

Volume 2 Issue 2 ~ Apr to Jun 2026

The Anaesthesia Pulse

The Official Newsletter of ISA Noida GB Nagar

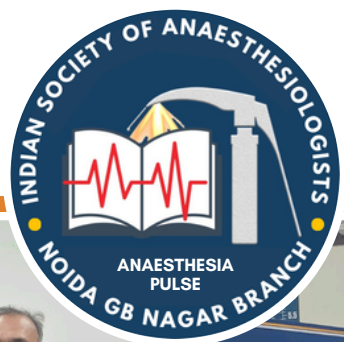


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Executive Members of ISA Noida GBN



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(President)



Dr. Kapil Singhal
(Founder President)



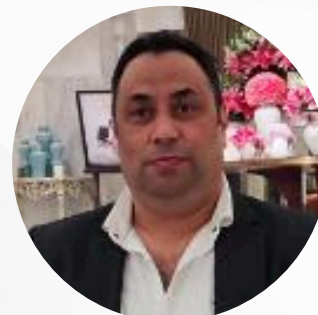
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Dr Peeyush Chaudhary

Dear Esteemed Members of ISA Noida GBN,

This quarter has once again reaffirmed our society's core commitment to good health and academic excellence. I am delighted to see the enthusiasm and participation from all of you which has made it one of our most vibrant quarters so far.

We saw tremendous energy and unity during the "Walk to Win" organized by the National ISA. Our members participated in large numbers, sending a strong message about preventive health, wellness, and the role of anaesthesiologists in promoting a healthy society. Thank you to everyone who walked, volunteered, and mobilized their teams.

Academics remained our top priority. The monthly CMEs conducted at Apollo Hospital, Cloudnine Hospital, and Mahanandan Hospital, Greater Noida were well attended. The topics chosen were contemporary, clinically relevant, and presented with great depth. I am especially proud that these forums provided an excellent opportunity for our young anaesthesiologists to present, share their research, and interact with senior faculty. This platform for mentorship and learning is exactly what will sustain the future of our specialty.

My sincere thanks to the CME convenors, the hospital teams, and all faculty members for their time and dedication in making these meetings a success.

Preparations are now in full swing for our Annual Foundation Day CME scheduled for next month. The scientific committee is curating an exciting program and I urge all of you to block your calendars and participate in large numbers. It promises to be a day of learning, networking, and celebrating the journey of our society.

I thank the Executive Committee, all office bearers, and every member for your continued support. Let us carry forward the same spirit of collaboration, learning, and service into the next quarter.

Jai Hind
Jai ISA.

With warm regards,



Dr Peeyush Chaudhary



Dr Sonia Mathur

Greetings!

The months of April to July 2026 were marked by a perfect blend of academic excellence, member wellness, and professional engagement, reflecting the vibrant and progressive spirit of the ISA Noida Gautam Buddh Nagar Branch. We began April on an energetic note with enthusiastic participation in the ISA National "Walk to Win" Competition, encouraging members to adopt a healthier lifestyle and reinforcing the importance of physician wellness. This was followed by the World Health Day Wellness Webinar on 7th April, where members benefited from expert sessions focusing on physical health, mental well-being, stress management, work-life balance, and overall wellness of anaesthesiologists. Our academic activities continued with the April Monthly CME held at Apollo Hospital, Noida featuring discussions on perioperative pulmonary complications and advances in regional anaesthesia. The interactive sessions were well appreciated and encouraged meaningful academic exchange among members.

In May, we celebrated Mother's Day through the special activity "The Heart Behind Every Doctor," where members shared heartfelt photographs and messages dedicated to their mothers and children. The initiative beautifully highlighted the compassionate side of our profession and strengthened the bond within the ISA family. The May Monthly CME, hosted at Cloudnine Hospital, Noida focused on contemporary practices in neuraxial ultrasound and evidence-based management of spinal hypotension in obstetric anaesthesia, providing valuable learning for all attendees.

Our academic journey continued in June with the Monthly CME at Mahanandan Super Speciality Hospital, Greater Noida where enriching discussions on neuroanaesthesia, perioperative haemodynamic management, and neurosurgical anaesthesia further strengthened our commitment to continuous professional development.

As Honorary Secretary, I express my heartfelt gratitude to our President, office bearers, Executive Committee members, faculty, host hospitals, organizing team, and every member whose dedication and enthusiastic participation continue to strengthen our branch. Together, we shall continue to promote academic excellence, professional integrity, and the spirit of fellowship while striving for newer milestones in the service of anaesthesiology.



Dr Sonia Mathur



Dr Priyankar Sarkar

Gracious Greetings to everyone!

