ISA
Indian Society of Anaesthesiologists
Delhi Branch
Eternal Vigilance

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(Delhi Branch)

Anaesthesia: A Tightrope Walk

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President ISA (Delhi) Branch
Message

Dear friends,

Warm greetings from me to all of you. After the monthly meeting held at Baba saheb Ambedkar hospital on 24th March, it's now time to look forward to next clinical meeting at Hindu Rao hospital and Big Bang Yuvacon.

It's interesting to watch young faculty come up with very creative ideas of new activities being planned for the event. I wish all HOD's encourage their young faculty and PG / SR to participate in both academic and non academic activities of yuvacon. I hope it will be a great success.

Brochures have been released with payment link for delegation fee. Sports activities are being planned at AIIMS Gymkhana sports club on 30th April 2023.

Hoping to see you all in these events.

With best wishes to all
Dr Mohandeep Kaur
President
ISA DELHI BRANCH

Vice President ISA (Delhi) Branch
Message

Dear Delhi ISA ians

Warm Greetings

The month of March was filled with festivities of Holi, RamNavami and Ramadan. These festivities bring people together to celebrate unique traditions of Indian culture and bring a lot of happiness, vitality.

The liveliness and zeal of the festival season was also reflected in the academic activities undertaken under the aegis of Delhi ISA. The workshop for OT technicians (WOTT) conducted by Department of Anaesthesia, showed a very enthusiastic and promising response from the participants.

The programme activities for much awaited, youth centric YUVACON 2023 has been finalised. On 30th April , Indoor and outdoor Sports activities will be held at AIIMS Gymkhana. The academic, cultural, art and literary events will be held on 6th and 7th May.We are looking forward to active participation of one and all. Let us enjoy and show our wholehearted participation !!

Dr Neerja Banerjee
Vice Presiden
Delhi ISA

Secretary ISA (Delhi) Branch
Message

Respected Delhi ISAians,

Happy Chaitra Navratri ,Ram Navami and Ramadan wishes to everyone. The list of Indian festivals is unending. Ours is a country divided by religions but united by festivals.Every festival is celebrated by people belonging to different religions. Celebrating these festivals together shows that unity binds the people of India together. We celebrate festivals to maintain our cultural and religious beliefs.

Continuing with the celebrations the dates for the upcoming YUVACON have been finalised. A day full of Sports events will be held on April 30th at Gymkhana AIIMS. The Gala Dinner will be held on 5th May followed by a day and half full of Academic and Cultural programmes on 6th& 7th May 2023 . I request all HODs and Seniors to encourage their young residents and PG students to be a part of this event.

Long live ISA! Long live ISA Delhi!

Warmest regards
Dr. Anuvijayant Goel
(Honorary secretary and treasurer, ISA Delhi)
9958895659Isadelhiexecutive@gmail.com

From the Editor's Desk
Message

It is my pleasure to release issue 5 of Anaesthesia Times. The month of March came with lot of festivities in the form of Holi, Navratras, month of Ramadan which is aptly depicted in the theme of Newsletter.

The Department of Anaesthesia, ABVIMS, Dr. RML Hospital successfully conducted Workshop for OT Technicians (WOTT) on 19th March 2023. It was received with lots of enthusiasm in not only delegates but with faculty as well.

This issue discussed the pre-anaesthesia preparations in a patient with one of the commonly known disorder, Diabetes Mellitus. There are off beat articles like Halasana Yoga, Incredible India like Shabebaraat, Humourb Stop etc. The role of communication within organization was emphasized. The Yuvacon is round the corner. There will be one day sports event and lots of cultural and literary events. Please participate in large number.

Keep sending the interesting articles at editorisadel@gmail.com

Dr. Akhilesh
Editor

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ISA DELHI
Schedule – ISA Delhi Clinical Meet 2022- 2023

- ISA Delhi Clinical meets as per the schedule. Each Meeting shall accommodate for presentations 1-2 Hospitals in addition to their own Institute presentations.
- Total of 4 presentations and a quiz – 1-2 Original Articles 1-2 case series/case reports/technical presentations. One quiz of around 10 questions.
- Zonal GC from the zone of HOST institute along with EC members from the Host and other participating Institutions of ISA Delhi shall coordinate in coordination and approval with ISA Delhi Headquarters – President and Secretary.

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

Day **3rd Wednesday**	**Primary Institute/Hospital. Each Clinical meet shall accommodate 1-2 Hospitals for presentations in addition to their own institute presentations.**	**Contact Person**
December 2022	UCMS	Dr. R S Rautela. 9625900699/9868399699
Jan 2023	VMMC and Safdurjung Hospital	Dr. Vandana Talwar 9811352251 drvandananatalwar@gmail.com
Feb 2023	MAMC	Dr. Kirti Nath Saxena 9968604215 kirtinath@gmail.com
Mar 2023	Dr. Baba Saheb Ambedkar	Dr. Vandana Chugh 7290095540 Deepakvandana786@yahoo.co.in
Apr 2023	Hindurao Hospital	Dr. Alka Chandra 9560044454 dralkadelhi@yahoo.co.in
May 2023	Apollo Hospital	Dr. Meera Kharbanda 9810063988 meera.kharbanda@yahoo.com
June 2023	Max Hospital Saket	Dr. Aparna Sinha 9810035503 apsin@hotmail.com
July 2023	Deen dayal Hospital	Dr. Sushmita Sarangi 9818990113
Aug 2023	LHMC	Dr. Maitree pandey 9810570515 maitreepandey@gmail.com
Sep 2023	Sir Ganga Ram Hospital	Dr. Jayashree Sood 9811294608 drjayashreesood@gmail.com

ISA Clinical Meet: Maulana Azad Medical College

4th Clinical Meet: Maulana Azad Medical College

The fourth clinical meet was conducted on 24th February 2023 at Maulana Azad Medical College and Lok Nayak Hospital, Delhi.

It was attended by all ISA office bearers, faculties and residents from various medical colleges, hospitals and Private practitioners.

The meeting began with ISA flag Hoisting and welcome address by Dr Kirti N. Saxena, HOD Anaesthesia MAMC. Two minutes silence was kept in the memory of Dr. VP Kumra.

