

Vapour



The official E-Newsletter of the Indian Society of Anaesthesiologists



HIGHLIGHTS

SUPRAGLOTTIC AIRWAY DEVICES

*An interview with Dr. Muhammed Aslam
Nasir - Inventor of i-Gel*

WORKPLACE COMFORT

By Dr. Vidya Mohanram G

PRIZE WINNING ESSAYS

VAPOUR Essay Competition

THE PRECIPICE OF MADNESS

Poem by Dr. Bhagirath. S. Naganath

ANAESTHESIOLOGIST- A SILENT HERO OF THE OPERATION THEATRE

Poem by Prof. Manpreet Singh

A TRYST WITH DR. PANNAGA RAMESH

Kaleidoscope

**Honorary Secretary ISA National
ISA National Headquarters**

27-A, Rattan Nagar, Tripuri, Patiala- 147004, Punjab, India

Mob: +91-9815125828 / +91-9915025828 Email: isanhq@gmail.com / secretaryisanhq@gmail.com

Website: www.isaweb.in

GOVERNING COUNCIL ISA



DR. M V BHIMESWAR
PRESIDENT



DR. MAHESH KUMAR SINHA
VICE PRESIDENT



DR. JIGEEESHU VASISHTHA DIVATIA
PRESIDENT ELECT



DR. SUKHMINDER JIT SINGH BAJWA
HONORARY SECRETARY



DR. MANOJ KUMAR
TREASURER



DR. RAKESH GARG
EDITOR-IN-CHIEF IJA



DR. VENKATAGIRI K M
PAST PRESIDENT



DR. NAVEEN MALHOTRA
PAST HONORARY SECRETARY



DR. VIRENDRA SHARMA
PAST TREASURER



Dr. Muralidhar Joshi
Immediate past EIC-IJA



DR. RAJIV GUPTA
GC MEMBER



R. BHARAT BHUSHAN BHARDWAJ
GC MEMBER



DR. SURAJIT GIRI
GC MEMBER



DR. CHINTALA KISHAN
GC MEMBER



DR. A. VASANTA RAO DESHPANDE
GC MEMBER



DR. SUNIL KUMAR SETHI
GC MEMBER



DR. REKHA DAS
GC MEMBER



DR. MANISHA D. KATIKAR
GC MEMBER



DR. PANKAJ RAMKRISHNA GUPTA
GC MEMBER

THE EDITORIAL TEAM OF 'Vapour'

Editor-in-Chief



Dr. Sukhminder Jit Singh Bajwa
Honorary Secretary, ISA National
Prof. & Head, Department of Anaesthesiology &
Critical Care, GSMCH, Patiala, Punjab

Associate Editor



Dr. Madhuri Kurdi
Prof. & Head, Department of
Anaesthesiology, KIMS, Hubli, Karnataka

Assistant Editors



Dr. Parul Jindal
Dehradun



Dr. Poonam Ghodki
Pune



Dr. Ridhima Sharma
New Delhi



Dr. Milon Mitragotri
Hubballi



Dr. Parna Thakkar
Thane



Dr. Gauri Arora
Nagpur



Dr. Ankur Khandelwal
Guwahati



Dr. Habib Md Rezaul Karim
Raipur

National Advisors

Dr. MV Bhimeshwar
President, ISA National

Dr. Mahesh Kumar Sinha
Vice President, ISA National

Dr. JV Divatia
President Elect, ISA National

Dr Venkatagiri K
Immediate Past President, ISA National
Chairman Academic Committee, ISA National

