



Eternal Vigilance

ISA
Indian Society of
Anaesthesiologists

HAPPY NEW YEAR

2023



HAPPY
MAKARSANKRANTI

HAPPY LOHRI

MERRY
CHRISTMAS

ANAESTHESIA TIMES

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Anaesthesia: A Tightrope Walk



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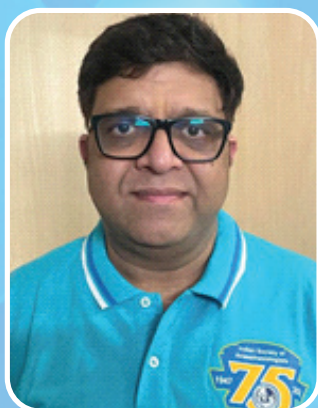
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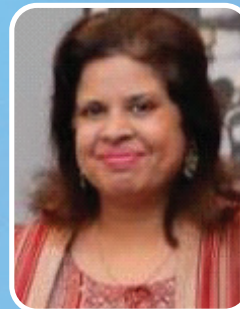
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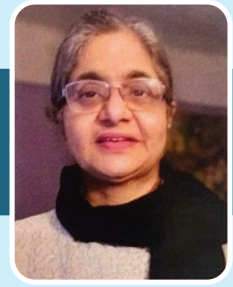
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President ISA (Delhi) Branch Message



Greetings to all from ISA Delhi

It's again my proud privilege to write this message. At year end after sparkling Christmas celebration we await the arrival of New year 2023. I wish everyone a very Happy New Year with loads of good things. May new year shower blessings and the entire mankind become disease-free and corona free. May each one of us come out to be a safe and learned professional with good patient outcome.

Hope everyone must have lot of expectations from new governing council of ISA Delhi. We are planning to strive hard to give you a striking performance like our predecessor team.

We are enclosing new years calendar of clinical meetings for your reference. It's my earnest wish to all to Head of Departments to make an endeavour to attend all these clinical program along their juniors.

I would like to involve all private and corporate colleagues to be part of these proceedings and present their academic work in these meetings with the help of zonal Governing council members like last year.

Suggestions and criticism are both equally welcome from you to make us perform better. Waiting to meet you all in person at VMMC & SJH.

With best wishes

Dr. Mohandeep Kaur

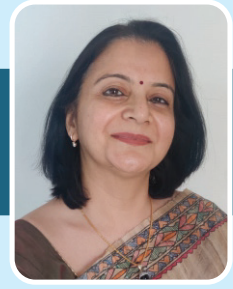
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ABVIMS & Dr. RML Hospital

President, ISA Delhi

Vice President ISA (Delhi) Branch Message



Greetings to all Delhi ISAians for a joyous start to the New Year 2023!

I hope the final wintry months of 2022 also brought for you a time of warmth and celebration together with family and friends - filled with the light from bright diyas gleaming on Diwali and the twinkling decorations of Christmas.

As I write to you today, a new phase of festivity pervades the atmosphere to mark the harvest season all over our country. Although celebrated in different ways, they convey to us a common inspiring message of hope and faith that hard work always bears rewards.

A New Year ushers in the expectation of new beginnings. But soon enough we find ourselves caught up once more in the trials and tribulations of everyday life and before we even realize it, the year appears to be drawing to a close. Let us hence take a few moments now to reflect on the year gone by and channelise the positive energy of the early days of the new year to imagine the many possibilities that lie ahead of us. Let us come together to make 2023 a wonderful year for everyone.

Long Live ISA.

Dr. Neerja Banerjee

Professor & Consultant

Department of Anaesthesiology

ABVIMS & Dr. RML Hospital

Secretary ISA (Delhi) Branch Message



Respected Delhi ISAians,

Happy new year and greetings for Lohri, Pongal, Sankranthi and Bihu. First of all, my sincere thanks to ISA for showing confidence in me and nominating me as the interim secretary. I will put in my best efforts to keep up with the good work done by the previous secretaries.

I would like to congratulate Dr. Rakesh Garg on being elected editor in chief of IJA. This is a matter of great pride for Delhi ISAians that we're representing ISA, Delhi on the national level as Dr. Rajiv Gupta is already holding the post of GC National. I hope to see this national recognition grow more and more.

I feel obliged to be getting an opportunity to work with the gems of our community, starting with Dr Nikki Sabbarwal, Dr Maitree Pandey and Dr. Mohandeep Kaur.

A New Year means more opportunities. More opportunities to start over and for filling new promises. Various harvest festivals being celebrated across the nation during this time bring about a feeling of merriment, hope and growth for all.

Coming out of the covid era, now all the ISA Delhi meetings are being conducted offline, which are being attended in large number and I just hope for these numbers to grow exponentially.

The annual calendar of clinical meetings and other programmes has been published, so I request all of you to help turn these events into a grand success.

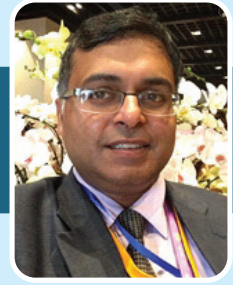
As you all know, our website is open and well functioning, please visit isawebdelhi.in regularly for all updates. I would like to request all the members to share their views regarding any changes they'd like so that we can make amendments and improve accordingly. You can mail us directly on our official email- isadelhiexecutive@gmail.com.

With your support and encouragement, we'll take ISA Delhi to new heights.

**Long live ISA!
Long live ISA Delhi!
Jai Hind.**

Warmest regards
Dr Anuvijayant Goel
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From the Editor's Desk Message



It gives me immense pleasure to release December issue of Anaesthesia News, a monthly magazine of ISA, Delhi Branch. As we enter into new year, there are new hopes and new vision.

The New Year is a time for looking back and for looking forward. Some people make resolutions to break bad habits, create new ones or maintain existing ones. The editorial team of ISA Delhi, RMLH also has a resolution it intends to keep: we promise to continue to collect informative articles, interesting write ups related to various aspects like gardening, pets corner and yoga, poems and paintings to keep you, our dear readers, informed and help you to rejuvenate reading them.

The airway assessment becomes an integral and important part of airway management. There are numerous scores of airway assessment available with merits and de-merits of each. This issue brings Line of Sight approach of airway assessment.

Communication skills are important non-technical skills of the anaesthesiologists. Types of Communications are highlighted in this issue.

Looking forward to the contributions and support of all fellow members. Do keep sending the material at editorisadel@gmail.com. Here's to making more cherished memories in 2023!

Dr. Akhilesh Gupta

Professor

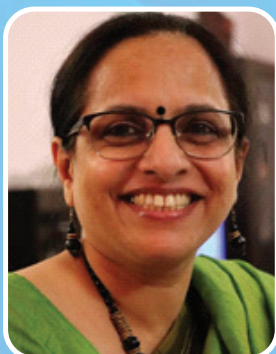
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CLINICAL MEET

ISA DELHI 2022-23

FIRST CLINICAL MEET was conducted at AIIMS, New Delhi, Board room on 15th November, 2022 from 4:30 pm onwards.

