NEW BEGINNINGS

NISHCHETNA

July 2024 Edition

NEWSLETTER OF INDIAN SOCIETY OF ANAESTHESIOLOGISTS
INDORE CITY BRANCH

INDORE SOCIETY OF ANAESTHESIOLOGISTS

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PRESIDENT MESSAGE

Dear friends & Colleagues.

Greetings from the President ISA Indore city branch.

As we all are aware that Indore City branch of ISA is known for being a pioneer in many respects and NISCHETNA as a newsletter is an avid example of that tradition.

After the revival of this newsletter the journey for the quest of knowledge will always be thrived by excellent articles, case reports and review of literature.

So quench your thirst by reading this edition of our very own newsletter NISCHETNA.

Long Live ISA

Jai Hind

Dr Sadhana Sanwatsarkar

President ISA-Indore City Branch

Dean L N Medical college

Indore

MESSAGE FROM SECRETARY

'NISCHETNA' as soon as we hear this name it resonates with academic acumen and scientific research of highest quality. We as Anaesthesiologist are always the first to adopt the new technology and endorse it in our day-to-day practice. In fact, artificial intelligence as a scientific tool was first used by our field and applied in the best of fashion for TARGET CONTROLLED INFUSION Pump.

This issue of NISCHETNA also will enlighten you with new avenues and possibilities to explore our own field in a new way and make further in roads into our depth of knowledge and its applicability.

Dr Mayank Masand
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FROM EDITOR'S DESK

Dear readers,

Namaste!

Rainy season gives us hope for enormous growth and renewed opportunities. At this point of mid year, you might have already witnessed culmination of few of your plans and thinking of new approaches to make this year a fruitful one. Nishchetna is also taking its shape and adapting to the needs of its readers. It has been suggested that it should be made theme based. This is where we will be heading further along the journey. As of now, this issue is an amalgamation of different aspects of Anaesthesia and Anaesthesiologist's life. I hope everyone finds it an interesting read.

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Awards and Achievements of our members

1. Dr. Pravesh Kanthed was awarded a scholarship by American society of Pain and neuroscience (ASPN)

2. Dr. Mayank Masssand is appointed as analytical editor of pub med indexed journal, Journal of Anesthesiology and clinical pharmacology (JOACP).

3. Our past president Dr. Rajendra Chouhan was felicitated by Pushyamitra Bhargava, mayor of Indore, for his exemplary devotion and hard work on Doctor's Day.

4. Dr. Mayank Massand and Dr. Pheroze Shah are elected as Vice President and executive member respectively of ISA M.P. State chapter.

NEWS WITH VIEWS

National CPR week, July 21-28'24, was celebrated with much vigour throughout the city with various training programs arranged by members of ISA, Indore city branch.

ISA, Indore city branch, organised a first of its kind cross talk CME on role of Carbetocin in postpartum haemorrhage on 22nd June'24. City's leading gynaecologist Dr. Asha Baxi and Dr. Neena Agarwal along with Dr. Dipti Saxena, Dr. Neetu Gupta and Dr. Radhika Dua enlightened on this topic of interest. The session was moderated by Dr. Meghna Maheshwari.

CASE SNIPPET-1

Thoracic segmental spinal anesthesia in upper abdominal and breast surgeries: case reports

Introduction

Regional anaesthesia techniques are now being preferred over general anaesthesia specially in patient with major medical problems. Thoracic segmental spinal anaesthesia has recently gained popularity because of its safety and efficacy in procedures like laparoscopic cholecystectomy, breast surgeries etc. Here we present two such cases conducted successfully under thoracic segmental spinal.

Case 1

An eighty-year-old female with average built and height (50 KG, 155 cm) presented with perforated gallbladder, gallbladder neck and CBD calculus, liver abscess along with hyponatremia, right sided pleural effusion with sepsis. ERCP was done under GA preoperatively. was present SP O2 94% on room air with right vessel, grapes present.