This was followed by three scientific presentations by postgraduates which were engrossing and thought provoking. After completion of presentations, the knowledge was shared by speakers and learned faculty members incl Dr. Ashok Kumar Saxena and others. Stalwarts like Dr. J S Dali and Dr. UC Verma were honored. Thereafter, thrilling and stimulating quiz was conducted. The monthly "Anaesthesia Times -Issue 3" was released by the office bearers and senior anaesthesiologists.

The following topics were presented during scientific session-
1) To evaluate correlation of SS-genotype of 5HTTLPR gene with post operative nausea and vomiting in patients undergoing major elective surgery
Speaker: Dr Aditya Tiwari
Moderator: Dr Kirti Nath Saxena

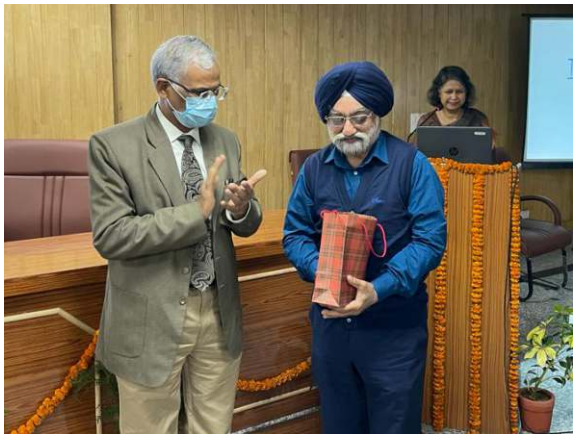
Background: Postoperative nausea and vomiting (PONV) is one of the most common causes of patient dissatisfaction after anaesthesia and is multifactorial with patient risk factors, risk related to anaesthetic techniques and surgical procedures. Various risk scores have been developed, the most used being Apfel risk score. However even patients at low risk of PONV by Apfel risk score can experience PONV, suggesting genetic predisposition4.

Aims: This study was aimed to study the correlation between genotypes of 5-HTTLPR gene with post-operative nausea and vomiting in patients undergoing elective surgery.

Methodology: We included 87 patients in study and after a basic pre anaesthetic evaluation and obtaining written informed consent, we drew 3ml venous sample for assessing the genotype of the patients and standard institutional protocol for general anaesthesia was followed. In the post-operative period, we observed patients at an interval of 0, 6,12, 24 hours post-operatively and PONV was assessed. Nausea was assessed using a numerical rating scale of 0 to 10

For assessment of vomiting, number of times patient vomited or retched was recorded.
Based on these two questions, a composite score was calculated, and patients was divided into no PONV group, intermediate PONV group and severe PONV group.

Results and Conclusion: Statistically significant correlation was seen with SS-genotype of 5HTTLPR (rs 4795541) gene polymorphism with PONV and significant correlation was aslo seen with the low activity allele clusters of 5HTTLPR (rs rs25531). Additionally, females were observed to have more PONV and prevalence of SS-genotype.



ISA CLINICAL MEET FEBRUARY

2) Anaesthetic Management of a parturient with leptospirosis posted for emergency LSCS.
Speaker: Dr Jyoti, Dr Surbhi
Moderator: Dr Prachi Gaba, Dr. Lalit Gupta

Leptospirosis is a zoonotic bacterial disease, caused by the spirochete bacterium, Leptospira interrogans, and is endemic in India, with outbreaks occurring regularly in different regions of the country. Leptospirosis in pregnancy is a rare but serious complication, associated with fetal and maternal morbidity and mortality that can cause serious complications during pregnancy.

Anesthetic management for pregnant women with leptospirosis can be challenging, particularly when faced with the decision of spinal or general anesthesia. In this case report, we present the successful management of a 24-year-old primigravida with leptospirosis and thrombocytopenia who required emergency caesarean section. Spinal anesthesia was chosen over general anesthesia, leading to a positive outcome with no systemic complications associated with leptospirosis or anesthesia.

Despite being an endemic disease, there is a paucity of literature regarding anesthetic management in pregnant women with this infection. Our report highlights the importance of considering spinal anesthesia as a viable option in such cases and calls for further research to explore optimal anesthetic strategies for pregnant women with leptospirosis.

3) An innovative technique for paediatric lung isolation
Speaker: Dr Nity
Moderator: Dr Bharti Wadhwa, Dr Wahaja Karim
An Innovative Paediatric bronchial blocker

Abstract-Paediatric one lung ventilation is a challenge due to the challenges of cost, availability, and technical difficulty of paediatric one lung isolation. A 4 Yr female child with Right sided Empyema thoracis was posted for VATS. General anaesthesia with one lung isolation for isolating the right lung and preventing the soiling of the Left lung was achieved by repurposing a foley's catheter to act as a bronchial blocker. The placement confirmed using fibreoptic bronchoscope and successful lung isolation was achieved. Foleys catheter as a bronchial blocker can be used an alternative to previously described techniques for SLV in paediatric patients.




PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

DIABETES MELLITUS (DM)

Key Points

- DM (Diabetes Mellitus) is an endocrine disorder of insulin deficiency or resistance, characterised by abnormal carbohydrate metabolism, causing hyperglycemia, chronic pro-inflammatory and pro- atherogenic state.
- End-organ damage due to DM, classified further as micro-vascular and macro-vascular complications, need evaluation pre-operatively (Peripheral vascular & cardiovascular disease, renal insufficiency, cerebrovascular & ophthalmic complications, & autonomic dysfunction)
- Classification as per American Diabetes Association (ADA) and World Health Organisation (WHO): Type1 – Insulin deficiency (Autoimmune destruction of pancreatic beta cells); Type 2 - Insulin resistance (Peripheral insulin resistance with failure to secrete Insulin); Type 3 – Others (Gestational DM)
- As per WHO guidelines, Diabetes Mellitus is diagnosed when fasting plasma venous glucose > or = 126 mg/dL (7mmol/L); or a 2-hour post-prandial glucose or random plasma glucose concentration > 200 mg/dL (11.1 mmol/L).
- As per ADA, fasting plasma glucose concentrations between 110-126 mg/dL (6.1 – 7 mmol/L) represents impaired fasting hyperglycemia.
- DM patients are more likely to have post-operative infections and sepsis.
- Metabolic syndrome (syndrome X): Impaired glucose tolerance due to insulin resistance, hypertension, raised plasma triglycerides, central obesity, albuminuria.
- Involvement of physician/endocrinologist in DM care is prudent.