Dr. Naveen Malhotra
Immediate Past Secretary, ISA National

Dr Virendra Sharma
Immediate Past Treasurer, ISA National

Dr. Manoj Kumar
Treasurer, ISA National

CONTENTS

• Editor's Note	4
• ISA Notice Board	5
SPOTLIGHT: ACADEMICS	
• Supraglottic Airway Devices – <i>Dr. Muhammed Aslam Nasir</i>	6
• Archives of a Thematic Philatelist & Anaesthesiologist – <i>Dr. Chandrasekhar Krishnamurthi</i>	16
• Workplace Comfort – <i>Dr. Vidya Mohanram G</i>	17
ISA ACTIVITIES	
• ISA National Sponsored CMEs & Workshops	19
• World Environment Day Celebrations	20
• World Music Day	21
• 100th ISA National Online PG Class Celebration	22
• Doctor's Day & Guru Purnima Celebrations	23
YUVA PARNIKA	
• Solutions to Crossword	25
• Spin the Word Wheel – <i>Dr. Parul Jindal</i>	26
• Crossword – <i>Dr. Parul Jindal</i>	27
• Prize-Winning Essays of Vapour Essay Competition June 2023	28
MY PAGES: ART, CULTURE & LITERATURE	
• Precipice of Madness – <i>Dr. Bhagirath S Naganath</i>	40
• Anaesthesiologist: A silent hero of operation theatre – <i>Prof. Manpreet Singh</i>	41
• Artwork by Anaesthesiologists – <i>Dr. Ayushma Jejani Padia</i>	42
• Artwork by Anaesthesiologists – <i>Dr. Somnath Shaha</i>	43
• Kaleidoscope: A tryst with <i>Dr. Pannaga Ramesh</i>	44
• Invitation to Contribute	46

EDITOR'S NOTE



Dear esteemed members,
Warm greetings from Indian Society of
Anaesthesiologists (ISA) National Headquarters!

It has been another month of hectic ISA activities and another issue of VAPOUR is now before you. Meanwhile, my job as Honorary Secretary of this esteemed body is getting busier by the day. Multi-tasking in this busy schedule with a loss of track of time has become routine for me. Nevertheless, a lot of goals have to be reached and visions have to be put into action in the coming days.

An interview with Dr Mohammed Aslam Nasir, the globally respected inventor of the popular supraglottic airway device 'i-Gel' is the highlight of this month's issue of VAPOUR. In June 2023, an essay-writing competition on supraglottic airway devices was held and the prize-winning essays are published in this issue. The essays depict the varied ideas, experiences and choices of supraglottic airway devices of our younger generation. On behalf of the editorial team of VAPOUR, I express my heartfelt gratitude to the judges of the essay competition, Dr Chandrasekhar Krishnamurti and Dr. Arunangshu Chakraborty for having spent their valuable time for us.

The section on 'Yuva Parnika' has brain-teasers including 'Spin the Word Wheel' and 'Crossword Wheel'. These test the readers' knowledge of supraglottic airway devices. I am sure that the sparkling art and literary pages with beautifully written poems, artwork by anaesthesiologists and an interview with an extraordinarily talented anaesthesiologist will emit the rays of inspiration and sunshine to other fellow anaesthesiologists.

I hope the news droplets of this issue of VAPOUR will disperse throughout the globe to connect all fellow anaesthesiologists in mind, brain and clinical practice.

Long Live ISA!

Dr Sukhminder Jit Singh Bajwa

Honorary Secretary ISA National

Editor-in-Chief

'VAPOUR'

(The official newsletter of the ISA National)

ISA NOTICE BOARD

Conference Calendar of ISA 2023

Conference	Location	Hosted by	Dates
ISACON Telangana 2023	Khammam, Telangana	ISA Khammam city branch	14th -16th July 2023
ISACON Tamilnadu 2023	Thanjavur, Tamilnadu	ISA Tamilnadu state	21st to 23rd July 2023
3rd YUVAMAHACON 2023	Nagpur	ISA Nagpur city branch	4th to 6th August 2023
South Zone ISACON 2023	Mysuru, Karnataka	ISA Karnataka state	9th to 13th August 2023
32nd East Zone conference & 50th State Annual Conference 2023	Berhampur, Ganjam Odisha	ISA Odisha state	8th to 10th September 2023
RAJISACON 2023	Udaipur, Rajasthan	ISA Rajasthan state	29th September to 1st October 2023
ISACON Maharashtra 2023	Pune, Maharashtra	ISA Maharashtra state & SAP Pune	5th to 8th October 2023
ISACON Kerala 2023	Thiruvananthapuram, Kerala	ISA Trivandrum city branch	13th to 15th October 2023
ISACON Gujarat	Abu Road, Rajasthan	ISA Mehsana city branch	13th to 15th October 2023
ISACON 2023 (Annual conference of ISA)	Gurugram, Haryana	ISA Haryana state	22nd to 26th November 2023

Note: The dates mentioned in the above table are tentative & as per the information received.
The list of upcoming conferences will be updated in subsequent issues.

ISA National PG online classes

These are being regularly conducted every Monday between 6.30 to 8 pm. Experienced PG teachers are taking PG-oriented classes including exam-oriented topics.