After considering the option and discussing them with both patient and surgeon, a combined spinal epidural block was planned. The epidural block was performed at T 9-10 level, and 16 G catheter was placed. SAB was performed at T10-11 level and injection LevoBupivacaine hyperbaric 0.5% 0.8ml and isobaric 0.5% 1.5 mL with injection fentanyl 25 µg as additive was given using 26 gauze spinal needle.

After four minutes, segmental sensory block extending between third thoracic and second lumbar dermatome was obtained. After 10 minutes, blood pressure decreased to 90/ 50 mm ofHg and heart rate from 96 to 54 bpm which was managed with IV atropine 0.6 mg and injection ephedrine 9 mg. Patient developed neck pain after pneumoperitoneum which was managed with IV ketamine 20 mg.

The circulation remained stable during the surgery with 1500 mL of crystalloid. Patient received oxygen 4 L per minute via Venti mask. SP O2 of 98% was maintained during surgery. Surgery duration was 100 minutes within internal pressure was 10 cm of water was performed easily and uneventful.

A continuous epidural infusion of injection levo bupivacaine 0.5%, 2.5 mg per mL and injection clonidine 3 µg/mL at the rate 2mL/ hr was started one hour after surgery and continued for 72 hours. Post-operative recovery was uneventful, and patient was discharged on seventh post-operative day.

Case 2

A seventy-seven-year-old female weighing 50 Kg with a height of 150 cm presented with carcinoma breast with type II diabetes mellitus and coronary artery disease (CAD). She underwent CABG in 2013. Echocardiography results were as follows- dilated cardiomyopathy, Ejection fraction 25% with moderate pulmonary hypertension. She was admitted for surgical intervention in the form of modified radical mastectomy (MRM).

After obtaining high risk consent, 16 G Epidural catheter was secured at T5-6 level and SAB was performed at the level of T 6-7 level with 1 ml of injection Isobaric Ropivacaine 0.5% and 25 µg fentanyl using 26 G spinal needle.

Intraoperatively bradycardia was noticed with 56 bpm which was managed with IV atropine 0.5 mg.

The continuous epidural infusion was started with 30 ml of Inj. Ropivacaine 5%, and Inj. Clonidine 1ml diluted to 60 mL given at the rate of 1.5 mL/ hour for 48 hours.

Discussion

Above two cases have provided some preliminary indication of the feasibility of segmental thoracic spinal anesthesia in patients undergoing routine laparoscopic cholecystectomy and breast surgery and is certainly supportive of wider evaluation. The spinal anesthesia technique was performed at the thoracic level with a 26-gauge spinal needle without any great difficulty.

Van Zundert et al. used combined spinal epidural technique for the same procedure using Bupivacaine and Sufentanil in equivalent doses. Paresthesia can occur with any technique of spinal anesthesia but are of potentially greater significance when the needle is inserted above the termination of spinal cord. However, we did not get paresthesia in our patients during needle insertion. Occurrence of paresthesia implies contact with the neural tissue and in those cases, needle should be withdrawn until the point where paresthesia disappears and then only anesthetic drug should be injected [1]. We used a narrow gauze (26 G) spinal needle which minimised the trauma to the patient and chances of PDPH.

Our patient did not experience dyspnea during abdominal insufflation and SpO2 was above 98% at all-time intervals. It is possible that the low dose of levobupivacaine used was a factor that minimised the degree of thoracic motor block. Other side effects such as pain, nausea, vomiting, and pruritus were also not noted. Although 20 mg ketamine had to be given for neck pain caused due to irritation of diaphragm by pneumoperitoneum intraoperatively. Low intrabdominal gas pressures were used during surgery.

