RESURRECTION

NISHCHETNA

March 2024 Edition

NEWSLETTER OF INDIAN SOCIETY OF ANAESTHESIOLOGISTS
INDORE CITY BRANCH

INDORE SOCIETY OF ANAESTHESIOLOGISTS

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PRESIDENT MESSAGE

Namaste my friends and colleagues.

Our society Indore City branch of ISA is known for its legacy in academics as well as knowledge sharing.

With this concept we started our own newsletter by the name of NISCHETNA but due to some issues we were not able to continue it .Now we have decide to revive this newsletter and bring it up as a soft copy so that the legacy continues .Please contribute your knowledge as well as your experiences to make it a success. As a President of Indore City branch of ISA I wish all the best to the new editorial team comprising of Dr Deepti Saxena & Dr Gaurita Shrivastava in this venture and at the same time appeal to all the members to keep themselves abreast with the new practices and keep the legacy alive of Indore City branch of ISA at the national level.

Long Live ISA

Jai Hind

Dr Sadhana Sanwatsarkar

President ISA-Indore City Branch

Dean L N Medical college

Indore

MESSAGE FROM SECRETARY

Dear friends and colleagues

Indore City branch of ISA is always known for pioneering academics to new level and our very own newsletter ' NISCHETNA ' is one such example. This journal was first edited by DR MEENU CHADHA and later by Dr HARSHA DESAI PHULAMBRIKAR. Now we are about the start this journey once again with a revised soft copy edition of NISCHETNA. So, I wish the new team comprising of Dr Dipti Saxena, Dr Gaurita Shrivastava all the very best!

Dr Mayank Masand

Sr. Consultant Anesthesiology & Critical Care

Care CHL Hospitals

Hon Secretary

ISA-Indore city Branch

FROM EDITOR'S DESK

Dear esteemed readers,

Greetings from ISA Indore city branch! It is my immense pleasure to bring forward this issue of NISHCHETNA, our very own newsletter of ISA, Indore city branch. Thanks to the hard work of its mentors Dr. Meenu Chaddha, Dr. Harsha Desai and Dr. Sadhna Sanwatsarkar,

Nishchetna has been a collection of informative and insightful articles with recent advances at its helm. It was unfortunately shelved due to covid pandemic. Just like the rebirth of phoenix from its ashes, this issue marks the beginning of a new era of Nishchetna. I seek the blessings and best wishes of all my teachers, seniors, colleagues and juniors to carry the legacy forward and take it a step ahead in the form of an indexed journal. This issue is also special as it coincides with the successful culmination of first conference of ISA, Indore city branch, INDOISACON' 2024.

Nishchetna will be published every three months and will include articles featuring different aspects of an Anaesthesiologist's life apart from scientific content. I request all the readers to contribute articles with scientific content in the form of case reports, original study, case series. Stories, essays, introspections, anything that reveals your hidden talents are also welcome. All future correspondence should be made on mail ID- saxenadipti08@gmail.com.

May NISHCHETNA continue to be a masterpiece of science and arts of anesthesia!

Dr. Dipti Saxena

Editor, Nishchetna,

Professor and In-charge,

Department of Anesthesiology,

MGM Superspeciality Hospital, Indore (MP)

INDO ISACON 2024
1st ISA, Indore city branch conference

It gives me immense pleasure to report our first annual city conference, INDOISACON 2024 held on 10th and 11th of February 2024 at the MGM Super Speciality Hospital Indore. The conference themed Footsteps to Future gave resourceful insights on recent updates in Anaesthesiology and Critical care which is the need of the hour for both PG students and consultants alike.

The conference was an astounding success with a strength of over 300 delegates. It was attended by ISA national president. Dr J.V. Divatia who gave a keynote lecture on THRIVE in OT. Sir discussed very important aspects of how to use high flow nasal oxygen to tide over difficult situations. The panel discussion on medicolegal aspects of Anaesthesia was attended by distinguished lawyers, surgeons and media personnel.

The conference was inaugurated by the Dean of MGM Medical College, Dr Sanjay Dixit and Superintendent of Super Speciality Hospital Dr Sumit Shukla.

