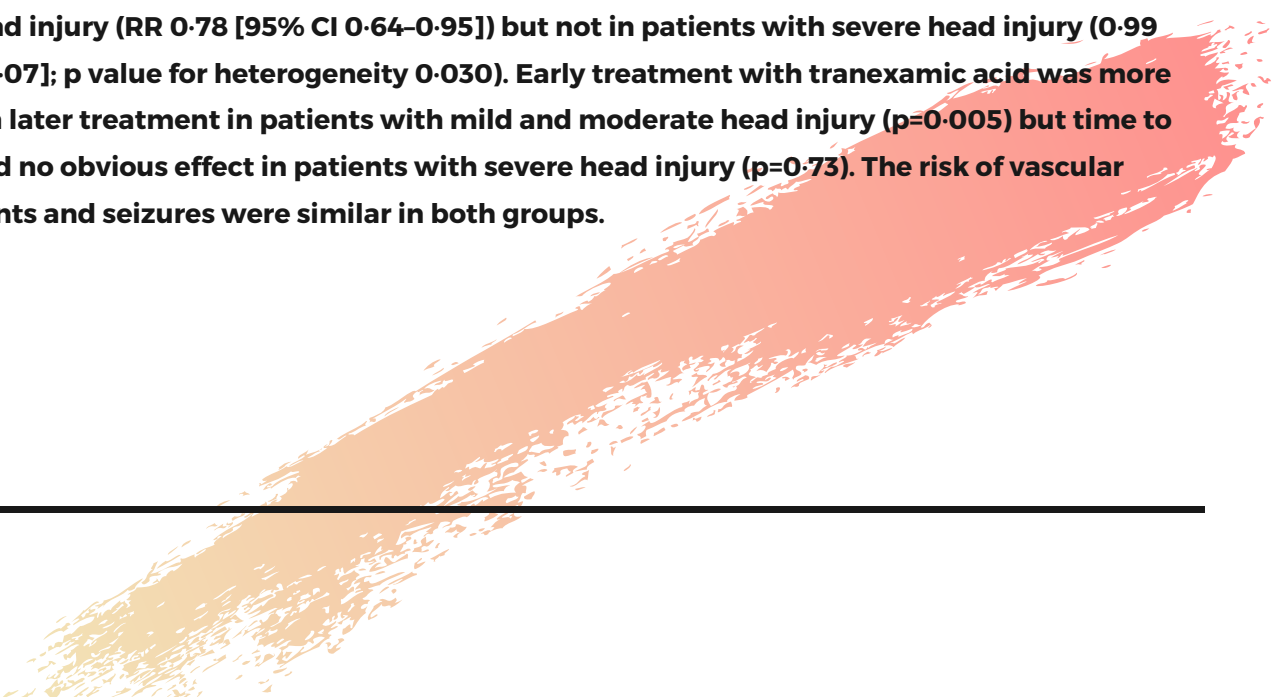
PUBLICATIONS IN NEUROANAESTHESIA

Effects of tranexamic acid on death, disability, vascular-occlusive events and other morbidities in patients with acute traumatic brain injury (CRASH-3): a randomised, placebo-controlled trial

The CRASH-3 trial collaborators

The Lancet. 2019. Journal of Emergency Medicine. 2020 Jan 1;58(1):171-2. DOI: 10.1016/S0140-6736(19)32233-0. (Published online October 14, 2019)

The authors of the CRASH-3 trial in their paper titled 'Effects of tranexamic acid on death, disability, vascular occlusive events and other morbidities in patients with acute traumatic brain injury (CRASH-3): a randomised, placebo-controlled trial' have studied the role of the antifibrinolytic drug, tranexamic acid in traumatic brain injury (TBI) patients on its effect on reducing 28 day mortality. 12737 patients with TBI were randomized to receive tranexamic acid (50.3%) or placebo (49.7%), of whom 9202 (72.2%) patients were treated within 3 h of injury. After exclusion of patients with baseline GCS score of 3 or bilateral unreactive pupils, the risk of head injury-related death was 12.5% in the tranexamic acid group versus 14.0% in the placebo group (485 vs 525 events; RR 0.89 [95% CI 0.80-1.00]). Tranexamic acid showed benefit in reducing the risk of head injury-related death in patients with mild-to-moderate head injury (RR 0.78 [95% CI 0.64-0.95]) but not in patients with severe head injury (0.99 [95% CI 0.91-1.07]; p value for heterogeneity 0.030). Early treatment with tranexamic acid was more effective than later treatment in patients with mild and moderate head injury (p=0.005) but time to treatment had no obvious effect in patients with severe head injury (p=0.73). The risk of vascular occlusive events and seizures were similar in both groups.