Injection at the thoracic level would have ensured that the opioid and the local anesthetic produced its highest concentrations in the surgically relevant segmental levels. Although managing

postoperative pain has been easier with epidural technique with a catheter in situ, postoperative pain in laparoscopic cholecystectomy and MRM patients can also be managed with other analgesic modalities such as paracetamol, nonsteroidal anti-inflammatory drugs (NSAIDs) and opioids

Conclusion

These cases have proven that segmental thoracic spinal anesthesia can be an effective and economical anesthetic technique for high-risk laparoscopic surgery & breast surgery. It provides good intraoperative hemodynamic stability with avoidance of complications of general anesthesia.

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CASE SNIPPET-2

Local Anaesthesia Systemic Toxicity (LAST) After Sub Arachnoid Block with Low Dose Bupivacaine: Is It a Possibility?

INTRODUCTION

LAST is a life-threatening adverse event due to excess plasma concentration of the local anaesthetic agent. Accidental intravascular injection of local anaesthetic while performing neuraxial or peripheral block is the most common mechanism for excess plasma concentration of local anaesthetic agents. A variety of factors influence the severity of LAST, including patient risk factors, location, technique of block, specific local anaesthetic, total local anaesthetic dose.

Bupivacaine is an amide local anaesthetic. The typical plasma concentration of bupivacaine associated with seizures is 4.5- 5.5 mcg/ml. The threshold at which CNS toxicity occurs is related more to the rate of increase of the serum concentration, than to the total amount of drug injected.

CASE REPORT :

We encountered loss of consciousness in a 90-yr old diabetic lady posted for pilonidal sinus excision under Sub Arachnoid Block. She had no other co-morbidities. All her blood investigations including serum electrolytes were in the normal range.2D ECHO showed 50% EF. Spine examination showed thoracic scoliosis. Sub arachnoid block (SAB) was administered at L3-L4 intervertebral space via paramedian approach, in 3rd attempt using 25G Quinkes spinal needle after trying median approach. In the 2nd attempt, CSF was blood tinged. So, 3rd attempt was taken which which again was blood tinged. After allowing blood to clear off and ensuring free flow of CSF ,1 ml of Heavy Bupivacaine 0.5% was injected. Ten minutes after spinal block, she became unconscious, unresponsive to verbal commands and pain stimuli. Throughout the peroid of unconsciousness her vitals and respiration were normal. We suspected it to be neurotoxicity because

of accidental intravascular migration of Bupivacaine. We started a drip of 20% intralipid which improved her level of consciousness tremendously, and at the end of surgery which lasted for 1 hour she was fully awake and started responding.

DISCUSSION

There are many conditions that may lead to unconsciousness after neuraxial anaesthesia.

1. Her blood glucose was 110mg/dl, which rules out hypoglycemia.
2. Her ABG was also normal.
3. There was no H/o sudden onset unconsciousness and epilepsy in the past.
4. Loss of consciousness may be due to severe hypotension from a high spinal block,but this patient had a stable hemodynamics and respiration which rule out high spinal and total spinal block.
5. There was no delayed onset of sensory and motor blockade which rules out Sub dural injection.

With a Sub dural injection, the motor block will be lesser as compared with sensory blockade and the sympathetic block may be exaggerated, and episodes of apnea are also present.

CONCLUSION

We came to the conclusion that it can be intravascular migration of bupivacaine which revealed as loss of consciousness. Although the dose used is far less than the dose reported to cause neurotoxicity, the rate of injection and the age of the patient could have been the possible factors for this kind of presentation.

RESULT

Loss of consciousness in our patient improved dramatically with 20% Intralipid emulsion. Intralipid was given in a dose of 1.5 ml/kg bolus

followed by 0.25ml/kg/min of infusion, continued for at least 10 min after circulatory stability is attained or until there is clinical improvement.

REFERENCE

1. Stoelting Pharmacology and Physiology, page no 288, First South Asian Edition, Chapter no 10 Local Anaesthetic
2. Miller Anaesthesia, page no 1445, Chapter no 45, Spinal, Epidural and Caudal Anaesthesia

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PATIENT BLOOD MANAGEMENT

PBM is a patient-centered, multidisciplinary approach that optimises a patient's own blood, minimizes blood loss, and enhances tolerance of anaemia to reduce the need for blood transfusions.