Types of Surgery in DM patients

1. Any type of elective or emergency procedures
2. Surgery related to the microvascular or macrovascular (short & long-term) complications of DM

History specific to DM

- History of polyuria, polydipsia, polyphagia
- Weight gain/weight loss, fatigue
- Gastro-esophageal reflux symptoms
- Previous H/O serious infections, especially respiratory and urinary tract infections
- Vision disturbances, Blindness
- Tingling & numbness in extremities
- Delayed wound healing
- Symptoms of hypoglycemia, like sudden unconsciousness, sweating, headaches
- History pertaining to anti-diabetic medications: oral or Insulin (injectable)
- History of neck and joint immobility with previous difficult intubation
- History of previous hospitalizations for any surgery (eg. Amputation) or various DM complications like hypoglycemia, diabetic ketoacidosis and coma.
- Autonomic symptoms assessed include: Light-headedness, Dry mouth/dry eyes; Cold feet; Decreased sweating in feet as compared to rest of body; Sexual dysfunction; Urinary urgency; Alternating diarrhoea & constipation (gastroparesis); Visual (pupillomotor) symptoms; Reflex syncope; Sleep disturbances.

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

S.No.	SYSTEM AFFECTED BY DM	HISTORY TO BE TAKEN IN PAC (pre-anaesthetic check-up)
1.	General	Polyuria, Polydipsia, Polyphagia, Chronic fatigue, Skin ulcers/Extremity blackening, Delayed wound healing, Recurrent infections
2.	CVS – cardiovascular system (To rule out coronary artery disease & peripheral vascular dis.)	Breathlessness or chest pain on exertion, Silent angina, Cardiac interventions done, Anti-platelet medications (if any).
3.	CNS – Central Nervous System (To rule out Stroke, Transient Ischemic attack, Sensory loss, Peripheral neuropathy)	H/O paraplegia, facial asymmetry, tingling & numbness in extremities (Glove & Stocking distribution), Trophic ulcers
4.	Eye	H/0 vision disturbances, blindness, any ophthalmic surgery in the past
5.	GIT (Gastro-intestinal system)	Gastro-esophageal reflux symptoms, Nocturnal diarrhoea, Weight loss/gain
6.	Autonomic Nervous System	Postural light-headedness, Dry mouth/dry eyes; Decreased sweating; Sexual dysfunction; Urinary urgency; Alternating diarrhoea & constipation (gastroparesis); Visual (pupillomotor) symptoms; sleep disturbances.
7.	Renal	Dysuria, Anuria, Need for dialysis, H/O UTI (Urinary Tract Infection)
8.	Airway	History of neck and joint immobility H/O previous difficult airway
9.	History related to treatment of DM	OHA (oral hypo-glycaemic agents) intake: Type, Dose, Frequency Insulin injections: Type, Dose, Frequency Blood sugar charting maintained by patient
10.	History related to acute complications of DM DKA – Diabetic Ketoacidosis HONK – Hyperosmolar Non-ketotic Coma	*Hypoglycaemic episodes/symptom *H/O DKA: excessive thirst, abdominal pain, nausea/vomiting, fruity breath, confusion, altered sensorium *H/O HONK: Warm/dry skin, increased urination, drowsiness, hallucinations *H/O previous hospitalization

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

Systems Involved & Examination

S.No	SYSTEMS INVOLVED IN DM	EXAMINATION
1.	General	Vital parameters, Hydration Status, Skin turgor, Pallor, Icterus, Neck Veins, Temperature, Weight, BMI (Body Mass Index), Skin condition, non-healing ulcers, Gangrene
2.	Cardiac	Metabolic Equivalent (METs), Heart Sounds, Postural fall in BP; Bedside evaluation of cardiac function
3.	Renal	Requirement for Dialysis (ESRD – End Stage Renal Disease) due to diabetic nephropathy), Urine output
4.	Ophthalmic	Cataracts, Vision charting, Evaluation for glaucoma or retinopathy if required
5.	CNS	Degree and areas of sensory loss, Motor power & Tone in all extremities; Presence or absence of Paresis; Sensorium & consciousness level
6.	Autonomic system (Valsalva Tests)	1. Heart rate variability to deep breathing 2. Blood pressure measurements during Valsalva manoeuvre 3. Blood pressure changes during a 10-minute, 70-degree head-up tilt compared to resting supine blood pressure 4. Valsalva ratio (VR)
7.	Airway & Respiratory system	1. Prayer sign: Difficult airway due to “Stiff Joint Syndrome” 2. Look out for signs of upper or lower respiratory tract infections 3. Respiratory rate, rhythm, breath sounds, pattern of breathing, adventitious sounds; Chest wall & Neck examination 4. Neck circumference & Range of neck movements; Other airway evaluations
8.	Vascular system	1. Examination of peripheral pulses: presence or absence of pulse, pulse volume, rate, rhythm, regularity, bruit 2. Quality & thickness of vascular wall 3. Allens' test (if invasive arterial line planned)

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

Tests for Autonomic Nervous System Dysfunction

- Tests of Autonomic Dysfunction: ASP (Autonomic Symptom Profile), COMPASS (Composite Autonomic Symptom Scale) are two validated scores for assessment. They assess the following autonomic symptom domains: Orthostatic; Sudomotor; Vasomotor; Gastrointestinal; Urinary, and Sexual dysfunction.
- Tests to be performed include the following:
  1) Heart rate variability to deep breathing: The ratio of heart rate response during expiration and inspiration, the expiration: inspiration (E:I) ratio, and Heart rate range (HRR) during respiratory cycle. [Normal heart rate should increase by over 15 beats/minute in response to deep breathing. Autonomic neuropathy is present if there is less than 10 beats/minute increase.
  2) Blood pressure measurements during Valsalva manoeuvre: Patient is asked to maintain an expiration pressure of 40 mmHg for 15 seconds. It consists of forced expiration against the resistance.
  3) Blood pressure changes during a 10-minute 70-degree head-up tilt compared to resting supine blood pressure: A decrease in systolic BP of at least 20mmHg or a decrease in diastolic pressure of at least 10mmHg within 3 minutes of standing occur in autonomic dysfunction
  4) Valsalva ratio (VR): Calculated by dividing the highest heart rate during Valsalva maneuver by the lowest heart rate (usually occurring during phase 4 of Valsalva). In autonomic failure, reflex bradycardia and blood pressure overshoot is typically absent. Low VR values (1.5) correlates with prevalence and severity of complications.