There was an amalgamation of national and international speakers who gave valuable insights on very pertinent topics and problem areas commonly encountered in our day-to-day practice. The conference was a concoction of interesting debates, panel discussions, How I do it sessions and a dedicated Private Practitioners Forum. We had also organised a Paper and Poster competition for PG students along with a Quiz competition which was attended very enthusiastically by them. There was a photography and art competition as well for all the delegates. We had a cultural program conducted by the consultants and PG students followed by Gala Dinner.

The conference presented an excellent platform for networking opportunities and exchange of innovative ideas. The overall event was

managed very successfully with adherence to the timings and completion of program as per schedule. The audience also participated wholeheartedly and enthusiastically.

The conference has been an important milestone in the chapter of ISA Indore city branch in terms of laying the foundation stone for all our further endeavours. It has brought out the best of our managerial skills and teamwork and also taught us how to improve and become more efficient for our next venture. I strongly recommend such regular CMEs and Conferences for our overall learning and development.

Lastly, I sincerely thank the entire Organising Committee of INDOISACON 2024 for their valuable help and support to make this conference a grand success.

Dr Gaurita Shrivastava
Co-Editor
Consultant Anesthesiologist
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GLIMPSES INDO ISACON 2024

GLIMPSES INDO ISACON 2024

CASE SNIPPET 1

Segmental Spinal Anesthesia : An Alternative To General Anesthesia For Lower Thoracic And Lumbar Spine Surgeries

Authors:

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Introduction

The incidence of spinal fractures varies between 16-64 per 100,000 population in India with fall from height and road traffic accidents being the most common causes, management of which can be either conservative or operative. Operative procedures can be done either under general or regional anaesthesia. Segmental spinal anesthesia is an upcoming technique offering several advantages like better hemodynamic stability, improved head and neck stability in awake patients, superior post-operative pain relief, reduced occurrence of postoperative nausea and vomiting (PONV), early recovery as compared to general anaesthesia.

Methodology

A case series involving 15 patients undergoing lower thoracic or lumbar spine surgery, specifically targeting one or subsequent two spine segments, was conducted after getting approval from the ethics committee. The study included patients of both genders, aged between 18 and 65 years, with ASA physical status of 1/2/3. Exclusion criteria consisted of patient refusal to participate, BMI >35 and contraindications for spinal anesthesia. In the operation theatre, baseline vitals were recorded. Spinal anesthesia was administered using Inj. Levobupivacaine 0.5% 2 cc + Inj. Dexmedetomidine 5 mcg one or two spaces above the level of the operating spine in left lateral position. Patient was positioned prone on the OT table after confirming the

adequacy of desired sensory blockade assessed by pin prick method. After stabilization of hemodynamic variations owing to spinal anaesthesia, concious sedation was provided with IV Paracetamol 10mg/kg + Inj. Dexmedetomidine 50mcg. To adress muscle twitching due to electric cautery in the upper segments, 15cc of 0.125% Inj. Lignocaine+ Adr was infiltrated in the area above the block, which is already a common practice by the surgeons.

Result

Intraoperatively, hemodynamic variables remained within 20% of the baseline vitals. Duration of surgery for all cases was less than 90 minutes, except for 1 case where it exceeded 120 minutes, hence intrathecal supplementation was done intraoperatively with 1cc Inj. Levobupivacaine 0.5%. Surgeon satisfaction score based on Likert 3 point scale, were adequate for all cases. Post operative analgesia ranged between 4-7 hours for all cases.

Discussion

Rung et al stated that isobaric spinal anesthesia offers significant benefits compared with general anesthesia for single-level lumbar disk surgery.This lies in concordance with our study.Tetzlaff et al and Dilger et al demonstrated that spinal anesthesia is an effective alternative to general anesthesia for lumbar spine surgery and has a reduced rate of minor complications. Their findings support our study.

Conclusion

Based on our case series, it can be inferred that segmental spinal anesthesia using isobaric local anesthetic drug is a viable option for lower thoracic and lumbar spine surgeries.However, further studies with larger sample sizes at multiple centres are warranted to gather additional evidence and ensure safety of this procedure in clinical practice.

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CASE SNIPPET 2

Game of glucose: insulinoma- a case report

Dr. Sanjay Ansolia, Dr. Rakesh Shivhare, Dr. Monit Gangwal

Introduction

Insulinoma is a rare tumor of beta pancreatic cells with an incidence of 1-4/ million. Whipple's triad which is pathognomic of insulinoma consists of recurrent hypoglycaemic symptoms, blood glucose levels less than 50gmi/ dL, and relief of symptoms following glucose administration. This case report highlights the anaesthetic management of laparoscopic resection of Insulinoma.