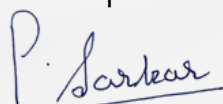
Firstly let us congratulate Dr Kapil Singhal, Director Anaesthesia Metro Hospitals and our founder president, for being elected to the Governing Council of ISA National from Central Zone. It is a matter of huge pride for all of us that one member from our city branch will be in such an important administrative body at the national level. On the other hand, this accolade for Kapil sir should not surprise us for he has worked tirelessly in various capacities for Indian Society of Anaesthesiologists. We celebrate his achievement as our own and pray that he go on to greater achievements in the future.

Secondly, it was heartening to see that despite the harsh summer temperatures, a good number of colleagues regularly turned up for the monthly academic meets and participated enthusiastically and whole heartedly in the academic activities of the day—be it case presentation or a CME topic. At the same time we are indebted to the various medical institutes and hospitals in Gautam Budh Nagar for supporting our monthly CME program, realising that this is the most important activity of our branch. In fact July will witness 2 academic meets—the Annual Foundation Day CME to be held at Max Superspecialty Hospital, Sec 128 and the monthly CME meet to be held at Sharda Hospital.

We have a case report from Dr Poonam Motiani/Dr Zainab Ahmed in this issue involving a difficult airway scenario—a floor of the mouth swelling in a pediatric patient. The report exemplifies how such a case should be approached with a written anaesthetic plan, back up options and a definite postoperative plan which may or may not deviate from the original plan. It is a must-read for postgraduate trainees as well as practicing anaesthesiologists.

Our two non-academic contributions are interesting pieces which reflect a well known fact: anaesthesiologists are sensitive professionals but they are proud of the job they do daily. I welcome such frank opinion pieces because they reflect the fact that we do a commendable job though the recognition that comes our way is not commiserate with our actual contribution to a successful surgery, or a successful discharge from the ICU or a successful intubation in the emergency.

I will welcome any and every feedback from my dear colleagues and would request everyone to keep sending their contributions and their thoughts to our email



Dr. Priyankar Sarkar

Mother's Day Celebration – “The Heart Behind Every Doctor”

- To celebrate Mother's Day in a meaningful way, ISA Noida Gautam Buddh Nagar organized a unique activity themed “The Heart Behind Every Doctor.” Members were invited to participate by sharing a special photograph—lady anaesthesiologists with their child/children and gentlemen anaesthesiologists with their mother—along with a heartfelt handwritten note describing their bond and a one-line message on what motherhood means to them. The response from members was overwhelming, with enthusiastic participation from across the branch. The entries beautifully reflected the love, gratitude, and emotional strength behind every doctor, making the initiative truly memorable.
- Three outstanding entries were selected and awarded cash prizes. The winners were felicitated during the monthly CME held at Cloudnine Hospital, Noida, where the prize distribution ceremony was conducted in the presence of members. This initiative was widely appreciated as a thoughtful and heartwarming celebration, and it successfully strengthened the sense of bonding and camaraderie among the members of ISA Noida Gautam Buddh Nagar.

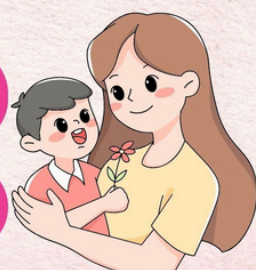



INDIAN SOCIETY OF
ANAESTHESIOLOGISTS
NOIDA GAUTAM BUDH NAGAR

MOTHER'S DAY ACTIVITY

Theme: “The Heart Behind Every Doctor”

LADY ANAESTHESIOLOGISTS
can send a picture with their
child/children



**GENTLEMEN
ANAESTHESIOLOGISTS**
can send a picture with their mother

Along with the picture, kindly add:

- A short handwritten note (1–2 lines only) about your bond with your child/mother
- “What does a Mother or being a Mother mean to you?” (In one line)

EMAIL YOUR ENTRIES TO BELOW MENTIONED EMAIL ID

📅 Last date for submission: 13th May
📢 Results declaration: 15th May
🎉 Prize celebration: Weekend (16th–17th May)

Pictures and notes will be judged, and prizes will be awarded.
All entries will later be displayed together as a beautiful memory wall.


Dr. Kapil Singhal
(Founder & past President)


Dr. Peeyush Chaudhary
(President)


Dr. Mukul Kumar Jain
(Vice President)


Dr. Sonia Mathur
(Hon. Secretary)


Dr. Sameer T. Bolla
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Apollo Hospital, Noida, hosted its monthly meeting in an offline format on 28 April 2026. The academic session featured one case scenario discussion and one continuing medical education topic.