Indian Journal of Anaesthesia

The ISA-IJA REAP academic webinar series (alternate Thursday, 5-6 pm) is being conducted.

ISA academic webinar series

The ISA-Clinical Practice-oriented webinar series (CLIP) (alternate Thursday 6:30 - 8:30 pm) and Clinical Reasoning and Problem-Solving webinar series (CRISP, alternate Thursday 6:30 - 8:30 pm) are being conducted regularly and they have received good feedback.

An interview with an international expert

Dr. Muhammed Aslam Nasir

Inventor of i-Gel & v-Gel

SUPRAGLOTTIC AIRWAY DEVICES



Sir,

A warm welcome to you from the Editorial team of 'VAPOUR'!

Thank you very much for accepting our invite.

Since the introduction of the classic laryngeal mask airway (cLMA) into clinical practice in 1988, supraglottic airway devices (SGADs) have now become an essential tool in airway management. Over the past three decades, these devices have been increasingly adopted as an alternative to face mask ventilation and endotracheal intubation. The indications for the use of SGADs have increased dramatically. SGADs are used in pre- and in-hospital settings, elective and emergency anaesthesia, in spontaneously breathing and ventilated patients, as conduits for intubation, as a bridge to extubation and for airway rescue.

You have done a lot of pioneering work in SGADs. The i-Gel that was invented by you is now a very popular and trusted airway device all over the globe.

Nevertheless, there are several limitations regarding SGADs which are of historical, practical, clinical, research and developmental interest. So, we would like to discuss these with you.

1) There are so many 2nd and 3rd generation SGADs that are coming up. More than 30 SGADs are now available in the market. Do you think that this is mainly due to competition by marketing agencies or largely due to evolution?

The 2nd generation SGADs are widely recommended and accepted for clinical use. The 1st generation SGADs have been superseded by the 2nd generation SGADs. However, no sound clinical reasons were brought to surface by a large audit project called the NAP4 (4th National Audit Project). NAP4 stated that the single most common cause of death during anaesthesia was regurgitation and aspiration during the use of 1st generation SGADs. Hence, NAP4 recommended the use of 2nd generation SGADs.

Professor Tim M Cook of Bristol/Bath medical school, UK was the first person to give us the definition of the first and second-generation SGAD. There is as such no clinically established definition of 'third generation SGAD' in literature. The first generation includes devices which allow the flow of air/anaesthetic gases from the machine to the patient. Second-generation SGADs have an additional feature of practical and clinical importance e.g. a gastric channel to warn and protect against regurgitation and aspiration.

Though some companies started marketing their SGADs as 'third generation', they have not been able to substantiate this advantage in any form or shape in clinical research .

2) We are keen to know about the new i-Gel Plus that has recently been launched by you and Intersurgical?

As per the results of the NAP4(the 4th National Audit Project that was carried out in 2008 & 9 by the Royal College of Anaesthetists and Difficult Airway Society, UK), that were published in March 2011 (<https://www.rcoa.ac.uk/nap4-major-complications-airway-management-united-kingdom>), 2nd generation SGADs were recommended to be used over the 1st generation. NAP4 also further defined that the 2nd generation SGADs should have following 4 features:

- Improved pharyngeal seal enabling controlled ventilation at higher airway pressures (and hence in a wider range of patients and clinical situations)
 - Increased oesophageal seal, which lessens the likelihood of regurgitant fluids entering the pharynx and leading to aspiration.
 - A drain tube which lies over the top of the oesophagus when the SGAD is correctly positioned. This may be used to assist insertion, confirm correct device positioning, enable access to the stomach, alert the user to the presence of regurgitation and enable gastric contents to safely bypass the oropharynx and exit the patient
 - Integral bite block.
- Interestingly enough, my earlier innovation i-Gel has been described to have five different unique features - Improved pharyngeal & oesophageal seal, pharyngeal stabiliser, gastric channel, ease of use and conduit for intubation. It offers an average airway seal pressure of 27cmH₂O and now i-gel Plus can offer an average seal pressure of 33cm H₂O.

i-Gel Plus is a new device introduced by Intersurgical in September 2022 during the Difficult Airway Society (DAS) meet in Newcastle and is available in the market at

present. It has three additional features – improved seal of about 33 to 35cm H₂O, a ramp to assist in intubation and a wider gastric channel. There is an ongoing multicentric trial across four countries along with UK, Scandinavia, Poland, Prague and Switzerland with about 10,000 cases. Professor Pavel Pafka Michalek from Prague has already presented the interim findings at the Turkish Anaesthesiology Conference at Istanbul in October 2022. i-Gel Plus is showing very promising results, even better than our current i-Gel. With further additional integrated clinically important features, should we be calling it a 3rd or even 4th generation SGAD? Further studies in its clinical use will define it.