Case history

A 77-year-old female weighing 95 kg presented with history of recurrent loss of consciousness. Her blood glucose level was found to be 34 mg/ dL. Despite 10% Dextrose infusion her blood sugar fluctuated between 40 gm/dL to 50 mg/dL. She was put on 20% dextrose infusion at 50 ml/hr. Persistent low blood glucose level raised suspicion of a possible insulinoma for which she was evaluated. Her investigations reports were as follows- HbA1C – 5.17, serum insulin level- > 300, c-peptide level- 173 ng/ml (normal values- 0.9- 7 ng/ml). MRI of the abdomen revealed 23 mm lesion at the junction of superior margin of head and neck of pancreas. Laparoscopic enucleation of the tumor was planned. Significant findings included short neck, edentulous status, mallampatti grading – III indicating difficult intubation.

Anesthetic management

Preoperative preparation included intravenous dextrose normal saline started at the rate of 100ml/hr in the night prior to surgery, after

patient had her dinner. Blood glucose level was monitored every 4 hourly. Sedatives were avoided so as not to avoid masking early symptoms of hypoglycaemia. Rate of DNS solution was increased if blood glucose levels went down to 35 mg/dl. Her morning fasting blood sugar (FBS) was 34 mg/dL. So 25 ml of 25% dextrose solution was administered causing increase in blood sugar level to 110mg/dL. After completing routine checklists and connecting monitors, induction was done with inj. Propofol 120 mg, Inj. Fentanyl 100 micrograms, Inj. Dexmedetomedine 50 micrograms, Inj. Succinylcholine 100 mg. Intubation was difficult as anticipated. After successful intubation Maintainence was done with Inj. Atracurium, Sevoflurane oxygen and nitrous oxide. Right internal jugular vein and radial artery cannulation was done after induction. The anesthetic plan was aimed to maintain Normotension, normocapnia, central venous pressure of 8 to 10 cm of H2O and glucose level around 100- 150 mg/ dL. Blood glucose level was checked in every 30 mins. Intraoperatively, along with fluids, IV 25% dextrose was infused intraoperatively at 50 ml/ Hr till resection of tumor. After resection infusion of DNS was substituted at 100 ml/ hr. Intraoperative course was uneventful. For postoperative analgesia, Paracetamol 1gm with 50 mg Tramadol and Xylocard 2 ml was given before shifting. Elective ventilation was planned in view of difficult intubation. Insulin infusion was started initially in ICU. Once sugar level was stabilised, it was tapered off. Patient was extubated uneventfully next day.

Discussion

Insulinoma is a rare tumor for which treatment of choice is surgical resection, either laparoscopic or open. It requires comprehensive approach for diagnosis and treatment. Careful glucose monitoring is required at every step. Medical management includes oral diazoxide and subcutaneous doses of somatostatin analogues (octreotide and lanreotide) to decrease the release of insulin. There are no specific guidelines for anesthetic management, but general anesthesia is preferred. Epidural catheter was not placed in this case as laparoscopic resection was planned. The signs of hypoglycaemia may

be masked under general anesthesia requiring frequent blood glucose monitoring. There may be rebound hyperglycaemia following resection due to circulating anti insulin hormones such as growth hormone, glucagon and glucocorticoids. Thus, insulin infusion was administered in ICU. A closed loop communication between surgeon and anaesthesiologist is mandatory for successful outcome.

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CASE SNIPPET 3

A Rare Incidence of massive subcutaneous emphysema during a routine ERCP done under sedation - A Case report

Dr Amita Chandel, Dr Swapnil Kumar Barasker, Dr Meghna Maheshwari, Dr Sarita Gohiya

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Introduction

Medical interventions are now moving towards less or minimally invasive procedures to manage patients. Endoscopic retrograde cholangiopancreatography (ERCP) is one such procedure that has been time-tested. It can be done under sedation or general anesthesia. Among the reported post-ERCP complications like infection, pancreatitis, cholangitis, bleeding, and perforation, the latter is a rare but devastating complication specifically in untrained hands. [1] We in this case report present one such case of massive subcutaneous emphysema which resulted in on-table cardiac arrest but was managed successfully.