SYNOPSIS OF THE TALK

1. Negative pressure pulmonary edema (NPPE) in the Operation Theatre: Early Recognition and effective management

It is also known as post-obstructive pulmonary edema (POPE), is a potentially life-threatening anesthetic emergency caused by forceful inspiratory efforts against a closed upper airway (typically post-extubation laryngospasm). Early recognition is vital because delayed treatment carries a mortality rate of up to 40%, whereas prompt intervention usually leads to a rapid, complete resolution within 12 to 48 hours. Early Recognition Protocols in the OT Anesthesiologists must maintain a high index of suspicion, especially when managing young, athletic male patients or individuals undergoing ENT, head, and neck surgeries.

Immediate Clinical Signs

1. Airway Occlusion Clues: Stridor, suprasternal/intercostal muscle retractions, or highly uncoordinated "rocking horse" abdominal breathing.
2. Rapid Hypoxemia: A precipitous drop in oxygen saturation ($\text{SpO}_2 < 90\%$) accompanying acute tachypnea and tachycardia.
3. Classic Secretions: Spontaneous presentation or suctioning of pink, frothy sputum from the oral cavity or endotracheal tube.
4. Auscultation: Sudden development of widespread, bilateral pulmonary rales (crackles).

Diagnostic Confirmation

- Point-of-Care Ultrasound (POCUS): Bedside lung ultrasound showing diffuse, bilateral B-lines indicating interstitial alveolar fluid.
- Chest Radiography: A stat portable chest X-ray will reveal diffuse alveolar infiltrates radiating from the hila without an enlarged heart structure.
- Differential Checklist: Rapidly distinguish NPPE from gastric acid aspiration, acute anaphylaxis, or dynamic fluid overload.

Step-by-Step Interventions

1. Relieve Airway Obstruction: Apply an aggressive jaw thrust maneuver, suction blood or secretions, and deliver positive pressure ventilation with 100% O₂.
2. Deepen and Paralyze: Bolus low-dose propofol to suppress hyperactive laryngeal reflexes. If the spasm persists, immediately give succinylcholine (0.1 to 0.2 mg/kg IV up to a full paralyzing dose) to forcefully relax the glottis
3. Apply Positive Pressure: For milder cases, apply non-invasive ventilation (CPAP/BiPAP at 5-10 cmH₂O). If severe hypoxemia persists, reintubate the patient. Use a lung-protective setting: low tidal volumes (6 mL/kg of ideal body weight), plateau pressures under 30 cmH₂O, and high positive end-expiratory pressure (PEEP) to push interstitial fluid back into circulation.
4. Fluid Optimization: Avoid aggressive diuretic use (like furosemide) unless volume overload is explicitly proven; overuse can worsen underlying perioperative dehydration and induce acute kidney injury (AKI).
5. Fluid Clearance: Administer inhaled β_2 -agonists (e.g., albuterol) via the breathing circuit to accelerate active sodium transport, speeding up alveolar fluid clearance. Systemic corticosteroids are not recommended as they do not affect the hydrostatic pressure mechanics driving NPPE.

Prevention Guidelines

- Neuromuscular Validation: Always rely on objective quantitative neuromuscular monitoring. Ensure a verified train-of-four (TOF) ratio ≥ 0.9 before proceeding with extubation.
- Thorough Toilet Suctioning: Aggressively clear the oropharynx of all saliva, blood, and surgical debris before altering anesthetic depth.
- Extubation Timing: Extubate patients when they are either completely deep or fully awake. Avoid pulling the tube during the unstable Stage II

2.Optimizing Neuraxial Blockade : The impact of preoperative imaging on success of regional anaesthesia in elderly patients

In elderly surgical candidates, regional techniques improve analgesia, reduce opioid use, and may lower postoperative morbidity and mortality compared to GA alone. Age related spinal changes (deformation, stenosis, deformity) make traditional landmark- based neuraxial techniques less reliable and increase the risk of haemodynamic instability and high or failed block.

Preoperative CT/MRI and point of care ultrasound help identify the safest interspaces, appropriate needle trajectory and likely spread enabling lower, individualized local anaesthetic dosing. Combining dose-sparing neuraxial techniques with ultrasound guided peripheral nerve blocks improves block success and analgesia while limiting opioids, hypotension and cognitive complications, thereby enhancing perioperative outcomes in the geriatric population.