Studies presented:

- 1) The Doppler Renal Resistive Index and Semi-quantitative Power Doppler Ultrasound for early detection of Acute Kidney Injury after perforation peritonitis surgery: presenter Dr. Surendar. Moderated by Dr Rahul Anand.
- 2) Association between preoperative frailty and post operative delirium and cognitive dysfunction in elderly patients undergoing surgery under general anaesthesia: prospective observational study. Presenter: Dr. Anjalee. Moderated by Dr Puneet Khanna
- 3) Analgesic efficacy of Ultrasound guided triple level ESPB Vs triple level CTFB in patients under going PCNL surgery: Randomized Parallel group double blinded non-inferiority trial. Presenter: Dr. Niharika. Moderated by Dr Dhruv Jain.

Attended by all ISA office bearers, Faculties and residents from various medical colleges, ISA Members from various Government hospitals and Private practitioners.



"GOING THROUGH THE GUIDELINES"

AIRWAY ASSESMENT GUIDELINES (LINE OF SIGHT)

Kumar R, Kumar S, Misra A, Kumar NG, Gupta A, Kumar P, Jain D. A new approach to airway assessment-"Line of Sight" and more. Recommendations of the Task Force of Airway Management Foundation (AMF). J Anaesthesiol Clin Pharmacol. 2020;36(3):303-315.

A thorough assessment of the airway is recommended by every airway guideline as the first step towards safe airway management. Numerous ways of conducting airway assessment have been proposed that include many unifactorial and multifactorial tests and scores. Compared to any single test, multifactorial tests, and a combination of multiple unifactorial tests alter both the sensitivity and specificity of detecting difficult airway, but the outcomes are variable. However, none of the airway assessment methods can ensure detection of all difficult airway situations. Even a comprehensive, detailed airway assessment that prompts the operators to look at multiple airway risk factors and document the likely areas of difficulty did not result in a better prediction of the difficult airway when compared with the "regular" airway assessment.

Airway Management Foundation (AMF) proposes a new approach to airway assessment, the AMF Approach. This approach offers a step ahead of the currently prevalent methods as it prompts the airway manager to view any difficult airway in the light of not only the patient factors but also the non-patient factors. The AMF "line of sight" method is a non-nemonic, non-score-based method of airway assessment wherein the airway manager examines the airway along the line of sight as it moves over the airway and notes down all the variations from the normal. Assessment of non-patient factors follows next and finally there is assimilation of all the information to help identify the available, difficult, and impossible areas of the airway management. The AMF approach is not merely intubation centric but also focuses on all other methods of securing airway and maintaining oxygenation.

The assessment findings categorize the areas of airway management as available, difficult, and impossible; difficult being optimizable as against impossible that is not optimizable. Optimizability is dependent on the available resources at the time when airway management is contemplated. The approach thus guides the airway manager in planning the airway management strategies. The AMF approach shall guide the airway manager about the management options for assessed difficulties simultaneously through its three-step approach:

Step I. Assessment of Patient

1. Focused History: history focused on detecting conditions that can have effect on airway management (diabetes mellitus, ankylosing spondylitis, rheumatoid arthritis, etc.).
2. Focused general physical examination (GPE): general examination focused to detect findings that can impact airway management, including considerations because of the specific patient condition (pregnancy/labor, obesity, age, etc.).
3. Focused Airway Examination using the AMF "Line of Sight" (LOS) Method: this approach recommends looking at multiple features along the line of sight moving systematically along the airway from parts of face and mouth to the neck.
4. Airway USG or other Imaging – only when needed.

STEP-II. Assessment of Non-Patient Factors

1. Resources

- Assessment of manpower: Manpower not only means extra hands but also people with more knowledge and skills.

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AIRWAY ASSESMENT GUIDELINES (LINE OF SIGHT)

Table 2 Suggested Method of Assessment of Patient, Including the AMF "Line of Sight" (LOS) Method for Focused Airway Examination. (References in Appendix I)

Focused History	Variation	Area of Possible difficulty
Mental status, Hearing/speech, Level of apprehension, Consent	Mentally challenged, Hearing/speech impaired, Apprehensive, Refusal	Consent and Cooperation
Snoring	Present	MV
Previous Airway Event	Present	As per the event
Known supra-glottic/glottic/sub-glottic obstruction	Present	MV, SAD, Intubation
Neck irradiation	Present	MV, Lx
Tobacco/Gutka Chewer	Present	SAD, Lx
Cervical spine trauma/surgery	Present	Lx
Diabetes, Ankylosing spondylitis, Rheumatoid arthritis	Present	MV, Lx
Focused General Examination	Variation	Area of Possible Difficulty
Age	> 45 years, >55 years	SAD; MV
Gender	Male	SAD; MV
BMI (Obesity)	BMI >30 kg/m ²	MV; Lx; Surgical access
Gait	Stiff	Lx
Voice	Hoarse	MV; SAD; Intubation
	Hyponasality	MV; Nasal intubation
Pregnancy	Advanced pregnancy	Lx; Intubation
	Active labor	
Prayer sign	Positive	Lx
Focused Airway Examination: Line of Sight (LOS) method	Variation	Area of Possible difficulty
Nose	Deformed, Narrow nares/nasal passage, Blocked nostril(s)	Nasal Intubation
	Bilateral blocked nostrils	MV
Malar Region, Cheeks	Deformed, Masses, Flowing beard	MV
Mouth	Deformed	MV
	Microstomia	SAD, Lx
Teeth	Edentulous	MV
	Missing, bucked, loose irregular, overbite, removable false denture	Lx
	IIG <3 cm	Lx
	IIG <2 cm	SAD
Oral Cavity	MMP >2	MV, Lx
	High arched, narrow, or cleft palate	SAD, Lx
	Space occupying masses	MV, SAD, Lx
Lower Jaw	Receding, prognathic	Lx
	Injury, Mass	MV
Lower jaw subluxation	ULBT Class 3 or ULCT Class >II/III	MV, Lx
Mandibular space	TMD <6.5 cm	MV, SAD, Lx

- Assessment of fallback capabilities– availability of ICU or higher referral center if needed
- Assessment of available equipment including Paraoxygenation equipment: a lot of optimization is dependent on the equipment that is available. Paraoxygenation includes (but is not limited to)
 - (a) use of nasal prongs with O2 flows up to 10–15 Lpm [attached to either common gas outlet (of older anesthesia workstations) or to auxiliary O2 outlet of newer ones], also called nasal oxygenation during efforts of securing a tube (NODESAT)
 - b) high-flow nasal cannula (HFNC), or (c) transnasal humidified rapid insufflation ventilatory exchange (THRIVE).