Case history

This is a case of a 29-year-old male, 48kg, who underwent laparoscopic cholecystectomy a month back but developed abdominal pain in the epigastric region 15 days later. On ultrasound epigastric collection was observed which on guided tapping revealed to be bile. The patient's vitals and blood investigations were normal all this while. A percutaneous pigtail insertion under ultrasound guidance was done because of repeated collection. However, the drain amount was significant for the next 5 days thus an ERCP with stenting was planned. The procedure was planned under sedation as routinely done in our setup. During the last step of the final placement of the stent and checking with the dye spread, the patient's O2 saturation started

dropping. Bradycardia was noticed and intravenous (IV) Inj Atropine 0.6mg was given, but it did not resolve. The endoscope was removed, and the patient was made supine. Administration of 100% O2 was done, and we observed massive subcutaneous emphysema extending from head to knee. Cardiopulmonary resuscitation (CPR) was initiated, Inj. Adrenaline 1 mg intravenous stat, and laryngoscopic intubation was done. The patient was revived after 1 cycle of CPR and was extubated 6 hours later. On performing a computed tomography chest and abdomen, revealed normal findings thus were managed conservatively. The patient was discharged 5 days later with resolved subcutaneous emphysema.

Discussion

The patient during ERCP is in a semi-prone position, and the airway space is shared, making it a challenging scenario for the anesthetist. The management of ERCP-induced perforation requires early diagnosis and diligent decision-making to decide the further line of management be it conservative or surgical. In our case, the first noticeable red flag was the bradycardia followed by a drop in O2 saturation and turning the patient supine for further management revealing the massive subcutaneous emphysema.

The perforation from ERCP usually occurs during the step of sphincterotomy or from direct trauma of scope. In a recent case series, the reported incidence of perforation was reported to be 0.3% to 1.3%. [1] And the resulting mortality secondary to perforation is high about 8 to 23%. [1] The duodenal perforation results in the collection of air in the retroperitoneal space which is exaggerated by continuous insufflation of gas pressure, and rarely it can become
massive subcutaneous emphysema.

In our literature search, we came across a single case report [2], with subcutaneous emphysema without pneumo peritoneum and mediastinum. The reason behind the cardiac arrest seems to be airway compromise secondary to massive subcutaneous emphysema and
hypoxia resulting in bradycardia.

This case underscores the necessity for careful monitoring and

effective management during minimally invasive procedures, as overlooking these aspects may lead to severe complications.

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Dr. Amita Chandel (Jr 3)
SAIMS, Indore

REMIFENTANIL
REALITY VERSUS EXPECTATIONS

Dr. Aseem Sharma1, Dr. Neetu Gupta1, Dr. Ritu Pauranik2, Dr. Manish Banjare3

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2. Associate Professor, Department of Anaesthesiology, MGM Medical college, Indore.

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After a long wait, when we were finally able to lay our hands on the highly coveted ultra short acting opioid, little did we know how the tiny 1 milligram magic ampoule was going to perform. We were fortunate to use Inj. Remifentanil on two patients in General Surgery Operation Theatre in MGM Medical College and MY Hospital, Indore. The drug was prepared in 50ml dilution to yield a strength of 20 micrograms/cc as per manufacturer's instructions.

The first patient was Ms Parvati, 69-year-old female, weighing 50 kg diagnosed with Carcinoma of right lateral border of tongue, posted for wide local excision with hemiglossectomy with modified radical neck dissection with PMMC flap. After noting down baseline vital parameters patient was pre-medicated with inj. Glycopyrrolate 0.2 mg iv and inj Midazolam 1 mg iv. Bolus dose of inj Remifentanil 1mcg/kg was given followed by continuous infusion of 0.3 mcg/kg/min (50 ml/h) via infusion pump. After induction with inj propofol 2mg/kg and inj succinylcholine 2mg/kg, nasotracheal intubation was performed. Hemodynamic fluctuation was minimal throughout the procedure. Heart rate was 70 bpm and blood pressure was recorded to be 100/70 mm of Hg just after intubation. Intubation response as well as hemodynamic response to