3. What is your take on the conversion of endotracheal intubation to i-Gel use, especially during laparoscopic abdominal surgery?

Owing to i-Gel's safe and high seal pressure, it is now very widely used during laparoscopic abdominal procedures, thus reducing the historically high use of endotracheal intubation in such procedures under general anaesthesia.

4. Do you feel it is advisable to use the i-Gel during prehospital resuscitation and military combat situations for intubation?

In case of a precarious emergency situation arising in the ambulance, on the road or in any area of the hospital such as the ward, outpatient department and emergency department, where you do not have immediate access to a fiberoptic bronchoscope, SGAD can play a pivotal role in securing the airway. However, suppose you are considering shifting this patient for a magnetic resonance imaging (MRI) /

computed tomography(CT) scan and you want to be really sure of the airway (as you fear dislodgement or for want of a definitive airway to prevent regurgitation), you can certainly go ahead and intubate through an i-Gel. A cuffed endotracheal tube (CETT) can gently be placed into the patient's trachea and the i-Gel can be removed by placing a Cook's catheter or a bougie and a CETT can be railroaded over it. It is highly recommended that the placement of the CETT through i-Gel must be achieved under vision by using a fibre-optic flexible scope but in the absence of one, careful and gentle placement of the CETT can also be achieved through the i-Gel blindly by preferably using a flexible tube or Parker's tube (with the tip bent). Utmost care has to be taken to avoid any sort of injury.

We have been using i-Gel for blind intubation, as a conduit for intubation and also in prehospital settings or wards as a rescue measure in the absence of a fibreoptic bronchoscope with a good amount of success. Now, i-Gel Plus has a built-in intubation ramp, which aids in intubation with a success rate of 97%.

Even though the success rates of intubation with i-Gel plus are high, we do not still recommend you to use it in intraoperative settings or controlled conditions, and to use it only if warranted and when a fibreoptic bronchoscope is not available. With the medicolegal repercussions in place, due diligence needs to be taken to avoid any kind of trauma to the oropharyngeal and laryngeal structures during attempting blind intubation. Especially in developed countries, many devices like videolaryngoscope, fibreoptic bronchoscope are being used 'to see and insert' and prove in the court of law that adequate care was taken.

The original Tactical Combat Casualty Care (TCCC) guidelines were published in 1996 and an update in 2012 reaffirmed support for the use of SGADs for the Tactical Evacuation Care (TACEVAC) phase. However, a specific device was not recommended, as it was not felt that there was sufficient evidence at the time to do so. However, in the latest update, i-Gel has been now designated as the 'preferred SGAD' as it was decided that it had a number of characteristics that make it favourable for use on the battlefield

5. Since we are talking about the prehospital settings which is an emergency setting, what tilts the favour to insert a SGAD compared to intubation?

In such situations as we all know, when a patient becomes unconscious, the brain starts dying in a matter of a few seconds compared to the controlled environment of an operating room. The patient coming with a Cormack Lehane score of one in the operating room becomes score four if we encounter him/her in the emergency room, on the road or on the floor of a house. We have a maximum of three to four minutes to respond in these cases. Untrained personnel have to respond in seconds to get oxygen into the lungs of the patient. Which one would you choose between spending ten minutes struggling to pass an endotracheal tube versus easy and early insertion of an i-Gel SGAD within 3-5seconds? In such cases, the risk of regurgitation and aspiration leading to messed-up lungs produced by insertion of a SGAD is similar to the risk associated with an intubation attempt. If you look at various published studies for data of possible oesophageal intubation in emergency settings, the incidence is between

1.7-28%. Isn't treating a messed-up lung better than treating a messed-up brain!

I would also choose to salvage the patient by inserting an i-Gel SGAD, stabilise the patient and then based on the clinician's decision would consider intubation later when the patient's body has had ample stores of oxygen.

6. So according to you the first-time insertion success rate should be high in these scenarios while choosing an airway device whether a SGAD or an ETT?