Airway

- DM have higher chances of difficult airway; Detailed airway evaluation
- Glycosylation of collagen in the cervical and temporo-mandibular joints can cause difficulty in intubation and limited neck extension: Stiff joint syndrome (in 30% DM)
- Prayer sign: Ask the patient to bring their hands together, as if praying and simultaneously hyper-extend to 90 degrees at the wrist joint: If the little fingers do not oppose, patient may have anticipated difficult intubation. (Advice regarding preparation of difficult airway cart to be mentioned in PAC).

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

Investigations

The following are the investigations to be done for elective surgery in DM:

S.No.	SYSTEM AFFECTED	INVESTIGATIONS TO BE DONE
1.	General	*Complete blood count (Haemoglobin, Total & Differential leucocyte count, Platelet count): To rule out anemia, infections, platelet dysfunction & sepsis
2.	Level of Blood Sugar Control	*Random, Fasting & Post-prandial blood glucose *HbA1C (Glycosylated Hb): Levels < 6.2% in normal subjects * Serum Fructosamine levels: reflects serum glucose levels over the preceding 2-3 weeks, as opposed to 2-3 mths (HbA1C). Elevated fructosamine levels (>292 micromol/L) is associated with greater risk of post-operative deep infection. Fructosamine testing is advantageous for patients in whom HbA1C levels may not be accurate (anemia, sickle cell disease, asplenia, splenomegaly), or if patient has recently made changes to their diabetic medications, and its less costly.
3.	Cardiovascular System	· 12-lead Electrocardiography (ECG) · Cardio-pulmonary Exercise Testing (CPET) · 2-D echocardiography for regional wall motion abnormalities & left ventricular function (as per cardiologist opinion).
4.	Kidney	· Serum Urea, Creatinine · Serum electrolytes, especially serum sodium, chloride & potassium levels. · Ultrasound KUB (if chronic kidney disease) · Urine routine & microscopic examination; Urine sugar & ketone bodies; · Urine for microalbuminuria (DMnephropathy) · Urine culture/sensitivity if urinary tract infection is suspected.

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

S.No.	SYSTEM AFFECTED	INVESTIGATIONS TO BE DONE
5.	Liver	· Liver function tests · Liver enzymes (SGOT/SGPT/ALP) · Serum Albumin/Proteins
6.	Respiratory system	· Chest X-ray
7.	Airway	· Cervical Spine X-rays: AP & Lateral
8.	Ophthalmic	· Vision charting & Glaucoma evaluation · Fundoscopy

Emergency surgery PAC

- DM Patients for emergency surgery generally present with uncontrolled blood sugars and diabetic complications, leading to poorer post-operative outcomes.
- Trend towards metabolic improvement must be achieved; Take short history/exam.
- Hypoglycemia, if present should be recognized & treated promptly.
- Insulin therapy is warranted to tide over the crisis and effective sugar control
- Pre-operative correction of dys-electrolytemias, especially hypokalemia
- Following investigations to be done (if time permits): Complete blood count, Blood sugar, Urine sugar/ketones/proteins, X-ray chest, ABG, RFT, LFT, ECG
- Cardio-pulmonary testing may not be possible due to paucity of time: Risk to be explained in consent; Poor risk/High risk consent and post-operative ICU (Intensive Care Unit) care to be taken.
- Clinical tests for autonomic dysfunction should be done along with ECG.
- ABG (Arterial Blood Gas Analysis): To be done in emergency operative cases with possible diabetic complications like Diabetic Ketoacidosis (DKA) & Hyperosmolar Non-Ketotic Coma (HONK).

PAC PROTOCOL FOR ENDOCRINE DISORDERS: DM

PAC ADVICE

- Diabetic patients should preferably be scheduled first on the surgical list.
- DM patients prone to all types of infections/delayed wound healing: Complete asepsis
- American Diabetes Association recommends a target HbA1c of < 7% (Type 2DM)
- Difficult airway cart to be kept ready (Stiff Joint Syndrome)
- Morning fasting blood glucose, serum electrolytes (Na+, K+ levels), Urine (sugar/ketones) to be done on morning of surgery.
- Elective surgery to be delayed in patients with suspected DKA.
- There is very little data supporting the practice of stopping Metformin for 48 hours prior to surgery due to purported risk of lactic acidosis: As per recent research, Metformin need not be stopped two days prior to elective surgery.
- Newer oral hypoglycemic agents (Acarbose & Pioglitazone) do not carry a risk of hypoglycemia in the fasting patient; Need not be stopped for minor or day-care Sx.
- Stop Chlorpropamide 3 days prior to surgery (as it is long acting).
- The following OHAs need to be WITH-HELD on the day of surgery:-
  a) Alpha-glucosidase inhibitors (acarbose, miglitol); b) Glucagon-like peptide-1 agonists (exenatide, dulaglutide, albiglutide, semaglutide); c) Meglitinide derivatives (Repaglinide, Nateglinide); d) Sodium-glucose cotransporter-2-inhibitors (canagliflozin, empagliflozin, dapagliflozin); e) Sulphonylureas (Chlorpropamide, Gliclazide, Glipizide, Tolazamide); f) Thiazolidnediones (Pioglitazone, Rosiglitazone)
- For major surgery requiring strict control of blood sugar (Transplant, Obstetric patients), shifting to injectable insulin is required for better peri-operative outcomes.
- For minor surgery, omit morning subcutaneous Insulin, if glucose < 126 mg/dL (7 mmol/L); Give half normal insulin dose if glucose > 126 mg/dL (7mmol/L).
- For major surgery in all types of diabetics, omit morning dose of OHA/normal SC (sub-cutaneous) Insulin, prepare IV regular Insulin infusion and check for blood glucose 1 hour preoperatively, hourly intra-operatively until 4 hours post-op, 2 hourly thereafter and 4 hourly later on (as per requirement & oral intake).
  Advice regarding pre-operative starting of 5% Dextrose infusion containing 20mmol/L KCL (potassium chloride) at the rate of 100ml/hour to provide carbohydrate substrate & potassium may be mentioned in PAC advice.