skin incision were successfully blunted by inj Remifentanil and it ensured stable hemodynamics throughout the period of infusion. Beyond one hour, analgesia was maintained by inj Tramadol 100mg iv, inj Paracetamol 1gm iv and inj. Diclofenac 75 mg iv. Surgery lasted for 2 h and the patient was extubated uneventfully after complete reversal of neuromuscular blockage. For postoperative analgesia, inj Diclofenac 75mg iv was given twice a day and total analgesic consumption was not reduced by remifentanil. There was absence of opioid related adverse effects like nausea, vomiting, pruritus, urinary retention or residual sedation in the said patient.The second patient was Ms Sheetal, 44-year female, weighing 40 kg, diagnosed with Carcinoma left breast posted for breast conservation surgery. After premedication, bolus dose of inj Remifentanil 1mcg/kg was given followed by continuous infusion of 0.25 mcg/kg/min (30 ml/h) via infusion pump.

After induction airway was secured with orotracheal intubation. As with previous case, hemodynamics remained stable at intubation with heart rate of 64 bpm and blood pressure of 96/58 mm of Hg. Just prior to skin incision, fall of blood pressure to 82/44 mm of Hg was noted which warranted the Remifentanil infusion to be stopped temporarily. Infusion was restarted at the same rate after correction of hypotension and continued throughout the surgery. The infusion rate was titrated to the hemodynamic response of the patient ranging from 0.125 mcg/kg/h to 0.3 mcg/kg/h. The surgery lasted for 1 hour 15 min. For postoperative analgesia inj tramadol 100mg iv and inj Diclofenac 75 mg iv were given prior to extubation. The remifentanil infusion was continued during extubation and was stopped just after extubation. The hemodynamic parameters stayed stable, and the patient was wide awake, pain free and was obeying verbal commands immediately after extubation. There was no reduction in postoperative analgesic requirements in this patient. Post operative course was otherwise uneventful just like the previous patient.

Remifentanil undoubtedly proved to be an excellent analgesic in both the patients. It ensured stable hemodynamics right from induction

upto the extubation thus minimising the requirement of other analgesics as well as inhalational agents for maintenance of anaesthesia. On first impression, Remifentanil proved to be a promising agent for us. It surpassed our expectations and will establish its place as an indispensable part of our armamentarium especially in high-risk cases.

However, limited availability and high cost are major obstacles in its use. Further studies are needed to substantiate its risks and benefits in various types of surgeries on different patient populations.

Conflict of interest: nil
Source of funding: nil

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DISCUSS THROW!

This section will be featured in next issue. It will focus on the valuable opinions from esteemed senior members and specialists on a selected topic. The topics will be addressing debatable issues and frontiers of research in anaesthesia and help in bringing out a consensus statement .This shall be of clinical, academic and practical relevance to young and senior anesthesiologists alike.

In next issue we will be addressing "Should video laryngoscopes replace routine laryngoscopes".