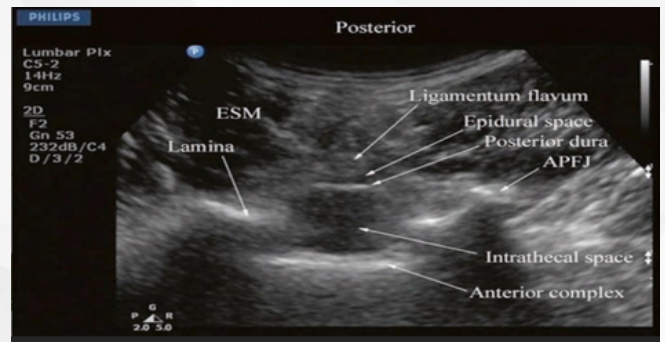
The monthly meet was conducted by Cloudnine Hospital, Noida on 19th May 2026 in an offline mode. An interesting lecture was presented by Dr Peeyush Chaudhary on “The use of USG for neuraxial blocks” and moderated by Dr Anil Pandey. Another interesting topic was “Optimizing the management of spinal hypotension in cesarean delivery- beyond phenylephrine ” by Dr Amrita Nandi and moderated by Dr Anil Pandey.

SYNOPSIS OF THE TALK

1.Topic-1

- The **use of USG for neuraxial blocks** transforms central nerve blocks—like spinal and epidural injections—from blind, landmark-based techniques into precise, visually guided procedures. Traditionally, clinicians rely on manual palpation of bony landmarks, which is frequently inaccurate due to obesity, edema, scoliosis, or degenerative spinal changes.
- USG resolves these anatomical challenges through preprocedural scanning. By using a low-frequency curved array transducer, clinicians can accurately map the true midline, pinpoint specific lumbar intervertebral levels, and measure the exact depth to the epidural or intrathecal space. This scout scan identifies the optimal interlaminar acoustic window, outlining a clear trajectory before the needle ever touches the skin
- Clinical evidence proves that incorporating ultrasound significantly enhances patient outcomes.
- Advantages
 - doubles first-attempt success rates
 - substantially reduces the number of painful needle redirections
 - lowers the risk of complications like accidental vascular puncture or post-dural puncture headaches.
- While real-time needle tracking remains technically demanding due to narrow bony windows, pre-procedural USG mapping has become an indispensable tool. It elevates safety, improves efficiency, and ensures reliable anesthesia, particularly in anatomically challenging patients.

Transverse sonogram of the lumbar spine with the transducer positioned such that the ultrasound beam is insonated through the interspinous space. The ligamentum flavum, epidural space, posterior dura, intrathecal space, and anterior complex are now visible within the spinal canal in the midline and, the APFJ and the TP are visible laterally.



2.Topic-2

- **Optimizing spinal anesthesia-induced hypotension (SAIH) during cesarean delivery requires a transition from traditional phenylephrine monotherapy toward norepinephrine and multimodal fluid dynamics.** While phenylephrine remains a gold standard first-line choice, its pure α_1 -agonist activity frequently causes reflex bradycardia, which can drastically lower maternal cardiac output.
- **Norepinephrine** has emerged as the premier alternative due to its dual-action profile. It combines potent α -adrenergic vasoconstriction with weak β -adrenergic activity. This mild β -agonist property safely counteracts reflex bradycardia, successfully maintaining maternal heart rate and preserving cardiac output. For clinical deployment, norepinephrine is administered via a secured peripheral intravenous line as a prophylactic, manually titratable infusion at **1.9 to 3.8 mcg/min** (or 0.05–0.08 mcg/kg/min), initiated immediately after the intrathecal block.
- Pharmacotherapy must be structurally paired with **crystalloid co-loading** to maximize efficacy. Administering a rapid fluid bolus at the exact moment of spinal injection expands intravascular volume precisely as the sympathetic block induces widespread vasodilation. In contrast, traditional fluid preloading is vastly less effective.

Furthermore, non-pharmacological interventions are mandatory to reduce overall vasopressor requirements:

- **Left Uterine Displacement (LUD):** A strict left lateral tilt minimizes uterine aortocaval compression, protecting venous return.
- **Lower Limb Compression:** Applying sequential compression devices or leg wraps prior to the block limits lower extremity blood pooling.

- Finally, management must be individualized for specific maternal demographics. For patients presenting with severe baseline bradycardia, ephedrine (5-10 mg boluses) remains the drug of choice to provide critical chronotropic support. Conversely, in preeclamptic patients, who experience less severe spinal-induced vasodilation, prophylactic infusions of norepinephrine or phenylephrine should be reduced by 50% to prevent dangerous maternal hypertensive spikes.



The Mahanandan Super Speciality Hospital in Greater Noida hosted its monthly meeting in an offline format on 13 May 2026.

The academic session featured two high-impact presentations:

- Anaesthesia Considerations in SOL Surgery: Presented by Dr Abhishek Jain and moderated by Dr Abhishek Deswal.
- Hemodynamic Considerations in Neuro-Anaesthesia: Presented by Dr Amit Sharma and moderated by Dr Abhishek Deswal.

SYNOPSIS OF THE TALK

1. Anesthetic management for Space-Occupying Lesion (SOL) surgery focuses on maintaining cerebral perfusion pressure (CPP), ensuring hemodynamic stability, and preventing intracranial hypertension.