Patient Blood Management (PBM) offers numerous benefits, including improved patient outcomes, reduced complications, faster recoveries, and shorter hospital stays by minimizing unnecessary blood transfusions and optimizing a patient's own blood. PBM also decreases healthcare costs associated with transfusions, enhances patient safety, and reduces the risks of adverse events related to transfusions, ultimately benefiting both patients and the healthcare system. It has been in many cancer patients that lesser blood transfusion reduces incidence of reoccurrence also .Globally, there is still a gap in awareness and implementation of PBM as an overall framework to address the risks of iron deficiency, anaemia, blood loss and coagulopathy.

Patient Blood Management (PBM) significantly improves patient safety by focusing on evidence-based medicine and ensuring that each transfusion is appropriate and safe. It helps in coordinating with care providers to prepare patients for elective surgeries, including screening for anemia and monitoring hemoglobin counts. It recommends dietary additions and iron supplements before surgery to increase iron levels and decrease the need for blood transfusions. PBM also works to minimize blood loss from blood draws and other procedures before and after surgery. By ensuring that right blood product is given at the right time, PBM enhances patient safety and reduces the risks associated with transfusions, ultimately benefiting both patients and healthcare providers.

The key components of Patient Blood Management (PBM) include:

1. Diagnosis and Treatment of Anaemia: Especially focusing on iron deficiency anaemia.

2. Minimisation of Blood Loss: Utilising measures like cell salvage and anti-fibrinolytic drugs to reduce bleeding.

3. Avoidance of Unnecessary Transfusions:optimisation of blood volume and red cell mass. Ensuring transfusions are only given when clinically indicated, not based on valve of haemoglobin.

The multidisciplinary approach in Patient Blood Management (PBM) is a collaborative strategy that involves various healthcare professionals, including surgeons, anesthesiologists, perfusionists, transfusion specialists, hematologists, anesthetists, intensive care specialists, and general practitioners. It emphasizes the importance of patient-centered decision-making and the timely use of alternatives to blood transfusions when appropriate. The multidisciplinary approach in PBM is essential for ensuring the best possible outcomes for patients and promoting responsible and ethical use of limited blood resources.

Anaesthesiologists contribute to Patient Blood Management (PBM) by focusing on managing anaemia, optimising coagulation, and implementing interdisciplinary blood conservation modalities. They play a crucial role in patient-centered decision-making and the timely use of alternatives to blood transfusions when appropriate. Anaesthesiologists also help ensure the right blood product is given at the right time, by doing repeated viscoelastic intraoperative testing,getting the mob and gauge counting plus weighting intraoperatively which help to calculate exact blood loss intraoperatively.By working collaboratively with other healthcare professionals, anaesthesiologists can help ensure the best possible outcomes for patients and reduce the risks associated with blood transfusions.

Potential risks associated with Patient Blood Management

(PBM) that anaesthesiologists should be aware of include known blood risks such as transmissible infectious diseases, transfusion reactions, and potential effects of immunomodulation (e.g., postoperative infection or tumour progression). Unknown risks include emerging pathogens transmissible by blood (e.g., new variant Creutzfeldt-Jakob disease and West Nile virus). Studies have linked allogeneic blood transfusions with occurrence of unfavourable outcomes including increased risk of postoperative infections such as sepsis, and longer hospital stays. Therefore, anaesthesiologists should be vigilant in implementing evidence-based practices and guidelines to minimise these risks and optimise patient outcomes.

Studies have shown that implementing PBM can lead to a significant reduction in hospital length of stay, indicating faster recovery times for patients.

A monthly or daily audit should be done according to the blood transfusion rate in hospital to find the reason of transfusion, the blood bank officer should repeatedly question and ask the indication of transfusion on the request form.

Blood is like a natural resource which is very essential component for life. Preserve it and optimise its use so that the needy gets it on right time.