2. Surgical Requirements

- Airway management is best tailored to meet the surgical requirements, if safely possible.
- Changes in airway management plan may be necessitated by patient positioning, sharing of the airway with the surgeon, surgical technique (e.g., robotic surgery, laser surgery), etc

3. Airway manager's mindset:

Some airway situations can be managed in more than one way, and the final method of management is guided by the mindset of the airway manager in charge. The same is true regarding the decision to continue with an SAD after it has been used to secure the airway in an emergency of intubation failure.

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STEP III. Assimilation of All Assessments

The third step of the AMF Approach is the assimilation of the findings of the assessment of the patient and those of the assessment of non-patient factors. AMF proposes to conduct this process of assimilation through a standardized method as shown in Table 3

Table 3

The AMF Suggested Method of Assimilation of Assessments to Aid Airway Management Planning

Areas	Available, Difficult or Impossible?	Optimization needed for Difficult (some examples)
Cooperation	A/D/I	Attendants/Medication*
Mask ventilation	A/D/I	OPA, NPA, Case specific [†]
SAD placement	A/D/I	2 nd generation SAD, Preshaped SADs, Laryngoscope, Bougie [‡]
Laryngoscopy	A/D/I	OELM, other blades (e.g., McCoy blade), Videolaryngoscope, Fiberscope, Case specific [§]
Intubation	A/D/I	Stylet, Bougie, Magill forceps, Cuff inflation, ^[19] Case specific
Front of neck access	A/D/I	Bandage removal, Scar incision, Ultrasound-guided
Emergence	A/D/I	Fully awake, Bailey's maneuver, ^[20] AEC [¶]
Resources	Available?	
Equipment	Yes/No	
Knowledge and Skills	Yes/No	
Extra hand	Yes/No	
Paraoxygenation**	Yes/No	
Fall back capabilities ^{††}	Yes/No	
Surgical requirement	Possible?	
Special patient position	Yes/No	Yes/No

Once the boxes in Table 3 are filled, the airway manager is led to clear-cut available (A), difficult (D), and impossible (I) areas of airway management, viewed in the light of not only the airway assessment findings but also those of assessment of available resources, surgical requirements, and airway manager's mindset.

Three points need to be made here: (i) with the patient's safety being the top priority, even slight doubt about the optimizability of any component should be enough to label it "impossible" and; (ii) same findings in assessment may be called "difficult" under some circumstances and "impossible" under other circumstances (depending upon available resources) or vice-versa; and finally, (iii) the AMF assimilation process promotes the concept that if used properly, SADs should be considered as definitive airway devices in many more cases than at present.

Outcome

These AMF recommendations for Airway Assessment, through the described AMF Approach, have the potential to make airway assessment all-inclusive yet simple to remember and apply in day-to-day practice. If practiced and conducted regularly, the whole process takes less than 5 min. It is not claimed that using the method of assessment put forward in these recommendations will recognize and successfully resolve all problematic airways. However, the three-step AMF Approach is much more holistic than any available mode

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AIRWAY ASSESMENT GUIDELINES (LINE OF SIGHT)

STEP 1- ASSESSMENT OF PATIENT

- (i) Focused history
- (ii) Focused general physical examination
- (iii) Focused airway examination
- (iv) Airway USG



STEP 2- ASSESSMENT OF NON PATIENT FACTORS

- (i) Assessment of resources
- (ii) Assessment of surgical equipments
- (iii) Airway manager's mindset



STEP 3- ASSIMILATION OF ALL ASSESSMENTS

Categorization into Available (A), Difficult (D), Impossible (I)

Appendix-I

The AMF "Line of Sight" Examination of Airway

Method of Focused Airway Assessment using the AMF Line of Sight (LOS) examination:

- Equipment needed
 - Torch
 - Measuring tape
 - Two scales (preferably 12 inches/30 cm)
 - +/- cotton wisp or metal spatula
- Position - Patient and operator sit face-to-face so that the operator's eyes are at the level of the patient's mouth.
- Procedure – Having conducted the focused history and general physical examination and explaining the LOS examination, start scanning the patient from the forehead downwards along the airway.
 - Look at the malar region, cheeks, and nose.
 - Gently evert the tip of the nose and look inside the nostrils in the torchlight.
 - Perform the test for nasal patency.
 - Now, look at the lips and teeth.
 - Ask the patient to open his mouth and measure the interincisor gap (IIG).
 - Perform the modified Mallampati (MMP) test and also look at the palate. (Mallampati is the name of a scientist, so M is always capital)
 - Examine the lower jaw next and perform the upper lip bite test (ULBT)/upper lip catch test (ULCT) as applicable.
 - Feel the compliance of the submandibular region next and measure the thyromental distance (TMD).
 - Examine the whole length of the neck.
 - Identify the cricoid cartilage.
 - Measure the neck length sternomental distance (SMD) and thickness (neck circumference).
 - Finally come to the side of the patient (by asking the patient to turn by 90° to the right or left or by standing and coming to the side of the patient) and measure the neck range of motion (ROM).
- Specific Tests that are part of the LOS examination
 - Test for nasal patency: The patient is asked to keep his mouth closed. He is now asked to block one of his nostrils and gently breathe in and out through the other nostril. His breath is felt on the back of the

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operator's bare hand or forearm. The in-out movement of the breaths can be compared better by observing the difference in the back and forth movement of cotton wisp held near the patient's open nostril. Alternately, the patient is asked to gently breathe out on a metal spatula held 1 cm away from each nostril keeping the other nostril closed. The side where the area of fogging due to condensation of the moisture in the expired breath is 1 cm more in diameter than the other side is considered to be more patent.^[22]