BEYOND ANESTHESIA

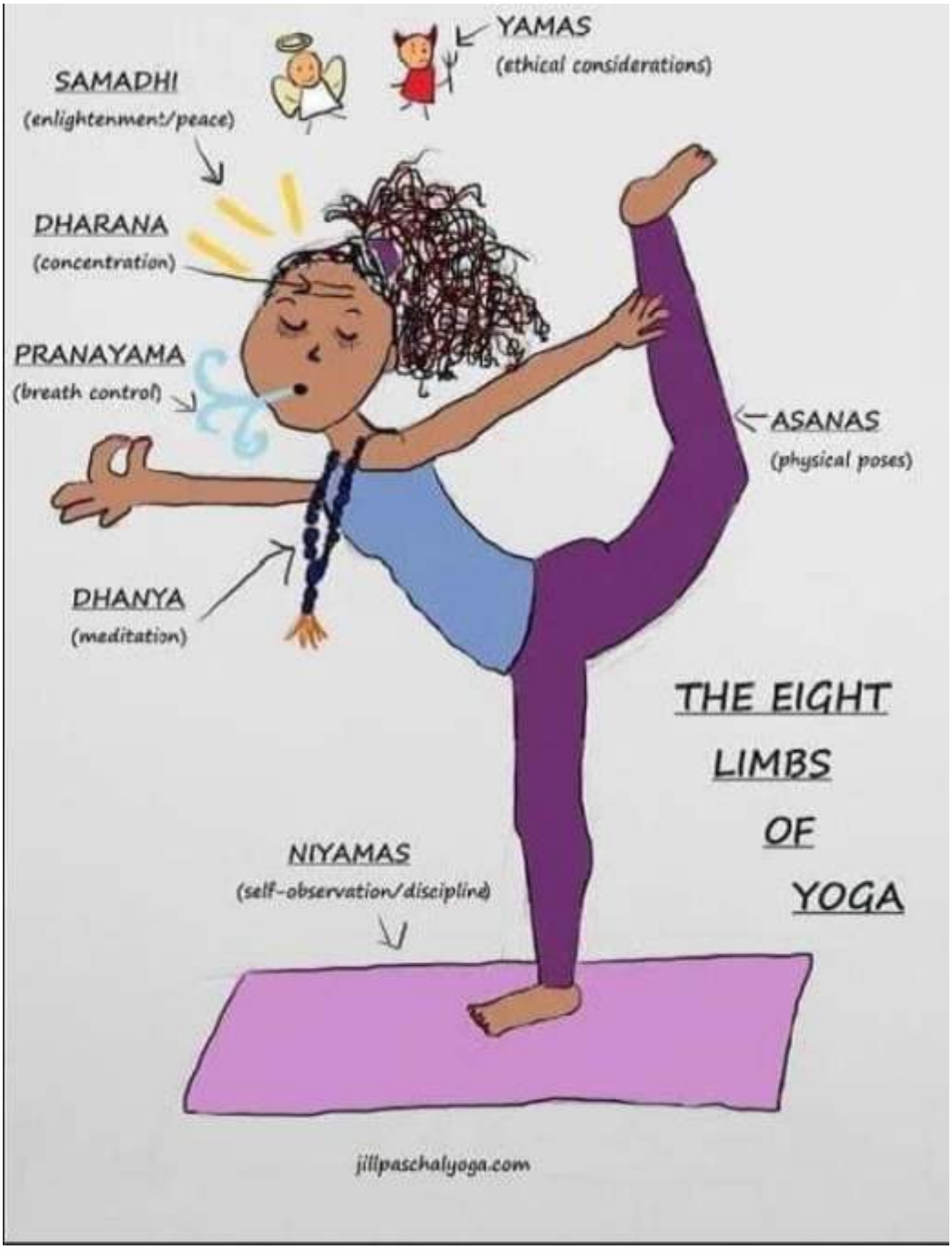
**"The Science of Consciousness (Yoga)
for the Science of Unconsciousness (Anaesthesiology):
Bringing in the Balance**

Understanding Yoga The term 'Yoga' signifies union or joining—the alignment of the external with the internal, the union of individual consciousness with collective consciousness. Among the diverse definitions found in various spiritual texts, the Bhagwat Gita provides a widely accepted one: 'योग: कर्मसु कौशलर्ं' or 'Yoga Karmasu Kauśhalam,' translating to excellence in one's actions or the art of working skilfully (in proper consciousness). Who better than an Anaesthesiologist can grasp the significance of consciousness while applying their skills?

Why Yoga for Anaesthesiologists? In the demanding field of Anaesthesiology, practitioners often face high stress, demanding long hours of intense focus and precise decision-making. To cope with this stress holistically, both physically and mentally, we turn to Yoga—a science that harmonizes complete physical, mental, emotional, social, and spiritual well-being. Remarkably, the definition of yoga aligns with the WHO's definition of health.

How to Get There Yoga philosophy, notably outlined in "Yog Darshan" by Maharishi Patanjali, predominantly emphasizes Raja Yoga as an eightfold pathway to liberation, hence the name "Ashtanga Yoga." The eight limbs include Yama, Niyama, Asana, Pranayama, Pratyahara, Dharana, Dhyana, and Samadhi. Asana, often misinterpreted as synonymous with yoga, is just one aspect. Learning Yoga requires a teacher, and finding an authentic school demands thorough research and experimentation.

Yoga Only Works if You Show Up!



Benefits to Anaesthesiologists:

1. Self-awareness: Conscious awareness of our body and mind empowers us to accept and implement changes.

2. Mind set: Yoga encourages acceptance and compassion, countering self-criticism common among high achievers, reducing stress levels.