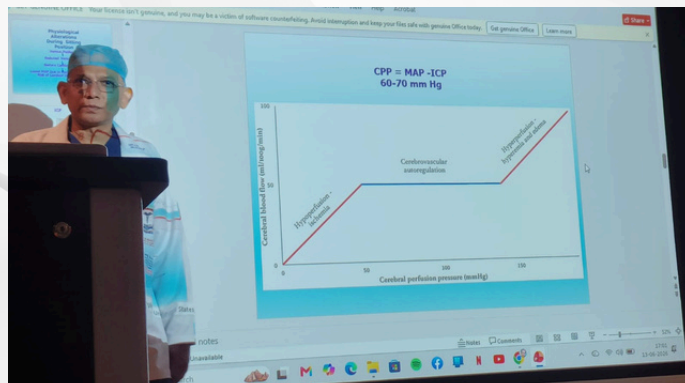
- Preoperatively, clinicians must assess for elevated intracranial pressure (ICP) using signs like headache, papilledema, or a diminished conscious level.
- Intraoperatively, the primary goal is a smooth induction to prevent dangerous ICP spikes during laryngoscopy. This is achieved using a **Total Intravenous Anesthesia (TIVA)** regimen with propofol and remifentanyl, or a balanced technique with low-dose volatile anesthetics (<1 MAC), as high doses cause cerebral vasodilation.
- Strict physiological targets must be maintained:
- Emergence must be highly controlled to prevent coughing, straining, and postoperative hypertension, which can trigger intracranial hemorrhage.
- **Postoperative Emergence Protocol**
 1. Transition to Dexmedetomidine: Initiate a low-dose infusion (0.2–0.7 mcg/kg/hr) during the closure phase. It provides excellent sedation and analgesia without inducing respiratory depression, facilitating a calm wake-up.
 2. Deep Tracheal Extubation: If the patient has no risk factors for aspiration or a difficult airway, consider extubating in a deep plane of anesthesia using a short-acting agent (like sevoflurane) to completely bypass the coughing reflex.

3. The "Remifentanyl Context" Technique: Maintain a ultra-low-dose remifentanyl infusion (0.02–0.05 mcg/kg/min) during emergence. This suppresses the cough reflex on the endotracheal tube while allowing the patient to follow verbal commands.
4. Intravenous Lidocaine: Administer a bolus of 1–1.5 mg/kg IV roughly 3 to 5 minutes before extubation to blunt the airway cough reflex and stabilize blood pressure.

2. Haemodynamic consideration in Neuroanaesthesia

- Neuroanaesthesia requires strict hemodynamic control to maintain **cerebral perfusion pressure (CPP)** and prevent brain injury. Because the brain sits inside a rigid skull, any shifts in blood pressure or volume directly affect **intracranial pressure (ICP)**.
- The core goal is keeping CPP between **50–70 mmHg**. Since injured brain tissue often loses its ability to autoregulate blood flow, cerebral perfusion becomes entirely dependent on **Mean Arterial Pressure (MAP)**.
- Key management strategies include:
 - Induction: Blunt sympathetic spikes during intubation using
 - Propofol: 1.5–2.5 mg/kg IV (titrate slowly to avoid hypotension).
 - Esmolol: 0.5–1.5 mg/kg IV bolus (given 2 minutes before intubation).
 - Lidocaine (2%): 1–1.5 mg/kg IV (given 3 minutes before intubation).
 - Fentanyl: 2–5 mcg/kg IV.
- Maintenance: Use **Total Intravenous Anaesthesia (TIVA)** with propofol. Avoid volatile gases above 1 MAC, as they cause vasodilation and elevate ICP.
- Ventilation: Maintain strict **normocapnia** (PaCO₂ 35–40 mmHg). Hypercapnia causes vasodilation, increasing swelling.
- Fluids: Use **0.9% Normal Saline**. Avoid hypo-osmolar fluids like Ringer's Lactate, which trigger cerebral edema. Use **mannitol** if brain swelling occurs.
- Emergence: Smooth extubation via **dexmedetomidine** prevents coughing and post-operative intracranial hemorrhage.
- Ultimately, maintaining systemic stability with **norepinephrine** protects vulnerable brain tissue from both ischemia and edema.