- Interincisor gap (IIG)^[23] – With head in the neutral position, the patient is asked to open his mouth as wide as possible. A scale is held between the central incisors or the corresponding alveolar margins (in an edentulous patient) so that its length matches the length of the patient's face. The distance between the free margins of the central incisors/gums is the IIG.
- Modified Mallampati class (MMP) (Mallampati classification^[6] modified by Samsoon and Young*)^[24] – With head in the neutral position, the patient is asked to open his mouth as wide as possible and put out his tongue without phonation. The operator illuminates the oral cavity and beyond with the help of a torch and looks for the fauces (the space between the tongue below and soft palate above through which at least some part of the posterior pharyngeal wall is visible), tonsillar pillars, uvula, soft palate, and hard palate and classifies these as follows:
 - If all four (soft palate, fauces, uvula, pillars) are visible –MMP class I
 - If soft palate, fauces, uvula visible – MMP Class II
 - If soft palate (+/- base of uvula) – MMP Class III
 - If the soft palate is not visible at all, only hard palate visible – MMP Class IV
- Upper lip bite test (ULBT)^[11] –The patient is asked to catch his upper lip with his lower teeth as high as possible. It is a good idea to demonstrate the same once. The ULBT is classified as:
 - Class I if lower incisors can bite the upper lip above the vermilion line thereby hiding the mucosa of upper lip fully; 312 Journal of Anaesthesiology Clinical Pharmacology | Volume 36 | Issue 3 | July-September 2020
 - Class II if lower incisors can bite the upper lip below the vermilion line thereby hiding only a part of the mucosa of upper lip; and
 - Class III if lower incisors cannot bite the upper lip at all.
- Upper lip catch test (ULCT)^[25] – If the patient is edentulous, the patient tries to catch the upper lip with the lower lip. The findings are classified as:
 - Class zero (0): The lower lip gliding or rolling over the upper lip reaching as high as the columella or else positioning itself at any point above midway between the vermilion line and the columella;
 - Class I: The lower lip catching the upper lip, completely above the vermilion line fully covering and passing past the vermilion reaching a point midway between the vermilion and the columella;
 - Class II: The lower lip catches the upper lip at the level of the vermilion line or positioning itself just above it (2 mm); and
 - Class III: The lower lip just caresses the upper lip, but falls short of obliterating the vermilion line.
- Thyromental distance (TMD)^[26] – The patient is asked to extend his head as much as possible with mouth closed and without moving the shoulders back. A scale is placed between the center of the chin above to the thyroid notch below. The straight distance between these two points is the thyromental distance. If using a flexible measuring tape, then the tape should be held taut between these two points to measure the TMD.
- Identifying cricoid cartilage – Instead of using the popularly recommended "laryngeal handshake"

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technique.^[2] we prefer to use what AMF calls the "laryngeal finger slide" technique, which is as follows:

- The airway manager asks the patient to extend his head as much as possible and gently places his nondominant hand on the patient's forehead.
 - With the thumb and middle finger of his dominant hand, he now holds the hyoid bone at the two ends (the two greater cornua).
 - The index finger now identifies the middle part of the hyoid in the center of the patient's neck.
 - The index finger in the midline is next slid down the midline as the thumb and the middle finger slide along the side of the larynx.
 - The first prominence felt by the index finger as it slides down in the midline is the thyroid notch.
 - As the finger in midline slowly slides down further, it meets a depression. This is the cricothyroid membrane.
 - Sliding down further, the next hard structure felt in the midline is the cricoid cartilage. The thumb and middle finger should be on the cricoid cartilage at this time.
- Sternomental distance (SMD) (neck length)^[8,27] – The patient is asked to extend his head as much as possible with mouth closed and without moving the shoulders back. A scale is placed between the center of the chin above to the center of the sternal notch below. The straight distance between these two points is the sternomental distance. If using a flexible measuring tape, then the tape should be held taut between these two points to measure the SMD.
 - Neck circumference (neck thickness)^[28] – The patient is asked to sit with his head in a neutral position. The neck circumference is measured at the level of thyroid notch using a measuring tape.
 - Neck range of motion (ROM) – Ask the patient to flex her neck as much as possible by bringing her chin down to touch her chest. Mark a point on the upper margin of her pinna and another one on the opposite (lower) margin of the ear on the ear lobule. Place the edge of one of the scales touching both these marked points. The lower margin of the scale can be rested on the soft tissue below to hold it securely in position. Holding the scale in this position, now ask the patient to slowly extend her neck as much as possible without moving the shoulders back. Place the edge of the other scale in such a manner that its edge touches both these marked points and also the edge of the first scale (the edge that was in contact with the marked points). The angle formed between the two scales now is the angle of neck range of motion (ROM)

Appendix IA

- Modifications suggested for airway assessment
- General preparation: Use Assessment Proformas wherever possible (online proforma are preferred over paper proforma). Use mike to make the communication with the patient easier across barriers.
- Preparation for the assessor: Assessor should be wearing a surgical gown, surgical cap, N-95 mask, gloves, and a face shield in the correct manner.
- Preparation for the patient: The patient should come wearing a mask (at least a surgical mask, if not N95) over her mouth and nose and maintain social distancing.
- Option 1: The patient should sit across a transparent plastic barrier with two openings for the assessor's hands and arms to pass. This may look a far-fetched idea but has the potential of becoming a norm if COVID-19 spills over into 2021, as some epidemiologists predict.

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- Option 2: The patient should also be wearing a mask (at least a surgical mask, if not N95) over her mouth and nose and sit at least 1 m (3 feet) away from the assessor while focused history and general examination are underway.
- The focused history should begin with a detailed history of any suspicious illness and/or contact (of the patient and all her contacts) in the past 2 weeks.
- Conduct of LOS Examination: After eliciting focused history and conducting the focused general examination, explain the LOS examination to the patient.
- Additional tools – A camera phone with flash covered with a disposable polythene cover.

Steps

- Counsel the patient and explain that she will be asked to perform certain maneuvers, which the assessor will demonstrate on himself. Also, tell her that photographs will be clicked to aid the assessment.
- Ask the patient to take off/pull down her mask.
- Click three photographs, one front and two side views (from either side).
- Demonstrate how to evert the tip of the nose. Now ask the patient to evert her nose gently. At this time click another picture from the front. The camera is zoomed to the nostrils with flash on at the time of clicking the picture.
- Now demonstrate how to perform the test for nasal patency. Hand over a cotton wisp to the patient and ask her to perform the test for nasal patency. Note the movement of the cotton wisp while the patient herself does the test. Ask her to dispose-off the wisp safely in a covered bin.
- Now examine the lips and teeth.
- Test for IIG should be conducted at the end as it involves the scale to be kept very close to patient's open mouth, almost touching her teeth or gums (if the patient is edentulous).
- For performing the MMP ask the patient to open her mouth fully and protrude the tongue. Take the lens of your camera phone in line with the oral cavity and about 1 foot away from her mouth. Click a picture with flash on. Now bring down the camera so that the hard palate is visible. Take another picture with flash on.
- Examine the lower jaw next and perform the ULBT/ULCT as applicable.
- Ask the patient to reapply the mask with the chin exposed.
- Feel the compliance of the submandibular region next and measure the TMD and SMD simultaneously with a 30 cm (1 foot) disposable cardboard/paper scale.
- Ask the patient to pull the mask over her chin as well.
- Examine the whole length of the neck.
- Identify the cricoid cartilage.
- Measure the neck thickness (neck circumference). If using a 30 cm disposable scale, place one edge of the scale on the thyroid notch, and gently bend the scale around one side of the neck. Place your finger at the point of contact of the other edge on the back of the patient's neck. Remove the scale and place it back

"GOING THROUGH THE GUIDELINES"

AIRWAY ASSESMENT GUIDELINES (LINE OF SIGHT)

so that edge on thyroid notch is now at the point that your finger was marking and gently wrap it around the patient's neck to reach the thyroid notch again. If the mark on thyroid notch is 6 cm then the neck circumference is a little over 36 cm (most scales have a few mm extra on either side of the beginning and end of markings).