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VIP TO RIP : DEALING WITH VIP SYNDROME

Introduction

It is not uncommon in our medical practice to come across a patient who may be socially, politically, administratively or even medically influential person. We on the other hand cannot discriminate our patients on the grounds of gender, religion, income or social background1. According to Darbari, in the midst of variety of medical opinions and prevailing pressure of treating a VIP patient, the physician lands up in an environment that is very vulnerable and may jeopardize the medical management. If not addressed properly this problem may also invite conflicts, litigations and violent episodes as patients disagree with recommendations that the primary physician believes is in the best interest of the patient.

Discussion

The term VIP Syndrome was introduced of Dr Walter Weintraub in 1964. A VIP by definition is a person who is given special privileges in view of status or wealth, common examples of VIP include politicians, celebrities, corporate leaders and wealthy individuals. In our day-to-day practice, we can also observe that medical personnel and their families have being on the receiving end of special treatment and may very well be considered VIP. The VIP patient due to his unique status receives the best care faster and gets access to enhanced and more convenient facilities along with special care from their medical care takers.

The earliest documented case of a VIP patient dates back to 1886 in Bavaria. King Ludwig II had a family history of paranoid depressive psychoses. He was diagnosed with primary insanity by his appointed psychiatrists who deemed him incapable of carrying out his royal obligation. During one of his permitted walks, King Ludwig attacked his psychiatrist and drowned him before drowning himself. In his case the VIP patient was being cared in a solitary castle in place of a staffed mental hospital where this suicide and murder could have been

prevented[3].

The VIP patient can be broadly classified into **three categories: Influential Patients** which includes prominent individuals in the community and their relatives and friends. **Professional Colleagues** which include physician, nurses, social workers or other persons whose work brings them close to the medical community. **Private Patients** who add to the burden on the hospital staff[4].

According to Khoo5, VIP Care can be singularly Harmful. One example is that of late world-renowned singer Michael Jackson who died as a victim of VIP medicine. He had unlimited access to Propofol, provided as a VIP service by his personal physician. Another example is the death of pop-star Prince due to an accidental high overdose of fentanyl. These two tragedies highlight the side effects of VIP syndrome and also reflect the complexity of issue when dealing with the demands of VIP for potentially life-threatening drugs or procedures, ethical tension and dilemmas, and breach of heightened privacy and confidentiality when providing evidence in court[3].

Guzman et al6 have suggested **nine principles** while dealing with VIP patients which are worth considering when dealing with VIP patients. **Principle 1:** "Don't Bend the Rules", any practice of deviation from routine clinical practice while dealing with VIP patients leads to disruption of promise of right care. **Principle 2:** "Work as a Team, Not in Silos". Teamwork is essential to ensure good outcomes. **Principle 3 :** "Communicate, communicate, communicate". There should be adequate communication with the patient, his family and other health care staff involved in providing care. **Principle 4:** "Carefully manage communication with the media". We have to ensure that we guard the physician – patient relationship and privacy at all times. **Principle 5:** Resist chairperson's syndrome. There is often undue pressure from the VIP patient and his family or his representative for the care to be

provided by the department chairperson. **Principle 6:** Care should be where it is most appropriate. The decision on where to provide care to the VIP patient should be based on the basis of venue where optimal care can be delivered. **Principle 7:** Protect the patient's security. There is added burden on healthcare to provide enhanced security to the VIP patient. **Principle 8:** Be careful about accepting or declining gifts. We physicians often decline the gifts so as to reduce the unmet expectations and misunderstandings and to ensure that the patients care is free of gifts. **Principle 9:** Work with the patient's personal physicians. The personal physicians can facilitate communication with the patient and help with decision making for the patient.