Written By:
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ABVIMS, Dr. RML Hospital

COMMUNICATION FOR ANESTHESIOLOGISTS

Dr Arun K Mehra

PART V : Communication Inside the Organization

It is worth remembering that, apart from communication with the patient and with family members and attendants, there is another very vital and crucial type of professional communication that doctors have to perform, namely communication with the organization they work in, and communication outside the organization. These forms of communication include communication with colleagues (both inside and outside the hospital or healthcare establishment), with their own department, with the administration, and, at times, with outside institutions like other hospitals, the press, politicians, legal and investigative agencies, and the society in general (which can include, but are not limited to, training and education programmes). Such communication, while still a form of professional communication, is different from that with the patient.

In the case of anesthesiology, there is yet another form of very highly specialized organizational communication, which is that within the OT and in the ICU and other critical care areas. These will be dealt with in separate articles later on.

This month we will briefly discuss organizational communication, as it is a critically required skill in today's highly complex work environment, essential not only for those in managerial roles, but for all doctors.

First of all, let us try to understand what is the need for organizational communication, and how it contributes to improving the functioning of the hospital (or healthcare establishment), ultimately leading to a better outcome for the patient.

We know that communication is the basis of all relationships, both personal and professional. Without it, there would be no relationships at all.

Basically, organizational communication contributes to managerial effectiveness through a variety of means. These include enhancing staff morale, improving performance, getting better collaboration, and increasing motivation, all of which promote greater productivity, reduce churning, and decrease attrition. It is pertinent here to remember that an anesthesiologist has vital managerial roles in the OT and in critical care and terminal care areas, where he or she has to manage not only the medical and clinical aspects of patient care, but also the non-clinical facets, like guiding the staff members, dealing with logistics, inventory management, checking that equipment is properly maintained, and much else.

As organizational communication is, commonly, less rushed than communication with a patient (where time is limited, and decisions often have to “instant”, especially in the OT and in critical care areas), the communication skills required are slightly different. While the basic skills of good communication remain the same (like being a good listener, being empathetic, and so on), knowing about the distinctions can prove very valuable in communicating better.

As mentioned above, there is the availability of more time to think things through more clearly, without the haste that may often accompany communication in an OT or an ICU. This, coupled with a greater knowledge of those you are communicating with (your own staff members), results in a huge advantage. In all communication, it is important to think through the reason for communication, your goal, what end result you want, etc. In organizational communication, you have available both the time and the resources to think about all this,

usually thus getting better results.
Then, another important skill is to “move higher”, something often not possible in communication with a patient. Introduce your idea briefly, in a simplified form, and then go to more complex explanations to convey the ultimate purpose.

There is also a greater scope to experiment, to diversify and to reflect on the outcome.

While these are some of the extra advantages available in organizational communication, one question obviously arises: “how can these skills be improved?”

As always, actively seek feedback. Ask what you should start doing, what you should stop doing, and which skills you already possess but should improve upon.

Be clear about your expectation from your staff, and also about their expectations from you. These are of critical value in the OT and in intensive care, where you cannot afford any laxity. Repeat what you say as many times as you may have to. Never forget that communication is a two way process.

Also remember that while decorum has to be maintained and channels of communication have to be followed, never allow this practice to become too rigid and formal, or to get ossified into an autocratic style, because if your staff fears approaching you, then no meaningful communication can take place. A “personal” level of communication, with the staff feeling comfortable, will bring out valuable inputs. It cannot be overemphasized that the most important information comes from the field level workers, so it is important to encourage them to speak up freely and frankly and fearlessly, and it is also important to be empathetic and sympathetic towards them.

One very useful tip in organizational communication is to look for discrepancies between what people say and their non-verbal communication. This reveals a lot, and can be an early hint in a critical environment (where anesthesiologists work all the time) that a course correction is needed.

An important change from traditional communication that is now taking place is that, in the age of computers and of telecommunications, the Management Information Systems (MIS) are acquiring a huge role in communication within an organization. The corresponding counterpart in the medical and healthcare sector is called Healthcare Information Systems (HIS).

Lastly, there are two very important things to remember in all communication: first that communication is context dependent. This should never be forgotten.

Second, there are cultural barriers to communication. While this is acquiring a wider recognition in today's globalized world, it has all along been something of immense importance in a country of vast diversities like ours. What you say, with the best of intentions, may be misunderstood or misinterpreted by your staff members due to their personal outlooks and experiences. While communicating, it is always wise to consider this possibility, and take precautions.

The topic of (not with patients) communication within and outside the organization is quite vast, and is acquiring more importance with greater regulation and legislation. The reader is encouraged to read more deeply about this. An OT and an ICU are areas where skills in this field go a long way in creating better working conditions for all, and in achieving better outcomes.

Workshop For OT Technicians (WOTT)

Under the aegis of ISA Delhi Branch, Department of Anaesthesia ABVIMS, Dr RML Hospital successfully conducted the workshop for OT Technicians (WOTT) on 19th March 2023. This was the first ever workshop conducted only for OT Technicians.
OT Technicians are the backbone of our operation theatres. Hence its our responsibility to train, educate and update them regularly with the latest technology. Keeping this in mind the first ever workshop for OT Technicians was planned and successfully executed.

More than 140 OT Technicians participated in the workshop from various govt as well as co-operate hospitals from Delhi NCR and North India. The workshop was a perfect amalgamation of lectures and hands on training in various fields of anaesthesia.