- Ask the patient to turn by 90 ° to the right or left and ask her to flex her neck maximally and take a picture. Now ask the patient to extend the neck to the maximum without moving her shoulders back and take another picture.
- Finally, measure the IIG. Hand over the disposable scale to the patient. Demonstrate the measurement of IIG by using another scale. Ask her to open her mouth and place the scale as shown by you. Take a picture of the patient with a scale in position.
- Dispose off the disposable scale and the camera phone cover safely and change your gloves once the airway assessment is complete.
- Use the pictures to assess the malar region, nose, face, IIG, MMP, palate, and neck range of motion (NROM) [Figures 3 and 44].

Note

- If using a reusable torch and measuring tape for assessment, these should be decontaminated appropriately before reusing.
- The assessor and the patient come in contact only during marking the cricoid cartilage, measuring the TMD, SMD, and neck circumference.

Appendix II

Known predictors

Over the years investigators have documented many predictors to identify areas that may cause difficulty in a particular patient.

1. Cooperation

- Age – children
- Mentally challenged
- Hearing/speech impaired
- Apprehensive
- Refusal

2. Mask ventilation

- Stiff gait
- Male sex
- Age > 55

- BMI > 30 kg/m²
- H/o snoring
- H/o neck radiation
- H/o ankylosing spondylitis
- Hoarse voice
- Hyponasality in voice
- Facial asymmetry
- Beard
- Bilateral blocked nostrils
- No teeth
- Modified Mallampati (MMP) class > 2
- Restricted jaw movement (Upper lip bite test-ULBT II/III)
- TMD < 6.5 cm
- Thick neck (Neck circumference > 40/42 cm (F/M))
- Thyromental distance (TMD) < 6 cm
- Decreased neck range of motion (ROM)
- Upper airway obstruction
- Poor lung/chest compliance

3. SAD

- Male gender

"GOING THROUGH THE GUIDELINES"

AIRWAY ASSESMENT GUIDELINES (LINE OF SIGHT)

- Age > 45 years
- Microstomia
- Interincisor gap (IIG) < 2 cm
- Swelling in oral/pharyngeal area
- TMD < 6.5 cm
- Neck range of motion (ROM) < 90 °
- Glottic or infraglottic obstruction (suggestive symptoms and signs)
- Reduced chest compliance

4. Laryngoscopy

- Stiff gait
- Advanced pregnancy and active labor
- H/o diabetes mellitus, ankylosing spondylitis, rheumatoid arthritis
- Prayer sign
- Microstomia
- Buck/Missing/Loose teeth
- Interincisor gap < 3 cm
- MMP > 2
- Intraoral growth
- High arched or cleft palate
- Restricted jaw movement (Upper lip bite test-ULBT II/III)
- Retro-/Micro-/Prognathia
- TMD < 6.5 cm
- Stiff, noncompliant submandibular region
- Sternomental distance (SMD) < 12.5 cm
- Neck circumference > 40 (F)/42 cm (M)
- ROM < 90 °

5. Intubation

- Hoarse voice (Glottic or sub-glottic obstruction)
- For nasal intubation
 - Hypo-nasality
 - Deformed, narrow nares/nasal passage, blocked nostril(s)

- Reduced IIG – (No space for laryngoscope (Lx) and endotracheal tube (ETT) together)
- Missing incisors – [Blade in the gap of missing teeth; Reduced space for ETT between teeth (canine, premolars, and molars)]
- High arched palate – narrow space for ETT
- Cleft palate – [Blade in the cleft; may cause injury and reduced space for ETT between teeth (canine, premolars, and molars)]
- Gross tracheal deviation

6. Surgical access

- Impalpable cricothyroid membrane (CTM)
 - Thick scar over the site
 - Neck swelling
 - Morbid obesity
- Short neck
- Restricted neck extension

7. Emergence

- Difficulty in airway access or in maintaining oxygenation still present at extubation or created intraoperatively

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COMMUNICATION FOR ANESTHESIOLOGISTS

Dr Arun K Mehra

PART II : Types of Communication

There are several ways to classify communication, and it is possible to keep on making up new ways to classify it, by expanding and re-defining. Here, let us consider the most common and practical aspects.

Communication, besides expressing and transmitting ideas, is also instrumental in imagining, in expressing feelings, and in influencing. In professional work (including the medical profession), communication is the often used (and, sadly, also misused) in influencing.

For these different roles (and also several others which we are not considering in our present discussion) there are various types of communication, performed in different ways.

The most common type, which immediately comes to mind, is speech. But there is much more to communication than just speech, which is simply one aspect of communication. There are others, too.

Before speech evolved (with, presumably, the development of the relevant areas of the brain, and the fine tuning of the verbal and auditory apparatus), there must have been grunts and other forms of sound. As these became more refined and combinations of sounds acquired specific meanings, language evolved. But over the course of evolution, ways to express ideas, like drawings, pictograms, and sketches all came about. Alphabets to express specific sounds, which are then combined into words, came over due course.

The importance of pictorial representation can be realized by the fact that we have never discarded it completely. We see it even today in charts and graphs and illustrations, which are the modern day continuation of the early pictographs found in many ancient archeological sites.

Even demonstrations of ideas, including formal demonstrations and informal ones like acting and drama, serve as a form of communication. This too has been important across the ages.

Speech has evolved further into languages, and these have become the principal form of communi-

cation today. This form has extended beyond speech now, and is also written. Written again can be hand written, typed, printed, and in other forms.

Language has, in fact, transcended speech, and it now includes speech (called verbal communication), and also includes an evolved form of the ancient pictorial representations, through symbols, now called written communication. All these combined have made the horizontal and vertical transmission of ideas feasible, thus making civilization itself possible.

But beyond this most important form of communication called language, there are many other aspects which may be less obvious, on the basis of which different types and styles of communication can be identified. Here are some of the important examples.

In non-verbal communication the following may be considered:

Body language, which includes your gaze and eye movements: are you looking at the person you are speaking to? If you are not interested in your patient or in his or her problems, it's easy to make out. Then there are subtle movements (including hand gestures), muscle tone, sitting attitude, etc. Looking at your watch, or out of the window, can all give you away. Eye contact shows you are listening, and value the speaker's words. All these convey meanings which a normal person can grasp subconsciously.

Facial expressions, too, are very meaningful. Even a sincere smile conveys interest and warmth.

The tone of the doctor's voice is also very important. It should not be condescending or paternalistic.

Touch is another form of non-verbal communication. Very often, touching a friend's hand conveys more meaning than a word. In clinical practice, of course, while touching is a part of the examination (and hence a technical skill), to the patient it may convey a feeling of being cared for.

Similarly, gestures such as answering a phone call

COMMUNICATION FOR ANESTHESIOLOGISTS

Dr Arun K Mehra

PART II : Types of Communication

or not, or abruptly calling someone into the room during a consultation, all are non-verbal forms of communication which the patient intuitively understands.