JUNE- 2026



Managing the Anticipated Difficult Airway in a Child with a Congenital Sublingual Swelling: Lessons from a Case

Poonam Motiani 1, Zainab Ahmad 2

¹ Professor, Department of Paediatric Anaesthesia, Post Graduate Institute of Child Health, Noida

² Additional Professor, Department of Anaesthesiology and Critical Care, AIIMS Bhopal (Previously at PGICH, Noida)

1. Introduction

- Intraoral space-occupying lesions are an uncommon but disproportionately challenging cause of difficult paediatric airway. Lesions arising from the floor of the mouth – congenital ranula (a mucous retention pseudocyst of the sublingual or submandibular salivary glands) and lymphangioma (a benign hamartoma of dysplastic lymphatic channels) – can elevate the tongue, obscure laryngoscopic landmarks, and produce dynamic airway obstruction that worsens supine.
- The published anaesthetic literature is sparse and almost entirely limited to single case reports. We describe an 18-month-old child whose perioperative course illustrates how careful preoperative planning, an inhalational induction with preserved spontaneous ventilation, primary videolaryngoscopy and – critically – readiness to perform a tracheostomy at extubation can be combined to deliver safe care

2. Case Summary

- An 18-month-old, 15 kg female child presented for excision of a large sublingual swelling that had been present since birth and had progressively enlarged. For several months she had had increasing difficulty swallowing solids, although liquids remained tolerable. Over the preceding month she had developed worsening noisy breathing that intensified in the supine position, with audible inspiratory stridor and visible drooling. There was no history bleeding, sudden enlargement or pain in the swelling.
- On examination she was conscious, alert and moderately distressed, with tachypnoea (respiratory rate 30/min), tachycardia (heart rate 120/min) and an oxygen saturation of 99% on room air. A large midline sublingual swelling was seen arising from the floor of the mouth, displacing the tongue upwards almost flush with the palate; tongue protrusion was not possible and the extent of the lesion could not be fully demarcated. Both nostrils were patent and neck extension was preserved. Ultrasonography and a plain neck radiograph demonstrated a large unicystic soft-tissue swelling confined to the sublingual region with no extension below the mylohyoid muscle and no tracheal compression. A provisional diagnosis of congenital ranula was made and the child was scheduled for excision the following day.

3. Airway Challenges in this Case

Anatomical distortion and limited oral space

The sublingual mass had elevated the tongue against the palate, eliminating the working space required for laryngoscope blade insertion and tongue displacement. Direct laryngoscopy in such a patient typically yields a Cormack-Lehane grade 3 or 4 view because alignment of the oral, pharyngeal and laryngeal axes – already imperfect in toddlers – becomes physically impossible.

Risk of dynamic obstruction on induction

Inspiratory stridor and worsening symptoms when supine indicated extrathoracic dynamic obstruction. Loss of pharyngeal muscle tone at induction can rapidly convert partial obstruction into complete obstruction. An infant has small functional residual capacity, high oxygen consumption ($\sim 6 \text{ mL kg}^{-1} \text{ min}^{-1}$) and consequently a much shorter safe-apnoea margin than an adult – minutes are simply not available for rescue.

Difficult mask ventilation and risk of cyst rupture

The supraglottic mass complicated mask ventilation; bag-mask ventilation can also force cystic contents posteriorly into the oropharynx, potentially provoking laryngospasm or rupturing a thin-walled lesion. Spillage of viscous cyst contents and blood obscures the laryngoscopic view, increases aspiration risk and can precipitate sudden complete obstruction.

4. Anaesthetic Strategy: a Stepwise Approach

Preoperative planning and a graded plan A-B-C

The cornerstone of safe management was a written, multidisciplinary plan agreed jointly with the operating surgeon and the otolaryngology team. Three escalating options were defined in advance:

- Plan A: inhalational induction with preserved spontaneous ventilation, followed by direct or video-assisted laryngoscopy.
- Plan B: needle decompression and aspiration of cystic contents to reduce mass effect, followed by repeat laryngoscopy.
- Plan C: surgical tracheostomy under local anaesthesia by the on-standby surgeon.

Equipment readiness was structured to support every step of this plan

Premedication and induction

- The child was kept fasted as per standard guidelines (6 hours for milk, 2 hours for clear fluids). Intravenous access (22 G) was established before induction. Glycopyrrolate 0.1 mg was given 30 minutes preoperatively to reduce secretions. Standard ASA monitoring was instituted. Following preoxygenation with 100% oxygen, induction was commenced with intravenous ketamine 5 mg and fentanyl 10 µg (titrated to maintain spontaneous ventilation), then deepened with sevoflurane in 100% oxygen. Spontaneous ventilation was preserved throughout –the single most important safety feature in this scenario, since any apnoea before the airway is secured would be very difficult to reverse.