3. Movement: Systematic yoga sequences enhance self-awareness of our bodies, highlighting areas of tension and strength deficiencies. Consistent practice brings positive physical well-being changes.

4. Mindfulness: Yoga focuses on the present moment, enhancing our ability to concentrate.

5. Self-Care: "How many of us genuinely prioritize and actively contribute to our own well-being?". Scheduling a weekly yoga class allows us to prioritize self-care.

6. Relaxation: Yoga provides a space for relaxation, turning off the sympathetic stress response and activating the parasympathetic nervous system.

7. Enhanced Healthcare Delivery: Prioritizing self-care contributes to improved patient care and fosters strong rapport with patients.

As B.K.S Iyengar says, "Words cannot convey the value of yoga – it has to be experienced" and so all there is left to say is, why not give yoga a try yourself?"

Contributed by

Yogacharya Dr. Parul Gupta,

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M.G.M Medical College, Indore.

Certified Yogacharya Completed Yoga teacher training

from Mokshayatan Yog Sansthan, Saharanpur,

Affiliated to Ministry of Ayush.

AWARDS AND ACHIEVEMENTS

1. Dr Dipti Saxena was awarded second prize in INDORE ANNUAL MEDICAL PUBLICATION AWARD for her international publication Endotracheal tube cuff pressure during laparoscopic bariatric surgery: highs and lowsAnesth Pain Med2022;17:98-103

2. Dr Swapnil Kumar Barasker Received Commonwealth scholarship for MSC Palliative Medicine, Cardiff University, Wales, UK

3. Award winning Photo by dr Vikas Gupta on national Anesthesia day

4. Award winning photograph for nature photography Athiapallay waterfall by dr Mayank Masand

5. Dr. Meghna Maheshwari Rathi Won **Ms. beautiful eys and Ms. photogenic** titles at CZISACON Srinagar Uttarakhand.

UPCOMING CONFERENCES

1. **32nd Annual National And 3rd International Conference Of Research Society Of Anesthesiologyclinical Pharmacology** 19-21 APRIL 2024 AIIMS JODHPUR

2. **SOAPCCON 6TH ANNUAL CONFERENCE OF society of onco anesthesiology and peri operative care.** 2-4 August ,Bengaluru

3. **TMC- 2nd Biennial National conference of Hepato- Pancreato-Biliary & Gastrointestinal Anesthesia & Perioperative care- 2024.** Department of Anesthesia, critical care & Pain, Tata Memorial centre, 27th and 28th April' 2024 ,Mumbai

4. **AORA' 2024, 14th Annual conference of academy of regional Anaesthesia of India** 22nd -25th august' 2024,Hyderabad

5. **ICACON'2024, 5th International and 15th National conference of Indian college of Anaesthesiologist.** Department of Anaesthesia & Critical care, King George's medical University, Lucknow 12th - 15th September' 2024,Lucknow

6. **International Conference on Anesthesiology and Critical Care Medicine ICACCM** 09-10 December , Goa, India

7. **Tata Memorial Hospital Anaesthesia Review Course** 5th - 7th April, 2024 (for post graduates)

8. **71ST Annual National Conference of Indian Society Of Anaesthesiologists ISACON** 2024 20th - 24th November 2024 PATNA, BIHAR

SUGGESTED READINGS

Special Articles from International Journals

1. **Sepsis-Induced Coagulopathy: A Comprehensive Narrative Review of Pathophysiology, Clinical Presentation, Diagnosis, and Management Strategies** Anesthesia & Analgesia 138(4):p 696-711, April 2024

2. **Perioperative Patients With Hemodynamic Instability: Consensus Recommendations of the Anesthesia Patient Safety Foundation.** Anesthesia & Analgesia 138(4):p 713-724, April 2024.