Few of the highlights of the workshops were:

1. How to prepare your OT: Highlighting the importance of communication and planning for each case.
2. Positioning of patient: Emphasized on the importance of correct positioning of the patient for various anaesthesia techniques as well as the positioning of patient under anaesthesia to prevent the perioperative complications
3. Oxygen Delivery Devices: The participants were familiarized with the various oxygen delivery devices and their correct method of use.
4. Various hands-on stations were there:
    a. Airway devices such as Fiberoptics/Supraglottic Devices/ ETT/Laryngoscopes: Participants were taught the correct method of equipment preparation and cleaning after the use
    b. Monitoring: Both invasive and non-invasive monitoring was shown to all the participants. The basics like correct place to put ECG electrodes were also taught to all the participants
    c. Basic Cardiac Life Support: Hands on training was given to all the participants for BCLS.
5. Visit to Oxygen manifold and Hyperbaric chamber were also included in the workshop which was well appreciated by all the delegates.

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The workshop ended with numerous positive feedback from the participants. Few said they felt appreciated and valued, some mentioned it was after almost two decades that they attended any class and many asked when will the next workshop conducted. All of them went with their minds full of knowledge and attitude bubbling with enthusiasm.

Yogasan

HALASANA

Halasana or literally plough pose.
PREPARATORY ASANA-Sarvangasana(which is described in previous issue)

Setu baandhasana
- This asana should be done slowly and gently.
- Avoid jerking while bringing the legs down.

FOLLOW UP ASANA – these asana could be done after halasana
- Bhujangasana
- Pavanmuktasana

HOW TO DO IT
- Lie in supine position, arms by the side and palm facing down.
- With inhalation ,raise the legs .
- Supporting the hips and back with hand and elbow on the ground, slowly lift hip and back oof the ground.
- Sweep the legs over the head till the toes touch the ground.
- Arms may be stretched out on the ground.
- Hold this asana and let the body relax with slow and deep breathing.
- Gently bring the legs down with exhalation.

BENEFITS
- Strengthens the neck, shoulder, abs, and back muscles.
- Reduces stress and fatigue.
- Tones the legs and improves leg flexibility.

AVOID
- This asana should be avoided if suffering from chronic neck pain or backache.
- During pregnancy.



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PET CORNER

Shadow

It was a usual december afternoon. I was studying for my hindi monday test and well it was extremely easy to get distracted doing that. My gaze went to a little, white pup with brown patches from head to toe. He was lying there in our verandah, listless as compared to his brothers and sisters. I picked him up and saw he was injured on one arm, a mighty big wound. I rushed inside and called out to my mother who instantaneously took him in to have a closer look at the arm. Spectacles on their noses, both my parents committed to removing one maggot after another from that wound. And of course my mundane evening of studying went for a toss. We were saving a puppy! He was just big enough to fit my mother's palm and was moaning and groaning with pain. None of us thought at that moment that this little bundle of joy would be called Shadow and would give us 13 years of happiness. We had two more dogs at the time, Buddy and Tubby. They were confused with the energy this miniscule creature had, jumping around here and there, hanging onto their ears, licking away at their faces when all they wanted to do was sleep. But Shadow didn't give up. He wormed his way right into their hearts and ours too.

Everytime we got back home from an outdoor activity, he would be waiting with absolute glee, ready to pounce at us, his fluffy tail flailing about in the air like it had a life of its own. And then he would settle down next to me, leaning against me with his entire weight on my legs, ready to slide straight down into slumber. I still remember vividly, that we had set up a cardboard box for him to sleep in. He would be tossing about in the box, being mischievious when my mother would say "Go to sleep Shadow!" and then we would hear Shadow give a sigh of dissatisfaction and go to sleep at once. He would wake up all energised in the morning and it was a ritual for him to come to our room and lick my sister's nose, almost like he was telling her its time to wake up. He would always steer clear of my nose though, he knew i hated being woken up early. But he was always true to his name, a shadow following me around the house, into every room i entered. Even till his last day, he did not leave my side. Like all good things come to an end, so did our time with Shadow. But we all know he is somewhere up in dog heaven, trotting about with his floppy ears, making new friends, chasing scooters and squirrels and watching over us.

PET corner:
By
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Shab- e- Baraat – the Night of Forgiveness

To err is human, to forgive is divine, is a common idiom that we have all read while growing up. Muslims follow the five pillars of Islam, and forgiveness is an important part of every pillar. These are the five pillars:

- **Namaz** - Praying five times a day – being grateful, and asking for forgiveness of sins
- **Roza** - Fasting in month of Ramadan – learn tolerance, build resilience and become forgiving
- **Haj** - Pilgrimage to the Holy City of Mecca – once in lifetime
- **Zakat** - giving charity – every year 2.5% of total annual income is to be distributed amongst the needy starting from family, to employees, and even strangers in need.
- **Khums** - charity given for religious purposes eg. funds given in rebuilding a mosque

There are about 72 sects in Islam, and Indian Muslims comprise of Sunnis (85%), Shias (13%), and small minority of other sects, all of whom believe in the five pillars of Islam, but there are certain occasions that are celebrated differently by some for various reasons. The Islamic year comprises of 354 days and has 12 months based on a lunar calendar. Some of the commonly known months are Ramazan (the month of fasting) and Muharram (the month of mourning for Shia community). A relatively lesser known cultural occasion that is celebrated amongst Muslims in the eighth month of Sha'ban, is Shab-e-Baraat, also called the Night of Forgiveness.

Shab-e-Baraat, Barat Night, Cheragh e Barat, is a cultural celebration celebrated in many South Asian, Central Asian, South East Asian and Middle Eastern Muslim countries, on the 15th night of Sha'ban. Shab-e-Barat's rituals and styles differ from region to region and, involves a festive nightlong vigil with prayers. In many regions, it is also a night when prayers are offered to ask for forgiveness of one's deceased ancestors. Most people visit the mosques and then go to the graveyard, to light the candles and place flowers near their loved ones, and pray at the site. This obligation is to remind them that life is basically ephemeral and what awaits everyone is death and God's judgement.

On this day, Muslims also collectively worship and ask for forgiveness of their wrongdoings. It is believed to reward them with fortune for the whole year and cleanse them of their sins. This particular night is also important because Allah is believed to decide the fortunes of all for the next year: who would live, who would die and who would be born.