Mariano and McLeod[7] share **three directives** for caring for VIP patients based on their experience of caring for three American presidents. **One –** Vow to value your medical skills and judgment. **Two–** Intend to command the medical aspects of the situation. **Three –** Practice medicine the same way for all your patients[5]. According to Mariano[6] et al "the acronym for VIP stands for very important person, but in the medical setting this acronym more appropriately stands for very intimidating patient". According to this definition a VIP patient is a patient who intimidates the physician and makes him anxious. A physician as a consequence of VIP syndrome faces a high risk of providing substandard care to their patients. Though a VIP patient expects to receive special care, actually receives substandard care which puts him/her at higher risk for morbidity and mortality.

Rendering proper care to a friend and colleague is no easy task. Even Sigmund Freud, introspectionist extaordinaire, was hesitant to acknowledge his devastating cancer of the jaw, addiction to cigars, putative hypochondriacal, cardiac and gastrointestinal symptoms, or his migraines and sinusitis. His personal physician, Dr Max Schur, provides an account of Freud as a different patient, with all the disagreements, distrust, physician shopping, and problems with

professional courtesy that characterize the behavior of physician as patient. Indeed, Schur often reprimanded Freud for smoking against medical advice, but nonetheless entered a corrupt bargain to smoke a cigar with him socially even when this was not Schur's customary habit[8].

Those who attend the VIP should have certain specific qualities of personality and character. They should be professionally highly competent, beyond professional and personal reproach, clearly not self-seeking, free of political and administrative involvement, and imbued with the moral courage needed to take and maintain a position. In short, their qualities and attributes should tend to enable them to be objective and immune to pressure9. Ideally VIP patient's hospitalization should be done at an institution where they have as little influence as possible. If a staff physician or hospital official becomes ill, he or she should go to other hospital for treatment. The hospital on the other had must be prepared to show the VIP special consideration. The patient does not leave his position, rank and accomplishment outside the door and these must be recognized and respected10.

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Discuss Throw : Expert Opinion

Should videolaryngoscopes replace routine laryngoscopes

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Videoaryngoscopes (VLs) are indirect laryngoscopes, having a camera at the tip to visualize the larynx. This provides a superior glottic view without the need for optimal positioning of the head and requires less force and cervical spine manipulation . VLs are available in adult and paediatric sizes, with blades having the Macintosh design or hyperangulated, channelled or non-channelled, and may be single-use or reusable. Costs vary widely, from a few thousand rupees for "do-it-yourself devices" to several lakhs for the high-end commercially available devices.

VLs are undoubtedly associated with increased first-pass intubation success rates especially in patients with a difficult airway and in obstetric, paediatric and trauma patients, and in critically ill patients.1 In addition, the ability to share the view on the screen is invaluable in confirmation of tracheal tube placement by more than one person, and in teaching and supervision of conventional direct laryngoscopy (DL) and intubation. Use of a VL may reduce the exposure risk from infected aerosols as in coronavirus disease 2019 (COVID-19) patients.

A pre-shaped stylet is often required to negotiate the oropharyngeal angle to facilitate tracheal tube passage with a VL.. Neither the use of a VL nor achievement of a good laryngeal view guarantees a 100% intubation success. Expertise with standard DL does not translate to expertise with VLs. Separate training and

experience with VLs is required.[2]

Videolaryngoscopy has clear advantages, and can dramatically improve the safety of tracheal intubation, and must become universally available in our country. Till such time, and because failure to intubate with a VL may be rescued by conventional DL, anaesthesiologists must remain proficient with DL.3

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VOICE OF A NOVICE

Changing times...

Whenever we think about providing formal education in schools and colleges, nowadays, all over the world, we cannot imagine a classroom without a smart board. Similar is the case of standard mobile phones, being replaced by new technology smart phones which have made our lives so much easier.