Various studies have concluded the first-time insertion success rates to be 97-99% if the i-Gel is used correctly. Two or three of SGADs which have inflatable cuffs have good insertion rates. Streamlined liner of the pharynx airway(SLIPA) was another non-cuffed SGAD, but it never took off. Recent studies (REVIVE Airways and AIRWAYS 2) carried out in many thousands of patients showed that the performance of the i-Gel airway in many regards was better than other SGADs and was equally good if not better when compared with endotracheal intubation.

7. When we need to insert the i-Gel or any other SGAD, what do you feel is the best airway assessment predictor to decide on the size of the SGAD?

An excellent question. We did indeed try to find out what is that one predictor which tells us the size of the device for a given patient. We looked at various options like mouth opening, shape of the neck, width and length of the neck, body weight, size of thyroid cartilage and even neck collar size. However, according to our research team, none of these works as an individual predictor but a combination of these may work. We chose body weight only as the predictor because it

is a universal practice to check the body weight of the patient first in every discipline of medicine. However, weight is not the sole predictor to determine the size of the device. For example, if a gentleman who is presently 70kg needs size 4 i-Gel, what would be the size of the i-Gel to be inserted when his weight becomes 170kg? Anatomically that adult patient's bony/cartilaginous structures remain the same but the fat/muscle/submucosal fat mass around the neck and pharyngolaryngeal space increases. Hence, the clinician instead of going in for a larger size SGAD, might in fact go for a smaller size such as size 3.

The amount of infiltration of fat depends on the space around the glottis, larynx, and hypopharynx. Hence, a bigger weight patient will not always need a bigger device. A holistic approach to the patient such as assessment of shape of the face, mouth opening, length and width of the neck, height and weight of the patient would be needed to decide on the size of the i-Gel SGAD.

8. What about those cases where we are unable to measure the weight?

The size of i-Gel should be on guesswork in such cases. We anaesthesiologists are good at guessing the weight of the patient or even choosing the best SGAD which can suit a patient by experience.

9. What do you think is the most important feature in the design of a SGAD that can reduce the risk of aspiration? Is it the drain tube? The oropharyngeal seal pressure? The bulk of the SGAD that occupies the pharynx? The functional and optimal size of the gastric channel, the mechanism of providing high seal pressure along with the device's ability

to remain in-situ and not get displaced will reduce the chances of patient aspirating even if he/she regurgitates.

This brings to my mind how I brought about designing the i-Gel. In 1998-1999, the unique LMA was in the market and I used it regularly for my patients. Three of the patients who underwent surgery with a unique LMA had a horrible sore throat. One of those patients was a solicitor and had threatened to sue me. I had to apologise and counsel the patient during the postoperative period. On the way back home, I was thinking of the idea I had thought of during my anaesthesia training days in Karachi in 1987-88, when I was not aware of the presence of SGADs because of the lack of literature available in Pakistan those days. We were used to red rubber tubes or black masks for administering anaesthesia. One day, I told my professor that I have an idea. I asked him why I could not put a small nasal mask at the distal end of the tube, so that I do not have to hold the mask all the day long. But my thought that time was that it should be of a very soft material that should correctly fit the space around the larynx and fill it correct anatomically. He just ignored the idea then and asked me to go away and get back to work.

That was when I started thinking about this 'potential space' around the perilarynx similar to the epidural space. Imagine this to be similar to packing of the nostrils to prevent epistaxis which is essentially done to occupy and exert enough pressure to stop bleeding. However, I had two concerns to solve: soft material and filling the potential space. Unfortunately, the silicone was too expensive and there were no other medical-grade materials available that were soft enough to create such a device, so we needed

to look at alternatives and reinvent the material to make it softer than the tongue. The cuff of the i-Gel used nowadays is three times softer than our tongue, yet it retains its shape.

A balloon-like structure does not necessarily mean it should work. Balloon means an inflatable, compressible doughnut which compresses and displaces the structures around. It pushes the structures anteriorly and tends to close the glottis rather than providing an adequate seal. For example, when we insert an inflatable SGAD and it does not sit properly, our usual tendency is to consider putting some more millilitres of air that will improve the seal. However, it only further bulges the front of the neck forwards and does not improve the seal. In females and children, this doughnut shape of the inflatable device can even envelope around the glottis and squeeze it to make it into a slit shape causing partial obstruction. We end up hearing grunting sounds which sound like a laryngeal spasm. In fact, that is air leaking out from the slit opening.