Yet another form of communication can be contextual. Often, the context of what is said or done conveys more meaning than the actual words exchanged. Every word or deed has a context, and good communication requires keeping that in mind. Listening is a form of communication in itself, where words need not be said. But listening without speaking does not have much relevance in medical practice, where a consultation needs words.

Another way of classifying communication is the attitude of the person making the communication. It can be passive, active, assertive or aggressive. While it's good to let the patient tell his or her story, being too passive may not get relevant information. Active communication is thus better. Assertiveness is needed only with uncooperative patients (whom it might be better to let go of, anyway), while aggressiveness should be avoided.

Then, communication can be personal, in groups, or mass. Meeting a patient individually would be personal, while with the family members would be in a group. Spreading awareness (for example about Covid) is mass communication. Mass communication can include examples like meetings with school or office groups, speaking on the radio or television, or disseminating information online.

Finally, has the communication served its intended purpose? Depending on that it can be classified as effective or non-effective.

It cannot be over-emphasized that it is important to choose the right channel of communication in each situation, whether verbal, written, demonstrative, audio-visual, or any other. The doctor has to evaluate the level of the patient's capabilities to understand, and then speak to the patient at that level. It often helps to avail the help of a family member or friend who knows the patient's abilities to comprehend. Very importantly, getting feedback helps to know whether the message has been effectively conveyed, or not.

Verbal communication requires confidence (which comes from having a thorough grasp of your subject or technical knowledge), clarity and conciseness. It also needs being a good listening.

Written communication has its own set of needs, which will be dealt with during the course of this series (it includes taking a written consent). The very important things to keep in mind are the need to be short and simple, and to avoid ambiguity.

In anesthesia, critical care, end-of-life care and palliative care, which are areas we deal with, communication becomes absolutely vital as it often involves life-and-death situations, and is also an emotional drain on the patient and his family. Patience, compassion and empathy are needed (these will be discussed in subsequent months).

No list of classification of the types of communication can be complete. Hopefully the above points serve our professional purpose reasonably.

YOGASANA



VIRBHADRASANA

Warrior pose is a group of related lunging standing asanas. The name is derived from Virbhadra, a mythical warrior created by SHIVA.

The asana Virbhadrasana I, II and III resembles his actions while destroying Daksha.

HOW TO DO IT

Virbhadrasana I

1. Starting from Tadasana, spread the feet wide apart.
2. Hips are turned to face the front foot, which is turned fully outwards; the back foot is turned
3. The front knee is bent to a right angle, keeping the back leg straight and the sole of back foot on the floor.
4. The arms are stretched straight upwards Back slightly arched and gaze directed upwards.

Virbhadrasana II

It is same as Virbhadrasana I except for the arms which are extended fully with the palms down or up, at shoulder level parallel to the ground.

Virbhadrasana III

Little advanced version needs more strength and balance again starting from Tadasana and feet are postured as Virbhadrasana.

Upper half of body is turned fully to face the front foot with arms extended straight forward.

Trunk is kept horizontal and back leg is then raised and stretched back in the air and parallel to the ground.

BENEFITS

- Strengthens: Back muscles, shoulder, arms, thigh ankle and calf muscles.
- Stretches: Shoulder, upper and lower abdominal muscles, calf muscles.
- Improves focus, balance and stability.
- Improves circulation and respiration.

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THE GARDNER'S GUIDE

5 COMMON HOUSE PLANTS | HOW TO TREASURE THEM !



SPIDER PLANT

Ideal for beginners as they are very easy to care for

LOCATION: in any room that has 7-24 degree temperature.

LIGHT: Bright, indirect light

WATERING AND FEEDING: keep the compost/soil moist. Water sparingly in winters. Feed every month except winters.

CARE: Repot/divide the mature plant when white, fleshy roots begin to push the plant from its container. Mature plants give plantlets or babies that can be cut off and grown individually. If these plantlets have

BUG ALERT: Prone to red spider mites on foliage. Treat it – spray with an insecticide or use a biological control (e.g. neem oil). Red mites thrive in hot, dry conditions, so mist your plants daily to raise humidity if the atmosphere is hot and dry.



SNAKE PLANT

This is one of the toughest plants to kill. Only way to kill it is over watering.

LOCATION: It can survive in any location whether its light, dark, draught or dry air.

LIGHT: Ideally provide bright indirect light. In low light levels. Its variegated leaves may revert to all green.

WATERING + FEEDING: Water moderately in spring and summer. Water sparingly in winters. Feed once in a month in spring and summer.

CARE: Wipe the leaves with wet cloth to keep them shiny. Only repot when roots are pot bound. Leaves turn yellow on over watering. Check base and roots of your plant for rot.

BUG ALERT: They are prone to mealy bugs and red spider mites on the foliage. Regularly wipe the leaves and spray it with biological control.

THE GARDNER'S GUIDE

5 COMMON HOUSE PLANTS | HOW TO TREASURE THEM !



CROTONS

This leafy foliage plant has very colourful appearance and is easy to grow.

LOCATION: place it in a reasonably warm room (at least 15 degree Celsius). It should be protected from fluctuating temperatures.

LIGHT: provide bright indirect light.

WATERING + FEEDING: water when top 2-3 cm of soil/compost has become dry. The leaves tend to droop when they are over/under watered. Feed once a month in spring and summer.

CARE: Wipe the leaves with clean damp cloth from time to time to keep them free of dust.

BUG ALERT: they are very prone to mealy bugs and red spider mites on foliage. Look under the leaves while cleaning them.



POTHOS (MONEY PLANT)

One of the commonest plant in household. It's very easy to care for and perfect for the beginners.

LOCATION: place it in a reasonably warm room (at least 15 degree Celsius). It should be protected from fluctuating temperatures.

LIGHT: provide bright indirect light.

WATERING + FEEDING: water when top 2-3 cm of soil/compost has become dry. The leaves tend to droop when they are over/under watered. Feed once a month in spring and summer.

CARE: Wipe the leaves with clean damp cloth from time to time to keep them free of dust.

THE GARDNER'S GUIDE

5 COMMON HOUSE PLANTS | HOW TO TREASURE THEM !



TRIDENSCARDIA ZEBRINA (Wandering Jew)

LOCATION: They flourish in a room which has temperature around 12-24 degree. Although it can tolerate cold breeze

LIGHT: it loves bright, indirect light

WATERING AND FEED : Water when the top 1 inch of the soil/compost dries out. Don't allow it to get water logged. Feed once in a month during spring and summer.

CARE: Remove any dry or green(unvariegated) leaves. Try to keep them in bright indirect sunlight.

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PETS' CORNER



Dogs typically claim the top spot as a man's best friend, but there is some friendly competition at our farmhouse from the very adorable cows. One fine day, my father realised that we're not in touch with the nature and our roots as much as we should be. So, he decided to adopt a cow with her calves. They stayed at our home, in the lawn for a few days till their shed was being constructed at the farmhouse.