I used to remember this day for the special “Chane-ki-daal” or “Sooji-ka-halwa” that used to be cooked at home. The lovely brown colour of the ghee roasted chana dal would be a mouth- watering delight for everyone. A small “Nazr” used to take place at my parent’s home where a part of this halwa was presented as a gift to the departed souls of the deceased relations and our twelfth Imam.

Shia Muslims commemorate this day with the birthday of their twelfth Imam Muhammad al-Mahdi (peace be upon him), the last Imam to have succeeded the Prophet. He is especially important, as he is believed to be the promised Mahdi, who would appear again to destroy the false messiah and save the world. He is like the Kalki Avatar of the Hindus, but Islam’s earlier link to Christianity becomes apparent when some legends mention that in his task of deliverance, the Mahdi would be supported by the Second resurrected Christ. In Shia dominated parts of the world, the localities are decorated on this great occasion, just as they are on Christmas. And just like children write letters to Santa every Christmas, my grandfather used to write a letter to the twelfth Imam, on the 15th Sha’ban, asking for his wishes and requests to be fulfilled. But there was a unique way of posting this letter. The letter would be made into a small paper ball, then covered with wet flour dough and thrown into the river. The city of Lucknow used to be lit up with lights, and children and teenagers used to throw their lot of wishes into the river. The waves of wishes that would be carried forward, would create a sea of hope and joy for the coming year.

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GARDENER'S GUIDE

Looking after Tulsi

Today's focus is on how to take care of the Tulsi plant (Ocuimum) in a pot. It is a common household shrub with legendary, healing, attributes, and social and religious importance. It is a hardy perennial plant, which thrives well with small and straightforward care. It tends to grow tall with very few branches, but you can make it bushy and with many branches by plucking the growing tips of the main branches. A young plant has rather large, fragrant leaves but after many flowering cycles, the leaves become small.

Soil: it needs aerated (regular gurai), well-drained (protected from flooding) soil. It requires organic manure once or twice a month depending on how heavy the flowering has been. Contents of an ideal potting mix for Tulsi, out of the total capacity of the pot, can be 1-part "Chuna", 3 parts vermicompost, 4 parts perlite, 4 parts sand, 8 parts peat moss and 8 part garden soil. When peat moss is used it is good to add Chuna to neutralise pH. Please note, out of 28 parts of the total quantity of potting mix, 20 are composed of soil, peat moss and sand.

Once the plant has established at self in the pot, small quantities of many other things are added by many Gardners for example urea (a pinch), DAP (a pinch), SAAF (antifungal, 5-6 pinches), single superphosphate (5-6 pinches), Alum (3-4 pinches) and magnesium sulfate (5-6 pinches)

Habits: It simply loves the sun, and can be kept in direct sunlight. It needs a minimum of four hours per day of sun and better still 6 to 8 hours. It simply loves water (wetness) but not muddy flooding. So a well-draining pot is ideal for it. The mixture of soil, peat moss and sand ensures such conditions. It may be watered once or twice a day depending upon the heat from April to July, once from August to November (and not if it rains), and twice a week during chilly winters. It can be grown easily from seeds or cutting and a sapling may be planted into the pot.

It is a heavy flowerer and makes itself weak with uncontrolled flowering. One needs to pick and prune its inflorescences to keep it healthy and green with good leaves. When under stress (dry soil, flooded pot or frosty winters), it starts heavy flowering desperately and runs the risk of wilting/drying. When it is too cold, it is best to cover it with a bedsheet, especially during frosty nights or transfer the pot indoors.
It helps by pruning dry shoots from time to time.

That's all, dears all.
Happy Gardening
Dr Vijay K Nagpal
Consultant & Professor
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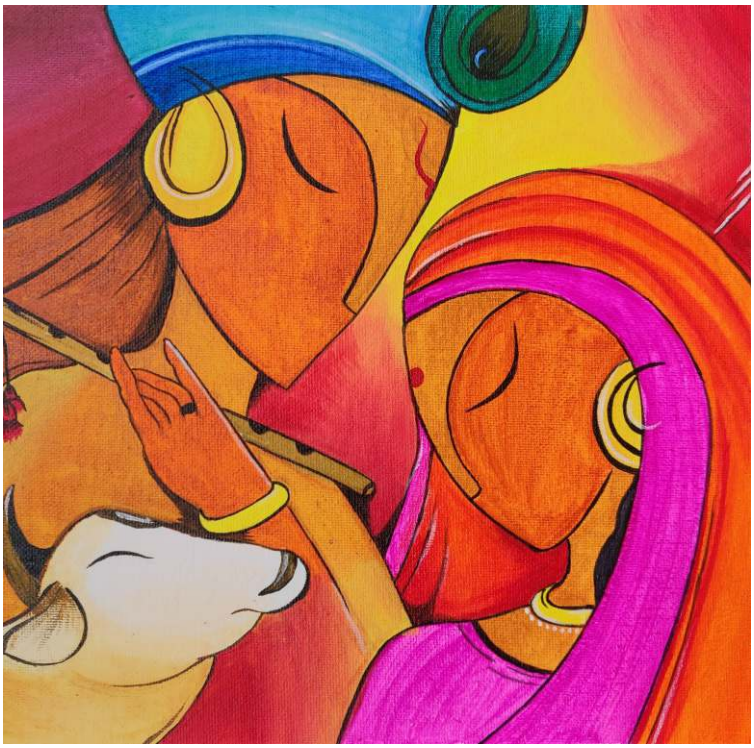
Artwork by Dr. Neelakshi



Protocol for Oral Caffeine Supplement Solution for Resuscitation of the Acutely Confused Anaesthetist

Indications
- Anaesthetist's Request
- Cognitive Disturbances (behavioural changes, agitation, acute confusion, falling GCS)

Contraindications
- Allergy
- Anaesthetist's Refusal (Competent)
- Tachycardia with compromise (see ICU Tachycardia algorithm)