The cuff of the i-Gel is a lump of soft material which is anatomically designed, based on studies conducted in more than 60 cadavers in Cambridge, UK and the United States in whom neck dissection, MRI, CT scan, mouldings, etc.. were carried out to perfect the shape of the device. The cuff of the i-Gel has a landscape structure that fills the anatomical space correctly and is not shaped like a doughnut.

10. What are the current major challenges with respect to the use of SGADs? Is the duration of surgery a deciding factor for

the choice of the airway device? - Endotracheal tube (ETT) /SGAD/SGAD of particular design?

Though many of the LMA companies have set a four-hour limit to the use of their LMAs and

all have followed that advice, there is no scientific reasoning behind it. As an example, if I sit on the ground, after half an hour, I will not be able to stand up. It is because of restricted blood supply to the muscles of my legs. Similarly, when we insert a doughnut-shaped device, it starts compressing and exsanguinating the capillaries that supply the blood to the mucosal structures within a matter of few seconds, hence, the four-hour limit does not hold any ground. The mean capillary pressure of the pharyngeal mucosa is around 24 cm H₂O and at the recommended infallibility of the LMAs, the pressure rises to over 100cm H₂O immediately and it may rise to 150-200 cm H₂O within half an hour if nitrous oxide is being used, as nitrous oxide dissipates through the cuff wall thus increasing the intra-cuff pressure.

'Four hours' has been mentioned as the limit with the i-Gel. But it really does not matter as it does not compress any structure. It only matches the structures within anatomically and correctly. The longest I have heard of i-Gel being used is seven to eight hours without any issue. However, I would suggest you to remove the i-Gel after every two hours of surgery for a few seconds and reinsert it to avoid compression if there was any.

None of our patients have a neutral head position during surgery, with the head usually turned to one side. Patients who have undergone four to five hours surgery like mastoid exploration, with any SGAD in place have developed mucosal compression due to

the SGAD being wedged on one side of the neck. So, the limitation of any device however soft it is, will be compression. We can avoid this effect by either keeping the head in neutral position or turn it occasionally to neutral position to avoid compression trauma.

11. So when you say the head should be in neutral position to avoid compression, is it to avoid the complication of sore throat?

Yes, a neutral head position will reduce the incidence of sore throat and more importantly will not cause compression and pressure symptoms like lingual nerve compression postoperatively. I feel that along with high pressure mucosal compression and exsanguination trauma, the insertion technique and lack of lubrication play a major role in the development of sore throat as well. With i-Gel, we always advise to lubricate the back, sides and the front of the cuff prior to insertion. With adequate lubrication and good insertion technique, you will find the incidence of sore throat being the least when compared with other SGADs.

12. What is your opinion about the use of SGADs in the prone position/ lateral position with the head alone turned to one side? Is it safe?

I will not use any SGAD in prone position other than i-Gel. I have personally used i-Gel many a times in the prone and lateral position. However, care has to be taken about securing the device properly. i-Gel should be secured by using an appropriate length and size of plaster/ sticky-tape by fixing it to maxilla to maxilla instead of mandible to mandible. And if the position is prone, the i-Gel must also be tied in as it may slip off due to sweat or secretions or the plaster may loosen up by

wetting. I know anaesthesiologists who have anaesthetised the patients in the prone position and then inserted the i-Gel. It goes in easily without any issue.

13. What is your advice with regards to use of the i-Gel for laparoscopic surgeries?

I have my best experiences with i-Gel for laparoscopy. I use only the pressure support mode of ventilation. Initially, I start with a pressure support of say 10-12 cm H₂O and after insufflation of intra-abdominal gas, when the tidal volume comes down, I increase the pressure support by 2cm H₂O at a time to reach to a desired tidal volume to be delivered that gives normocapnia. With the average seal pressure of 27cm H₂O and a gastric tube in place, i-Gel works well for all laparoscopic procedures. I know anaesthesiologists who use i-Gel in bariatric surgeries like laparoscopic banding as well as gynaecological laparoscopies too.

14. When we speak of SGADs for laparoscopy, everything depends on the pressure the surgeon uses and/or the condition of the patient like chronic obstructive pulmonary disease (COPD), the duration of surgery, repeated alteration of the position of the patient's head by the surgeon. What are your views on this?