Now, considering technological advancements in the field of Anaesthesia, the introduction of video laryngoscopy was certainly a boon for anaesthesiologists. For almost 60 years, direct laryngoscopy was the sole technique to insert tracheal tube into the trachea. The search for a bigger and better angle of view during difficult intubations led to the development of devices using video assistance. In video laryngoscopy, the visual field is much better than direct laryngoscopy. This is more beneficial for rapid and efficient emergency intubations compared to conventional direct laryngoscopy. Also, its easier to teach intubation via live video laryngoscopy rather than conventional method. Video laryngoscopy ensures improvement in overall success at tracheal intubation without increasing complications.

The best part is that the video can be recorded and can be used for teaching purposes for aspiring anaesthesiologists.

I personally believe, that video laryngoscopy should certainly replace direct laryngoscopy for endotracheal intubations in future.

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DISUSS THRAU : VOICE OF A NOVICE

Lights, Camera, Action: A Novice's take on video laryngoscopy v/s traditional laryngoscopy

Embarking on my journey as a first-year anesthesia resident, the realm of airway management presents itself as a captivating yet intricate landscape.In the array of techniques available, the deliberation over video laryngoscopy versus traditional laryngoscopy is a pivotal choice. Here, I'll share my insights as a novice in the field, grappling with the complexities of these two approaches and pondering the elusive question: which path to choose? As a fledgling resident, the prospect of video laryngoscopy ignites a spark of excitement. The notion of gazing upon a magnified airway projection fills me with a newfound confidence, especially when confronted with complex intubations. Yet, amidst the allure of innovation, the practicalities cannot be overlooked. The financial burden associated with video laryngoscopy equipment looms large, posing a barrier to entry for institutions with limited resources. Additionally, Video laryngoscopy's reliance on a camera and screen system can lead to issues such as glare, fogging, or poor resolution, which may compromise airway visibility and complicate intubation procedures.Conversely, traditional laryngoscopy embodies a sense of time honoured tradition.As a novice in the field, mastering the art of direct visualisation instills a sense of pride and accomplishment. Furthermore, the widespread availability and affordability of traditional equipment ensure accessibility across diverse healthcare settings. However, the shadow of limitations looms over traditional laryngoscopy. The challenge of inadequate visualisation, particularly in cases of difficult airways, casts a veil of uncertainty over the procedure. In conclusion, the dichotomy between video laryngoscopy and traditional laryngoscopy presents a multifaceted decision. As a fledgling anesthesia resident, my journey entails navigating the intricate balance between innovation and tradition. While videolaryngoscopy offers undeniable advantages in terms of

visualization andeducational opportunities, traditional laryngoscopy provides a reliable fallback option with its simplicity and familiarity.

As I embark on this odyssey, I endeavour to embrace the nuances of both approaches,forging a path that optimises patient care while honouring the anesthesia traditions.

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Dr Divya Rana

Discuss Throw has been introduced to dissect and discuss a dilemma or a controversy which we face while dealing with routine practice. Suggestions, feedback and contributions are most welcome! Next issue's topic for Discuss throw will be '~~usefulness of invasive monitoring in day-to-day practice~~. 'Use of colloids in major surgeries'

BEYOND ANAESTHESIA

Musings of an Anaesthesiologist

Beep beep beep Is all I hear,
There is continuous ringing in my ear,
My eyes glued to the monitors on top
I struggle hard to hold myself and stand tall
The muffled cries of patient,
Struggling hard with oxygen deprivation

I try hard to help them breathe
Hour by hour I watch them grieve
Sometimes I stand beside the bed all night
Assuring them so they could sleep through the night

I go home to sleepless night
I am haunted by the struggling sight

The faces of relatives when anxiously they wait
Hoping for a miracle as they pray

I get up from bed with a single thought,
God please don't make me tell them ' I am sorry for your loss '

Sometimes I suddenly get these thoughts
I call at home to check them all
Miles away I too have a family
Scared and lonely I know they too need me

And as I work hard every day in this madness
They too put a brave face hiding their sadness

But all is worth for a single smile
Cherishing it even if I could save one life

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Beyond Anaesthesia

THROUGH SOLO TRAVELLER'S LENS

- Trip to Leh, Ladakh

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