That is where they met Bruno, Tyson, Sultan and Oscar for the first time. None of us knew how our furry friends would react to their presence. The interactions were interesting to watch but more than that, scary at the same time. Over time, Bruno was slowly trying to get acquainted with their peculiar scents when one day, suddenly, for reasons unknown (probably fear or anxiety), a calf decided to race Bruno to the other end of the garden. And as expected Bruno followed with a sprint.

The mother cow became terrified (just like all of us) of the scene in front of her and was moving very loudly. But to our surprise, Bruno just blocked the calf's path as he was running out and escorted him back to his mother safely.

The calf then licked Bruno in a playful thank you gesture and they became friends. Tyson seemed unbothered about their

presence, and Sultan & Oscar considered them as a type of some huge dog.

After a while, the cows left for the farmhouse, and over the next few days, the cow family expanded. However, the caretaker heard constant mooing throughout the night. Something was wrong which no one seemed to figure out. One week later, while going out of station, we dropped off our furry friends at the farmhouse with the caretaker. It was a happy reunion for all. That night, the cows slept peacefully and there was no mooing.

We then understood that the dogs make them feel safe in the new environment. That's how it was decided that Bruno and Tyson should shift to the farmhouse and live with the cows. They now jump around with the calves playfully and roll around in cow fodder just to smell like cows. Dogs are predators by nature, but they do well as a protector, guardian and saviour when presented with the opportunity.

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FIRST GLIMPSES

It wasn't too long ago that I stepped into the OT of my hospital for the first time as a PG resident. It felt like I had landed on a different planet, far from home. They were speaking a language that everyone, except I, could understand. Words that sounded familiar were strung together but conveyed no meaning, at least to me. The room was a blur of hands, tubes, vials and syringes flying around, interspersed with commands being given every now and then. I could not have felt more out of place. For an impressionable girl like me, I must confess that the situation didn't seem too promising. I would be lying if I said that, in those very early days, I had no doubts about my choice of specialization.

But with time, I realised that I was no different in this regard from anyone else. This sense of disconnect is an unsaid rite of passage that residents have to go through as they start their training, whatever speciality they may have chosen. It was only when the nerves started to wear off that I felt at ease in this environment.

Like every doctor in the world, I too had undergone clinical rotations in the department of Anesthesia in my medical college, and studied some basics of the subject as an undergraduate. But nothing could have prepared me for what the work realistically entails. In a class recently, I was introduced to a title given to anaesthesiologists, 'the peri-operative physician'. It paints a picture that lends clarity to the responsibilities in anaesthesia, and has stuck with me since.

However, like every other journey, we started off small. For the first few days, we could not even load drugs without supervision, and with good reason. It felt a bit strange that we could not be trusted with this simple task. But I soon realized that I could not have been more wrong. Of course, in all medical practice, any drug can pose a risk to the patient, but the drugs we use in our speciality can never be fooled around with. In a short time I could understand how accurate and precise the drugs need to be. A simple slip up can compromise someone's life.

Another 'simple task' that we had to ask permission for was starting an IV line. To me, it was unimaginable that an intern could complete their training without learning how to place an IV cannula. It wasn't a big deal. Or so I

thought. Alas, I found how wrong I was, yet again. There was still much to learn. Very early on I was given a dictum that could not be truer: 'A patent airway and a functional line are the lifelines of an anaesthesiologist'. It was a lesson for me to not underestimate the simple things. It is these 'simple things' that can, and will, save lives.

Yet another simple thing that saves lives is hydration and nutrition. I feel foolish thinking back to my internship days when I did not pay attention to the staff providing fluids and nutrition to the patients. I too would feel agitated if I skip a meal, yet I never gave much thought to patients' dietary requirements, and how it impacted their well-being.

But most importantly, another change was expected of me. As interns, most of us fall prey to the habit of obeying orders without thinking much about what we were doing. But in an OT or an ICU, every action needs to be validated and justified. Our focus has to be on the 'why' besides the 'what'. It is taking a lot of unlearning and relearning on my part to think for a moment before I do anything. Curiosity and presence of mind are my biggest allies in this endeavour. Carrying out tasks mechanically just won't do anymore. I have to think, 'how will this benefit my patient?' and ponder on the possible consequences.

Initially, I felt very unsure of my actions and doubted everything. It is a learning curve, and things are slowly falling into place. I would be foolish to think that in a matter of a few weeks I would understand and appreciate the nuances of our craft, but we can safely assume that I am beginning to recognize just how much more there is to know. As I spend yet another day in the OT, I am able to mould myself better into the environment, all thanks to the compassionate seniors, both residents and faculty, watching over me.

Now, the beep of the monitor provides a sense of familiarity. That is certainly promising.

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INCREDIBLE INDIA - THE LESSER KNOWN...

Marghazi Maha Utsavam | The Festival of Music & Dance, Tamilnadu, Incredible India



Come December, the beautiful state of Tamilnadu gears up for the much-awaited classical music extravaganza at the year end, known as the Marghazi Utsavam. Carnatic music is a sea of scintillating swaraas, reverberating ragaas, and tantalising taals. "Margazhi" festival epitomises the fact that music connects you directly to divinity. This month in which bhakthi and music engulf the devotees is more of a heritage and legacy being followed for decades. Several significant Hindu festivals take place throughout the states of Tamilnadu, Kerala, Telengana and Karnataka during this time, and people commemorate them with devotional music.

The month is adored not just by humans, but also by the Devas (celestial beings). Every December, the cities of Chennai, Thiruchirapally, Thanjavur and Madurai celebrate classical music and dance forms with renowned musicians and artists gathering to play in various temples, sabhas or auditoriums. The festival provides a chance for junior performers to demonstrate their abilities, while sharing the stage with their older peers in the profession.

The performances revolve mostly on Tamil, Telugu, Sanskrit and Kannada songs, showing the enchantment of instruments such as the flute, veena, gottuvadyam, nadhaswaram, thavil, mridangam, and ghatam. The

classical dance performances including Bharatanattiyam, Kathakali, Mohini Aattam are also performed during the fest. Special poojas and music events are organised even in foreign countries to honour the almighty.

In the holy Srirangam temple at Thiruchirapally, the month of Margazhi (Dhanurmasam) is divided into two segments of 10 days being honoured as "Pagal Pathu" (daytime ten) and "Ra Pathu" (nighttime ten).

Thousands of devotees engage in non-stop bhajans throughout the day and keep an unceasing guard all night, singing and dancing to the rhythm of cymbals. Two notable hymns known as the "Thiruppavai" (30 stanzas composed in Tamil in praise of Lord Perumal/Vishnu) and "Thiruvempavai" (20 stanzas in Tamil composed in praise of Lord Shiva) are recited in different healing raagas for ushering in purity and prosperity in Maarghazhi month.

It is a matter of great pride to perform at this festival as a mark of respect to your gurus and the almighty.