We need to play according to how the surgeon plays. Based on the intraabdominal pressure used by the surgeon, we need to adjust the pressure support to achieve an adequate tidal volume. But the greatest advantage of using a SGAD is of not using a muscle relaxant or using the minimum doses. I have worked with a surgeon who does laparoscopic tubal ligation in 5-7 minutes and I have worked with surgeons who may take two hours. Most of the experienced surgeons are pretty quick so the

anaesthetics and requirement of muscle relaxants can be gauged accordingly when using an i-Gel SGAD in such procedures.

15. Then there is this controversy of the use of SGADs in pregnant patients. No medical literature or metanalysis states that i-Gel is a superior device for pregnant patients compared to an ETT. Will you advise us to use it?

The dilemma of the possibility of a pregnant patient being full stomach starts with 3-4 months to full term gestation. The question is that when a patient comes in for appendectomy at say 5 months of gestation or for an elective/urgent/emergency caesarean section, whether to use an ETT or an i-Gel with rapid sequence induction? There is no clear answer as always in the absence of clinical data and evidence of the safety and efficacy profile of the use of i-Gel in such clinical scenarios. In the court of law, an ETT with rapid sequence intubation would be considered the right way. However, you need to play according to your expertise and the condition of the patient when using an i-Gel in such clinical times, gauging the need to deliver anaesthetics safely and NOT endangering the life and wellbeing of the patient.

Our recommendation for the use of i-Gel in routine/elective/urgent or even emergency section is a straight 'no' as there is no published data available in this domain. I had one gentleman enquire recently about this in the US ASA conference, where he asked 'why not to use i-gel during caesarean section?' It for a simple reason that there is no ethical committee which will allow me to do a study on a statistically significant sample of pregnant patients undergoing caesarean section with i-Gel. There is no way we can do

a study or no published data till date to support its use in pregnant patients. But he repeated his same question 3 times and my answer remained NO. He ultimately told me that he has done several hundred caesarean sections since last 4 years from elective to emergency with i-Gel. He said that he would pre-oxygenate the patient for 3min or to 3-5 vital capacity breaths, induce with propofol or thiopentone sodium, ask the assistant to apply cricoid pressure followed by suxamethonium, place the i-Gel in, give 3 ventilatory breaths manually, confirm the ETCO₂ waveform, secure the i-Gel, put the patient on the ventilator, insert a gastric tube through the gastric channel of the i-Gel, apply suction, decompress the stomach and then allow the cricoid pressure to come off. He never had any problem with any case. I requested that anaesthesiologist to publish his experience as a case series for the benefit of others, but I have not seen that come to the surface as yet.

16. So, do you feel that the obstetric airway and use of SGADs is a potential area for research?

Yes, any study even on a minimum of 30 standardised sample of obstetric patients with respect to use of the i-Gel can support and confirm our belief on its use. Once any published literature becomes available, we can take comfort from it that i-Gel can be safely used in obstetrics.

17. How to avoid misplaced and failed SGADs? i-Gel many a times gets displaced due to the dragging by the breathing circuit. How to avoid this?

The real problem is that many anaesthesiologists who are very well used to using an i-Gel routinely, do not secure it because once the i-Gel is in situ, it looks very

stable. It sits in so nicely that they do not secure it. And then, if a nurse or an operation room staff member trips over the breathing circuit, it can get misplaced. It being a supraglottic device and not an infraglottic device, it must be secured in place by taping it from maxilla to maxilla or tied in. As I said earlier, the plaster sticky tape needs to be brought from front of the device and secured maxilla to maxilla.

18. The epiglottis is a common culprit in a failed SGAD situation. Are any future modifications expected to come up in the design of the SGAD to prevent this?

Epiglottis downfolding has been a problem with many inflatable SGADs, especially when used with the bars in front like those in LMAs. There is an epiglottis rest in the i-Gel, that helps keep the epiglottis safe from downfolding. We have confirmed by using a fiberoptic bronchoscope that no epiglottis downfolding occurs with the i-Gel. But in some rare patients with a broad and large epiglottis, downfolding does occur with i-Gel. i-Gel has a soft and wide cuff bowl, so neither does it obstruct the airway nor does it cause any harm to the epiglottis even if downfolding occurs.

19. Do you propose to widen the gastric channel of the i-Gel?

The new i-Gel Plus has a wider gastric channel. We can now insert even a size 16-18F gastric tube through it.

20. Numerous studies have shown that blindly inserted SGADs are sub-optimally placed in 50 to 80% of all cases. Placement under direct vision has been recommended. Nowadays, videolaryngeal mask airway (Laryngeal mask with incorporated

videoscope at the flexible tip) has come up. Do you think these direct-vision SGADs will improve the first pass insertion success rate? Will all SGAD insertions in the future be under direct vision? Do you propose to design a video i-Gel?

