well as her close relatives and the higher risk was explained to them with regard to anaesthesia. Sedative premedication was avoided and once the patient was in the theatre, an injection of pethidine 25 mg, slow intravenous, was given while supplementing O₂ by a face mask. Patient was monitored with ECG (lead II and V5), SpO₂, NIBP and CVP (right IJV). A lumbar epidural anaesthesia was initially planned, even though we were anticipating a technical difficulty in placing the epidural catheter, considering her difficult spinal anatomy. Two unsuccessful attempts were made with patient in the right lateral position, and that procedure was abandoned. Our next anaesthetic plan was the left lumbar plexus block. A lumbar plexus block by the posterior approach was established with 15 ml of 0.5% bupivacaine and 10 ml of 2% plain lignocaine using a 10-cm insulated stimuplex needle and a peripheral nerve stimulator. The onset of the block was around 15 min, after which the patient was placed in the right lateral decubitus position and the procedure was started. The whole surgical procedure was completed in an hour. The patient was on 35% O₂ and 65% N₂O by the face mask, spontaneously breathing, and additional bolus dose of pethidine 25 mg, iv, was supplemented during the procedure. The patient was haemodynamically stable throughout the procedure. Postoperative analgesia was maintained with NSAIDs.

With time, the number of geriatric patients who have to undergo surgical procedures which most often need the services of an anaesthesiologist is on the increase. They would have multiple co-morbidities associated with their age, which only get more complex with the increasing age. Patients undergoing hip fracture surgery constitute a high-risk group with considerable mortality and morbidity and an often protracted postoperative hospital stay. These patients often have a depleted intravascular volume in the perioperative period. Also, in view of the poor cardiovascular status of our patient, we went for CVP monitoring, so that prompt treatment of any haemodynamic aberration could be instituted.

In certain subset of elderly patients, central neuroaxial blockade may not be the best anaesthetic choice, for example, in patients who would have undergone angioplasty with stenting and were on an antiplatelet regimen and general anaesthesia may not be that safe. We selected a single shot technique for establishing the lumbar plexus block, expecting the time duration of the block to be adequate for the procedure. However, a continuous lumbar plexus block using Tuohy-style tip needle with a catheter is an advanced regional technique, especially useful for postoperative pain management, for which adequate experience with the single shot technique is a prerequisite to ensure its efficacy and safety.

With increasing life expectancy, the anaesthesiologist comes across these set of patients more often, which not only tests the knowledge and experience but also the skill level. Present day anaesthesiologists should be familiar with the wide range of techniques in order to deal with such challenges so that anaesthesia could be made as safe as possible, especially in such a vulnerable age group.

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Oculocardiac reflex during endoscopic transsphenoidal removal of pituitary adenoma

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Sir,

With the advent of endoscopic neurosurgery, the endoscopes have now been applied to access intracranial tumours with favourable result. The literature revealed that this method has very few complications, including vision loss. We
report a case of sudden bilateral vision loss after endoscopic surgery for pituitary tumour, where intraoperative haemodynamic instability was possibly suggestive of a devastating postoperative complication. A 23-year-old, 70-kg male presented to the neurosurgical department with a complaint of coarsening of features for past 2 years. He was a known case of diabetes mellitus. A clinical diagnosis of acromegaly was confirmed by his growth hormone (GH) assessment (GH >90). Other investigations were within normal limits. Magnetic resonance imaging (MRI) revealed a $2 \times 2 \times 1.8$ cm suprasellar lobulated mass, suggestive of pituitary tumour. His preoperative vision was 6/6 in both eyes. The patient was scheduled for endoscopic transsphenoidal removal of pituitary macroadenoma. Anaesthesia was induced with fentanyl 2 mcg/kg, propofol 2 mg/kg and rocuronium 1 mg/kg. Standard monitoring was applied. Anaesthesia was maintained with propofol infusion and a oxygen–nitrous oxide mixture (1:2) along with intermittent boluses of fentanyl and rocuronium. At the time of tumour removal, sudden bradycardia occurred and the heart rate dropped from 86 beats per minute (bpm) to 37 bpm. The surgeon was immediately informed, who stopped further manipulation and within 15 s, the heart rate came back to the baseline value. During these episodes, the mean blood pressure remained near baseline value of 85 mmHg and did not fall significantly. The surgery was allowed to continue and there occurred three episodes of bradycardia. All these episodes occurred when surgeon was operating in close proximity to the optic chiasma. No pharmacological intervention was required during any of the episode of bradycardia. At the end of surgery, anaesthesia was discontinued and neuromuscular block reversed with neostigmine 0.5 mg/kg and glycopyrrolate 10 mcg/kg. The patient was shifted to the neurosurgical intensive care unit (ICU). Six hours later, the patient complained of bilateral vision loss. Ophthalmic examination revealed bilateral negative perception of light. Immediately, computed tomography was performed which revealed haematoma of $10 \times 7$ mm size in the sellar region, compressing optic chiasma, along with remnants of the tumour [Figure 1]. Immediately craniotomy and evacuation of haematoma was performed. Postoperatively, his ophthalmic examination revealed a 6/6 vision in the right eye while in the left eye only finger counting was present. No further improvement in vision of the patient was observed during his hospital stay. The mechanisms involved in visual complications include direct injury or devascularisation of the optic apparatus, fracture of the orbit, postoperative haematoma, cerebral vasospasm and prolapse of the optic chiasm into an empty sella[1] and tension pneumosella.[2] During the postoperative period, our patient developed bilateral vision loss that may be due to tumour residue and optical chiasmal compression by sellar haematoma. However, intraoperative events of repeat bradycardia, possibly resulting from the oculocardiac reflex cannot be ignored. The reflex elicited may act as a warning signal and at the same time predict the surgical outcome also.

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