WHATS NEW ?

PUBLICATIONS IN NEUROANAESTHESIA

Diclofenac Is Superior to Paracetamol in Postoperative Pain Scores and Analgesic Consumption in Supratentorial Craniotomy With No Difference in Platelet and Clot Function: A Prospective Randomized Controlled Trial

Ragula Rajkiran, Shiv Lal Soni, Kiran Jangra, Hemant Bhagat, Ajay Singh, Apinderpreet Singh, Nidhi B. Panda, Narender Kalaria

J Neurosurg Anesthesiol 2021;00:000-000. DOI: 10.1097/ANA.0000000000000765 (Published online, ahead of print)

The use of nonsteroidal anti-inflammatory drugs (NSAID's) as analgesic agents in neurosurgery has remained a concern because of their effect on platelet function and the potential risk of intracranial hematoma formation in the postoperative period in patients undergoing supratentorial craniotomy. Hence, paracetamol remains the non-opioid analgesic of choice in a multimodal analgesic regimen to manage post-craniotomy pain in such patients. Rajkiran et al, in their paper titled 'Diclofenac Is Superior to Paracetamol in Postoperative Pain Scores and Analgesic Consumption in Supratentorial Craniotomy With No Difference in Platelet and Clot Function: A Prospective Randomized Controlled Trial', sought to address this concern. 110 adult patients undergoing craniotomy for supratentorial tumors were randomized to receive either intravenous paracetamol (15 mg/kg) or intravenous diclofenac sodium (1.5 mg/kg) 30 minutes before the end of surgery and postoperatively at 12-hour intervals for up to 48 hours. At 24 hours post-surgery, pain scores and requirement of rescue analgesics were lower in the diclofenac group compared to the paracetamol group. Coagulation profile and platelet function were similar between the two groups. There was no difference in the incidence of postoperative tumor bed hematoma between the groups.

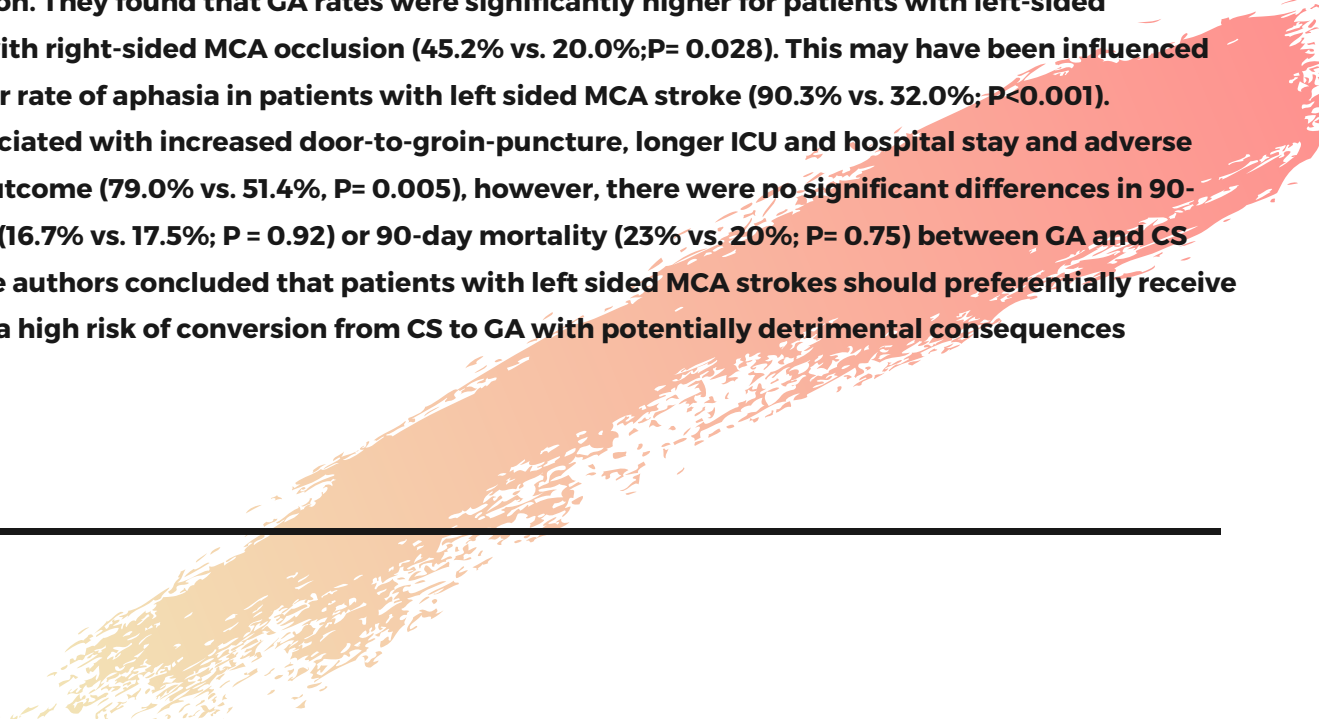
WHATS NEW ?