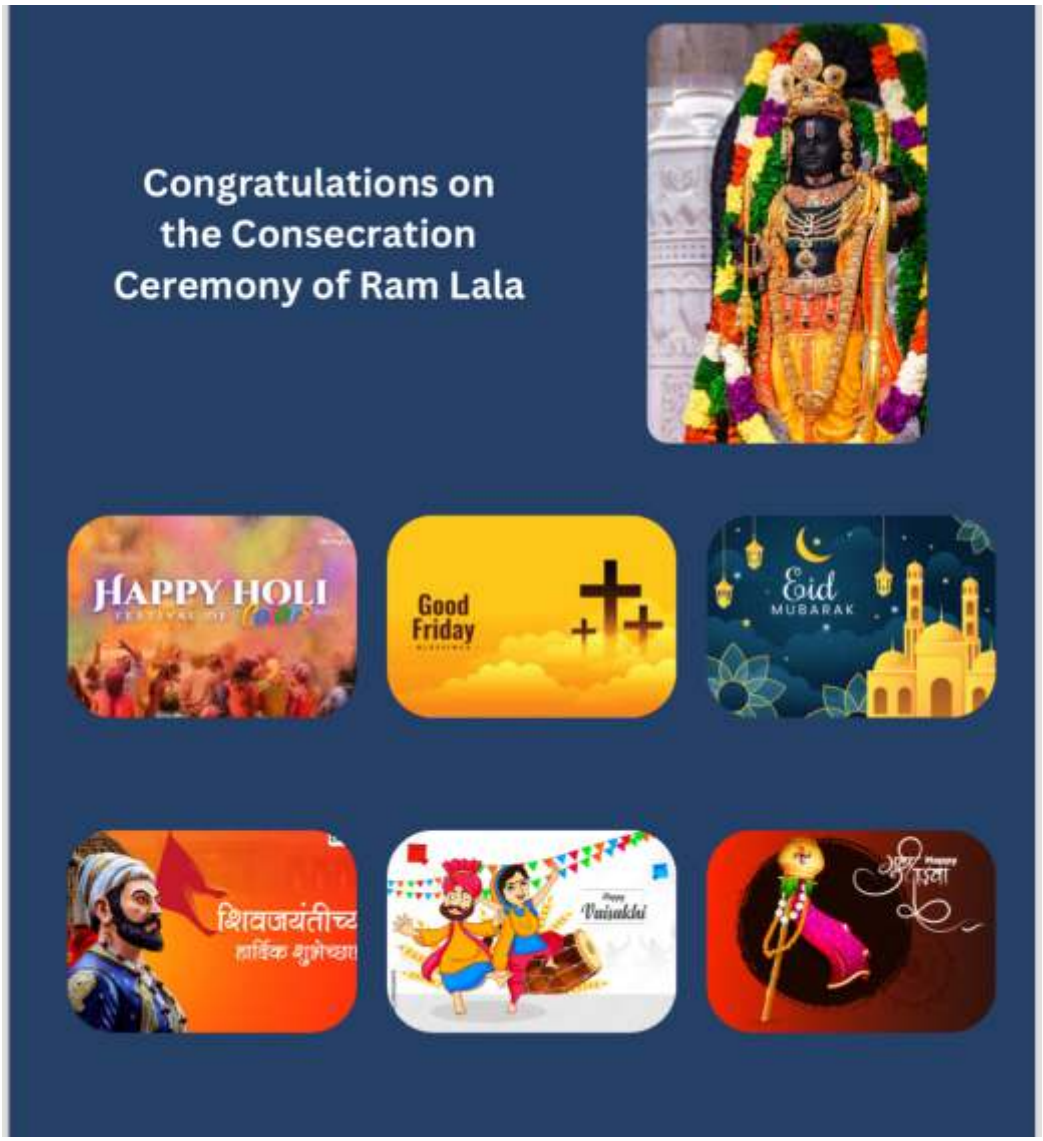
3. **Robotic Anesthesia: A Vision for 2050.** Anesthesia & Analgesia 138(2):p 239-251, February 2024. |

4. **Rethinking ketamine as a panacea: adverse effects on oxygenation and postoperative outcomes.** Br J Anaesth. 2024 Apr;132(4):635-638.

5. **Opioid-free Anesthesia Protocol on the Early Quality of Recovery after Major Surgery (SOFA Trial):** A Randomized Clinical Trial. Anesthesiology 2024; 140:679–689.

6. **Operating Room Table Malfunction: Would You Know What to Do?.** Anesthesiology 2024; 140:805–807.

FUNNY CORNER



"Anaesthesia is the art of balancing pain and awareness, risk and benefit, science and compassion. It is a privilege to be an anaesthesiologist and to serve humanity in this way."– Dr. Jannicke Mellin-Olsen,

Suggestions, feedback, contributions and new ideas are welcome whole heartedly at **diptisaxena08@yahoo.com**