Procedure

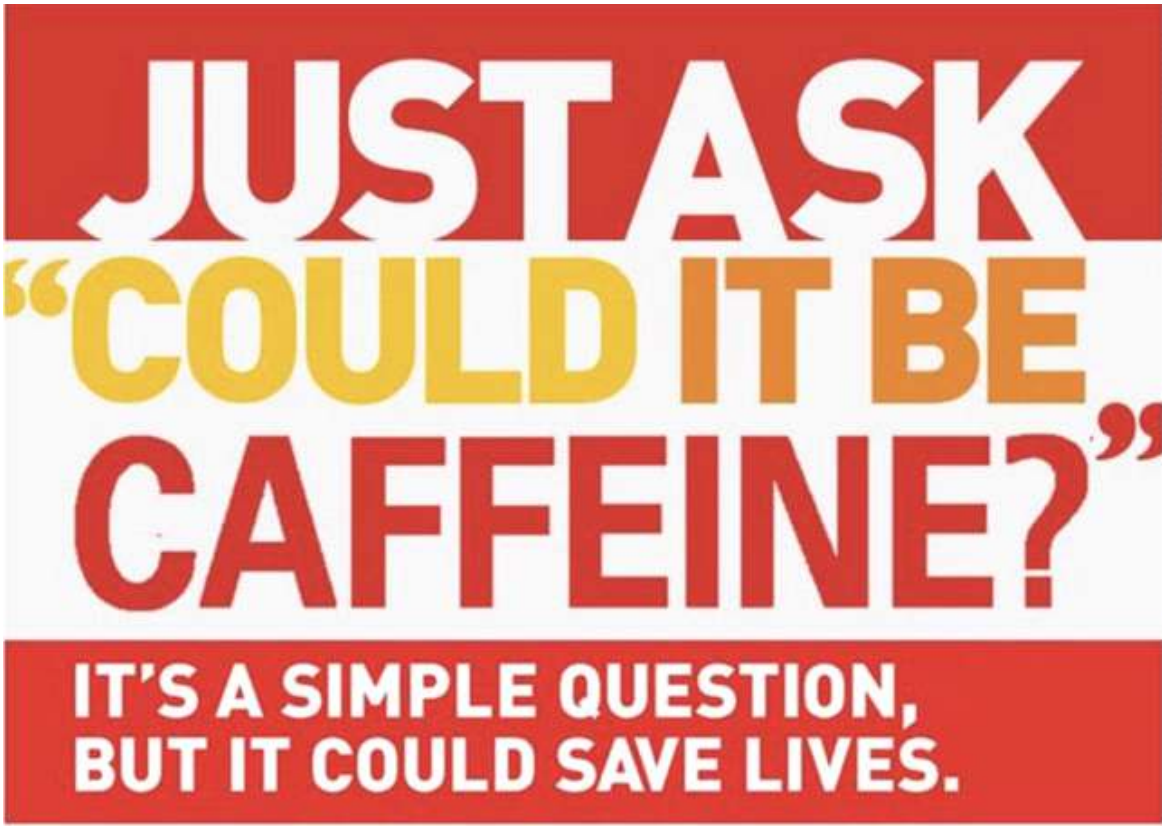
1. Wash hands. Boil kettle.
1. Confirm Anaesthetist details, check allergy status.
2. Confirm Anaesthetist-specific Supplementation Regime. If Anaesthetist is unable to provide, collateral history may be obtained from fellow practitioners. Obtain Anaesthetist-specific Caffeine Delivery Device (Fig 1 and 2)

Figure 1

Figure 2

4. Prepare Solution according to Anaesthetist-specific Supplementation Regime, An example regime is as follows:
1-2 tea bags or one teaspoon coffee (anhydrous) reconstituted in 250ml water at 90-100°C.
1-2 teaspoons of milk powder +/- sucrose granules as per Anaesthetist preference.
Stir until homogenous. Check the mixture for signs of precipitation.
5. Administer to Anaesthetist and monitor closely. If inadequate response, repeat dosing may be required.

Hypocaffeinaemia is a common emergency in anaesthetic practice. If allowed to develop, it commonly results in high collateral mortality and morbidity in associated patients, trainees, and medical students.



Compiled and modified from
Meme Valley NHS Foundation Trust
Dr Shreyash Agrawal
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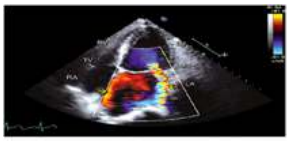
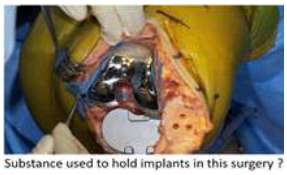
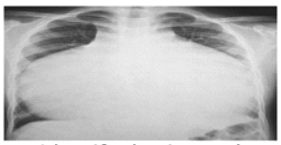
BRAIN TEASER

Unscramble the words and match them to their corresponding image and surgery

Word	Image	Surgery
1.YMTHLYLPOE HCRAETYLETMA- _____ A.	 Effect causing 'wall-hugging jets' on ECHO	**i. cone procedure**
2. LUUFRS AUODEFLRIXHE- _____ B.	 Paradoxical effect of a drug utilized before this surgery	**ii. scleral buckle**
3. ADNCAO- _____ C.	 Substance used to hold implants in this surgery ?	**iii.Thyroidectomy**
4. FOFLW- IHCAOFKF _____ D.	 Identify the Anomaly	**iv. MVR**
5. SENBEIT _____ E.	 Intravitreal injection limiting N2O use	**v.TKR**

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The correct answers to be sent to editorisadel@gmail.com by 15-04-2023

Answers of Last Edition Brain Teaser-
1.CONSORT- (f) 2. MOUNT-FUJI– (c) 3. TOPIRAMATE –(g) 4. ADENOSINE – (b) 5. __TREACHER-COLLINS- (i)
6. PRILOCAINE-(a) 7. BROMAGE SCORE- (d) 8. LARYNGOSPASM- (j) 9. SUCCINYLCHOLINE –(h) 10. CARBOPROST- (e)

Answers to March edition-
1.Methyl Methacrylate – (c) – (v) TKR
2.Sulfur Hexafluoride – (E) – (ii) Scleral buckle
3.Coanda – (A) – (iv) MVR(Mitral valve replacement)
4.Wolff- Chaikoff – (B) – (iii) Thyroidectomy
Ebstein – (D)- (i) Cone procedure

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West Zone

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Head of Department	Dr. U K Valecha	BLK Superspeciality Hospital		9810001903	

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