PUBLICATIONS IN NEUROANAESTHESIA

Site of Occlusion May Influence Decision to Perform Thrombectomy Under General Anesthesia or Conscious Sedation

Jeffrey A. Steinberg, Jaspreet Somal, Michael G. Brandel, Keiko M. Kang, Arvin R. Wali, Robert C. Rennert, David R. Santiago-Dieppa, Scott E. Olson, J. Scott Pannell, Alexander A. Khalessi
J Neurosurg Anesthesiol 2021;33:147-153. DOI: 10.1097/ANA.0000000000000642

The conduct of mechanical thrombectomy in patients with acute ischemic stroke under general anaesthesia (GA) versus conscious sedation (CS) remains controversial, with earlier retrospective studies favouring CS and newer prospective randomized trials favouring GA for better neurological outcome. Steinberg et al, in their paper titled, 'Site of Occlusion May Influence Decision to Perform Thrombectomy Under General Anesthesia or Conscious Sedation', sought to identify risk factors for GA and determine if the side of vessel occlusion potentially impacts GA rates. 112 patients who underwent mechanical thrombectomy of the middle cerebral artery (MCA) for acute ischemic stroke were retrospectively reviewed. 62 patients suffered left-sided MCA occlusion and 50 suffered right-sided MCA occlusion. They found that GA rates were significantly higher for patients with left-sided compared with right-sided MCA occlusion (45.2% vs. 20.0%; $P=0.028$). This may have been influenced by the higher rate of aphasia in patients with left sided MCA stroke (90.3% vs. 32.0%; $P<0.001$). GA was associated with increased door-to-groin-puncture, longer ICU and hospital stay and adverse discharge outcome (79.0% vs. 51.4%, $P=0.005$), however, there were no significant differences in 90-day mRS ≥ 3 (16.7% vs. 17.5%; $P=0.92$) or 90-day mortality (23% vs. 20%; $P=0.75$) between GA and CS patients. The authors concluded that patients with left sided MCA strokes should preferentially receive GA because a high risk of conversion from CS to GA with potentially detrimental consequences



WHATS NEW ?

PUBLICATIONS IN NEUROANAESTHESIA

Neurologic Involvement in Children and Adolescents Hospitalized in the United States for COVID-19 or Multisystem Inflammatory Syndrome

Kerri L. LaRovere, Becky J. Riggs, Tina Y. Poussaint, Cameron C. Young; Margaret M. Newhams, Mia Maamari, et al

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Although the neurological effects of COVID-19 in adults have been established through various studies since the onset of the pandemic, the spectrum of neurologic involvement in children and adolescents is unclear. LaRovere et al in their paper titled 'Neurologic Involvement in Children and Adolescents Hospitalized in the United States for COVID-19 or Multisystem Inflammatory Syndrome', studied patients younger than 21 years, who tested positive for SARS-CoV-2 or had symptoms suggestive of acute COVID-19 or met the criteria for multisystem inflammatory syndrome in children, over the course of 10 months at 61 US hospitals. Of the 1695 patients included, 365 (22%) had neurologic involvement. Patients with underlying neurological involvement were more likely to have neurological symptoms. 322 (88%) had transient symptoms, while 43 (12%) developed life-threatening conditions including severe encephalopathy (n = 15), stroke (n = 12), central nervous system infection/demyelination (n = 8), Guillain-Barre syndrome/variants (n = 4), and acute fulminant cerebral edema (n = 4). Among patients with life-threatening neurologic involvement, 17 patients (40%) had new neurologic symptoms at discharge, and 11 patients (26%) died.

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