Laryngoscopy and intubation

- Laryngoscopy was undertaken once a deep level of anaesthesia was achieved while spontaneous ventilation continued. The C-MAC videolaryngoscope (Karl Storz, Tuttlingen, Germany) with a Miller size 1 blade, and subsequently a Macintosh size 2 blade, provided a Cormack-Lehane grade 3a view with optimal external laryngeal manipulation
- A 4.0 mm cuffed flexometallic endotracheal tube, preloaded with a stylet, was negotiated beyond the cords at the first attempt. Tube position was confirmed with sustained capnography and bilateral chest rise, and the tube was secured. Atracurium 8 mg and dexamethasone 2 mg were given only after tube position was confirmed (Figure 1). The pharynx was packed with a moist ribbon gauze.

Why videolaryngoscopy was the first-line device

Videolaryngoscopy decouples the laryngoscopic line of sight from the operator's eye, removing the need to align the oral, pharyngeal and laryngeal axes – exactly the problem created by an elevated tongue. The 2024 ESAIC/BJA neonatal-and-infant guideline now recommends a videolaryngoscope with an age-adapted standard blade as the first-line device for tracheal intubation (1B recommendation).

5. Intraoperative and Postoperative Considerations

- At excision, the lesion was found to be a macrocystic lymphangioma masquerading clinically and sonographically as a ranula – a reminder that intraoperative pathology can diverge from preoperative imaging in cystic floor-of-mouth swellings. The mass was poorly demarcated and could not be completely excised; subtotal excision was performed and 3% hypertonic saline was injected as a sclerosing agent. Blood loss was minimal.
- By the end of surgery, however, significant peri-incisional and lingual oedema had developed. (Figure 2). The combination of impaired tongue mobility, residual mass, post-operative oedema and the prospect of repeated returns to theatre for further sclerotherapy made the postoperative airway distinctly more threatened than at induction. After multidisciplinary discussion, an elective tracheostomy was performed before reversal of neuromuscular blockade. The child was allowed to wake up with a secured airway and was transferred to the high-dependency unit.

6. Discussion

Three themes from this case deserve closer attention

- Diagnosis is provisional, the plan must be robust– The anaesthetic plan must therefore be built around the dominant airway feature – a fragile, mobile, midline mass occupying the floor of mouth – rather than around the histological label, because the airway plan is the same for all of them.
- Alternative airway strategies, considered and discounted – Several alternative approaches have been described in the literature such as aspiration of cystic contents before laryngoscopy, lateral-position laryngoscopy, awake fiberoptic intubation, tongue traction were considered and either declined or kept as back up.
- Postoperative airway: tracheostomy as a planned, not panicked, decision – Tracheostomy in a child carries significant short- and long-term morbidity . Yet for an intraoral mass that has produced demonstrable airway compromise, that has caused significant intraoperative oedema and that will require repeated returns to theatre for sclerosant injection, an elective tracheostomy at the end of the index procedure is often the safest, most controlled and most humane choice

Key Learning Points

- Floor-of-mouth swellings in young children may look benign on imaging but produce one of the most challenging anticipated difficult airways encountered in paediatric practice.
- A written, graded Plan A-B-C, agreed jointly with the surgeon and explicitly equipped for, is more important than the clinical diagnosis itself.
- Inhalational induction with preserved spontaneous ventilation remains the default; do not paralyse until the airway is secured.
- Videolaryngoscopy with an age-adapted blade (e.g. C-MAC Miller 1 or Macintosh 2) is the first-line device – supported by ESAIC/BJA 2024 guidance and PeDI Registry data – not a rescue.
- Anticipate the postoperative airway with the same rigour as induction. Surgical oedema, repeat procedures and prolonged recovery may make elective tracheostomy the safest endpoint.
- Surgeon scrubbed and at the head end with tracheostomy set open before induction is not over-preparation – it is appropriate preparation.

Large Swelling under Tongue



Elective tracheostomy in view of residual mass and post-operative lingual oedema



My day begins before the world fully awakens. By the time the first light filters through the hospital corridors, I am already in the operating theatre—standing at the head of the table, in a space where silence, precision, and responsibility coexist. To many, the anaesthetist is a quiet presence—often unnoticed, working behind monitors while the surgeon takes center stage. But those of us in this field know a deeper truth. We are not observers. We are the guardians of a delicate threshold—the space between consciousness and oblivion, between fear and trust, between life and uncertainty. The most important moments often come before the anaesthesia begins. In those brief preoperative encounters, I meet a patient at their most vulnerable—anxious, uncertain, and placing complete trust in someone they have just met. In that moment, I do more than assess airways or calculate drug doses. I offer reassurance. I offer presence. “I will be with you throughout,” I say—and I mean it.

Because once the monitors begin their rhythmic beeping, the responsibility becomes absolute. Every fluctuation in heart rate, every change in blood pressure, every breath is a conversation I must interpret. Anaesthesia is often described as a science, but in truth, it is also an art—a constant balancing act requiring vigilance, anticipation, and calm under pressure.