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OFFBEAT

Painting



*Nature
never goes
out of style*

Dr. Alka Chandra

HOD Anaesthesia and critical care
Hindurao hospital and NDMC Medical
college, Delhi



OFFBEAT

तनकि बैठो

तनिक बैठो

तनिक बैठो

आँख मिचौली खेलती सखियाँ बोलीं

ना! सूरज छिपा, अभी घर जाना है।

अँधेरा होने को, माँ राह देखती

गृहकार्य निबटा सुबह स्कूल जाना है॥

तनिक बैठो

कॉलेज की सखियों ने किया आग्रह

अभी चलती हूँ, राह लम्बी, विलम्ब हुई।

याद आए घर पर राह देखते अनेकों कार्य

हँसी ठिठोली छोड़ उठ खड़ी हुई॥

ज़रा बैठो माँ

अभी और खेलना है, आँचल थामे बेटा बोला

और फिर खेलेंगे, अभी खाना बना लूँ।

मन को थामे, जल्द हाथ चलाते

गृहस्थी का दायित्व ज़रा निभा लूँ॥

थोड़ी देर बैठो

शाम की चंद क्षणों की भेंट पर माँ बोली

रुकने की इच्छा को छिपाते, हँस पड़ी।

अभी वे घर आते होंगे, चलती हूँ

बच्चे घर सँभाल, आराम करूँगी कुछ घड़ी॥

तनिक बैठो

अपने ही मन ने कहा, कुछ पल छोड़ दो सब

मेरी सुनो, बस ऐसे ही कुछ न करो।

झकोर कर अपने को हुई उठ खड़ी

सीमित समय, दायित्व अनेक, आलस न भरो॥

तनिक बैठो

समय बीता, कर्म का चक्रव्यूह जीवन

अनेकों पूर्ण - अपूर्ण आशायें, चाह।

मैं अब अपने मन की ही करूँ

मृत्यु द्वार, ले चली अपनी राह॥

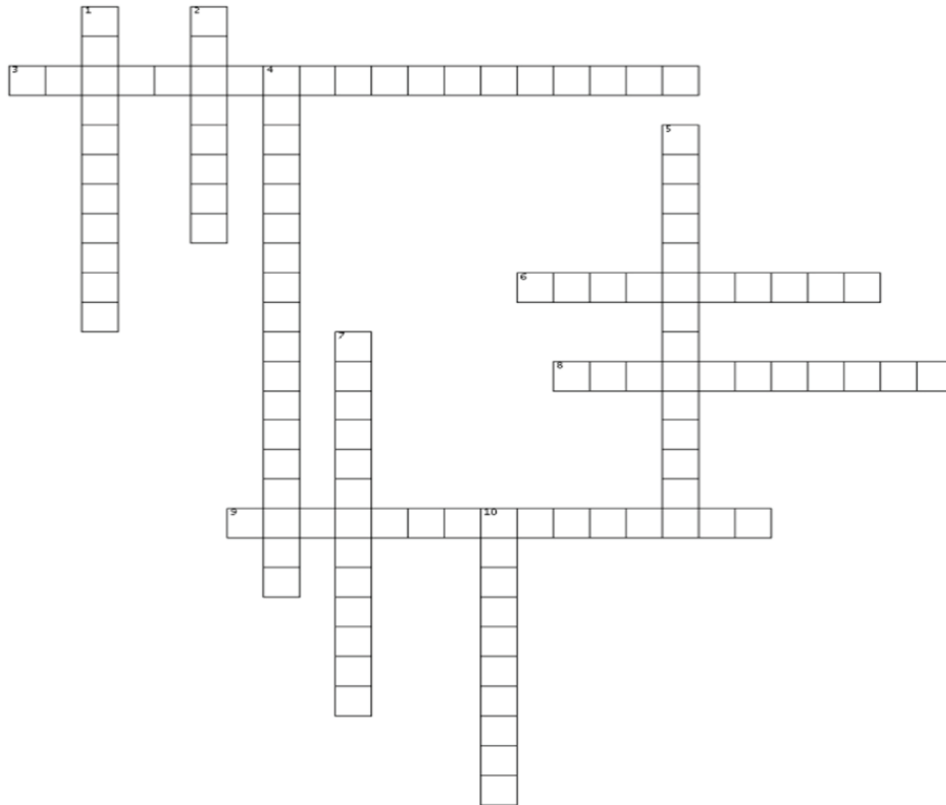
कविता की कविता

कवयित्री- डा॰ कविता शर्मा

वर्धमान महावीर मेडिकल कॉलेज

नई दिल्ली

BRAIN TEASER - CROSSWORD



ACROSS

3. Metabolite responsible for hepatitis following halothane administration (19)
6. Local Anesthetic associated with Methemoglobinemia (10)
8. Most common complication of celiac plexus block (11)
9. Stellate ganglion lies in close proximity to which vascular structure (15)

DOWN

1. Drug used to reverse sedative effect of Dexmedetomidine (11)
2. Most common side effect of intraspinal narcotic in obstetric patients (8)
4. Nerve located immediately lateral to trachea (18)
5. Local Anesthetic which undergoes least hepatic clearance (14)
7. Naturally occurring anticholinesterase alkaloid (13)
10. Which antidysrhythmic drug can result in both hypo and hyperthyroidism in a patient (10)

Dr. Abhilasha Singh

Senior Resident

ABVIMS & Dr. RML Hospital, New Delhi

The correct answers to be sent to editorsadel@gmail.com by 25.01.23

Answers of Last Edition Brain Teaser

ACROSS - 4. Pemberton 6. Ryanodine 7. Boston 9. Beerlambert 10. Desflurane
DOWN - 1. Cushing 2. Adenosine 3. Sevoflurane 5. Methergine 8. Roizen

HUMOUR STOP

Q: Why do mushrooms get invited to all the parties?

A: Because they're such fungis! (Fun guys, get it?)

Q: Which food was once close to you?

A: Pas-tha.

Q: Why shouldn't you trust atoms?

A: Because they make up everything.

Q: What time is it when you have to go to the dentist?

A: Tooth hurty! (2:30, get it?)

Q: Why do beets always win?

A: Because they are un-beet-able.

Q: Which food talks a lot?

A. Ba-ta-ta

Q: Why did the student eat his homework?

A: Because the teacher told him it was a piece of cake.

Q: What is a cat's favourite dessert?

A: Mice-cream.

Q: Why can't a cycle stand on its own?

A: Because it's too tired.

Q: Can February march?

A. No, but April may.

Q: Why was 6 afraid of 7?

A: Because 7 8 9. (7 ate 9)

Q: Why do we tell actors to "break a leg"?

A: Because every play has a cast.

Q: why can't a nose be 12 feet long?

A: Because then it would be a foot.

Q: What do you call a fake noodle?

A: A im-pasta (imposter)

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**Next Clinical Meet:
Maulana Azad Medical College
24th February 2023**

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