As women, many of us learn to navigate another balance as well—between professional intensity and personal roles. We step out of the operating theatre and into lives as daughters, mothers, partners, carrying with us the invisible weight of the lives we have held in equilibrium. And yet, there is quiet fulfillment in this work. At the end of every procedure, when a patient opens their eyes and returns safely from that carefully guided “sleep,” there is a moment of silent satisfaction.

We are the calm in chaos. The voice when the patient cannot speak. The unseen hands that guide both descent and return.

We are, and always will be, the guardians of the threshold.

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While reading a leading daily newspaper couple of months back I came across this sentence that “operation theatre is the most opaque part of any hospital.” The article obviously was talking about the disadvantage of that with regard to the bills a patient receives, talking at length that somethings are added to the bill and patient has no way of knowing what was done and what wasn’t since they are anaesthetised.

Since I am working in this very area under scrutiny in this article, it made me think about its pros and cons. In tune with the human nature which has a habit of looking at the flaws first, be it their own or someone else’s, let’s look at the cons.

THE CONS

Anonymity

So many healthcare workers right from preoperative unit, OT to post operative unit working day in and day out like a well-oiled machine. These include the anaesthesiologist, scrub nurses, technicians, housekeeping and many more. All of them have a single goal of giving best care to the patient that comes for surgery. But you know only the surgeon you met in the OPD.

Inability to build Trust

The doctors and staff working in the peri operative area get little time to interact with the patients. With the concept of “Time is money” ingrained in our DNA by now, patients want their surgery as soon as possible, surgeon and hospital want more surgeries done in a day. But since a day has only 24 hours, the peri operative physician aka Anaesthesiologist and the perioperative staff have little time to interact and explain to the patient as to what happens in an OT complex so as the TIME lacks the TRUST cracks!

Risk taking

The amount of risk an anaesthesiologist takes for a patient to have even a simple surgery done smoothly, should be a case study especially if the patient is 80, hypertensive, diabetic, with a few stents here and there! I still do not understand how we wake up every day with the same zeal to risk it all so that you go to sleep, get your gall bladder removed and wake up feeling painless and beautiful! Magic of Anesthesia for you should not be the drugs, it should be the person on the head end, who is going to risk it all and make sure you wake up safe and healthy!

Enough of the cons, let us talk about the pros.

There must be something good in this “theatre of opacity” that hundreds of people choose to work here daily.

THE PROS

No facade, no judgements

Working in a high-stakes area leaves no room for facades. Everyone is raw and real, trying to do their level best so that the experience a patient has is forgettable! It is not a spelling mistake. We really do not want you to remember the day you went for a surgery and got scarred for life!

No social skills needed

You can be as quiet as you want. There is no stress of interaction and communication. Patient is already counselled by the star of the show, the surgeon. The show is on the cruise, the ship's master (Anaesthesiologist) speaks if the ship is going to go through choppy waters. The rest of the staff can do their work as usual without uttering a single word, just like a well-oiled machine, as I said earlier.

Getting patients and diagnosing diseases

There is no stress of bringing the patient to the hospital, diagnosing their disease, and then convincing them to get a surgery done. That part has been dealt with before they enter the "shrine of secrecy."

Joy

Of taking care of a patient when they are completely unaware and seeing their happy/groggy face when they wake up, no matter how big or small their surgery was. This is definitely one of the main pros for anyone working in this field.

If I had to conclude, I would say some days we see only the cons, days when surgery doesn't go as planned, days when patient is not happy with the outcome, days when surgeon doesn't like what we are doing, yes, we are a sensitive bunch of people! But most days we see only the pros, days when a patient smiles with us in preoperative area, days when a complex surgery is followed by the patient sleeping peacefully and pain free in postoperative unit, days when a patient remembers your name from last time you gave them Anesthesia and is happy to see you.

OT is not the most opaque part, it is the most transparent and honest, you just need the eyes and heart to actually see it.

Dr Apurva Sadhoo
Anaesthesiologist
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List of venues for the monthly CME events of ISA Noida

- Jan – Post Graduate Institute of Child Health, Noida
- Feb – Metro Hospital & Heart Institute, Noida
- March – Max Superspeciality Hospital, Sector 128, Noida
- April – Apollo Hospital, Noida
- May – Cloudnine Hospital, Sector 50, Noida
- June – Mahanandan Hospital, Greater Noida
- **July – Sharda Hospital, Greater Noida**
- **August – Government Institute of Medical Sciences, Greater Noida**
- **Sept – Yatharth Superspeciality Hospital, Greater Noida**
- **October – Kailash Hospital and Neuro Institute, Sector 71, Noida**
- **November – Neo hospital, Noida**
- **December – ESIC Hospital Noida**
- 4th Annual Foundation Day CME 2026-- TBA

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