These videolaryngeal mask airways are extremely expensive and the question arises as to how many as a manufacturer will you be able to sell and at what price? Disposable or Reusable? Price point to the end-user? My view is that it will be too expensive to manufacture such devices to sell at a right and affordable price to the end-user.

We had started that project about eight years ago but the cost benefit was not substantiated. We found it to be a pointless exercise to advance this project with embedded video fibres in it since the price will be too high and hence, nobody would want to buy it. You would only prefer to use such a device in a case where you plan to intubate the patient through it. To fulfil that purpose, there are plenty of flexible fibre-optic scopes available in the market.

21. Does i-Gel warm up after insertion and improve the seal?

No, it will not do that. This was much discussed after probably an editorial published in 2007. The i-Gel is made of SEBS (Styrene-Ethylene / Butylene - Styrene), a thermoplastic elastomer that does not change its shape or softness in ambient and normal body temperature and does not change / warm up at body temperature.

This phenomenon will never be seen if the patient is paralysed. This phenomenon is only experienced by some clinicians where the patients are spontaneously breathing. During the initial few seconds to few minutes after induction of anaesthesia, the patient may not be relaxed enough or may not have reached

the level of surgical anaesthesia and may still have some higher tone in the laryngeal and perilaryngeal musculature. Hence, we see this phenomenon only in patients who are not adequately anaesthetised. Initially, there may be some leak due to the time taken for the anaesthesia to set in. Once the depth of anaesthesia is adequate, the i-Gel fits in correctly and will work perfectly fine.

22. What is your advice to the newer generation of anaesthesiologists: The 'Yuva anaesthesiologists'

My advice to the 'Yuva anaesthesiologists'

i. Always think and work like an anaesthesiologist and not like a mechanical operator or technician. We often work mechanically and we need to correct that. One should work as a scientist, a pharmacologist and a physiologist when handling a patient before altering the patient's state of alertness to unconsciousness. One MUST be fully prepared to return that state of alertness from unconscious as an endowment and with total control/conviction/drive and devotion that the patient had entrusted you for.

ii. Think that the patient on the table is your mother, sister, husband or child. Always decide your course of action accordingly with righteous sentiments of passion, care, sympathy, respect and heartfelt kindness.

iii. 'Never allow an idea to die down in imagination.' We are never taught about entrepreneurship during our medical career.

iv. I suggest all medical schools/universities should have a teaching & training module, even if it is only a 'once a week' module where we bring in the inventors, innovators, marketing guys, legal teams, patent

attorney, trade markers and marketing teams either physically or online for the final year students, where we can speak and encourage them to innovate. Most of the ideas among many doctors and allied sciences die in the imagination phase. They have an idea but do not know where to go or how to protect their intellectual property. I would be glad to create inventors and innovators in the future. That will be my personal legacy.

23. What do you think are the areas that need to be researched upon in the field of SGADs?

Even though many people say I am a 'Guru of SGADs' or I am an expert in airway management, I feel I know only 10% of it. I feel this space needs to be researched a lot especially with the invent of ultrasound or computer tomography where we can separate the soft tissue from the hard structures. We can outline the airway very well. At present, we have been developing v-Gels which are SGADs available for different animals. We call them species-specific SGADs. I feel we can start designing patient-specific i-Gels. This is warranted considering people from different countries of the same weight require different size of i-Gel due to different body habitus. In the future, we may see the ultrasonography or CT/MRI data being transferred into a computer or an artificial intelligence (AI) enhanced machine next door, that prepares an i-Gel for the given patient.

24. When you say patient-specific i-Gel, developing countries have different challenges especially with the use of LMAs which are expensive; so do you propose having different sizes of i-Gel like 4.1, 4.2, 4.3?

I do not think that is needed. When it comes to i-Gel, it is very forgiving. A study was done by

Professor David Gabbott and colleagues in 2007-8 in the UK where they chose to use i-Gel size 4 for all patients irrespective of their weight coming into the operating room. They used same size of i-Gel for patients weighing 45kg to 110kg and the success rate was 98%. However, in paediatrics, we definitely do need various sizes.

Thank you once again for this interview for VAPOUR!

It was indeed my pleasure. Thank you for inviting me.

ABOUT THE EXPERT

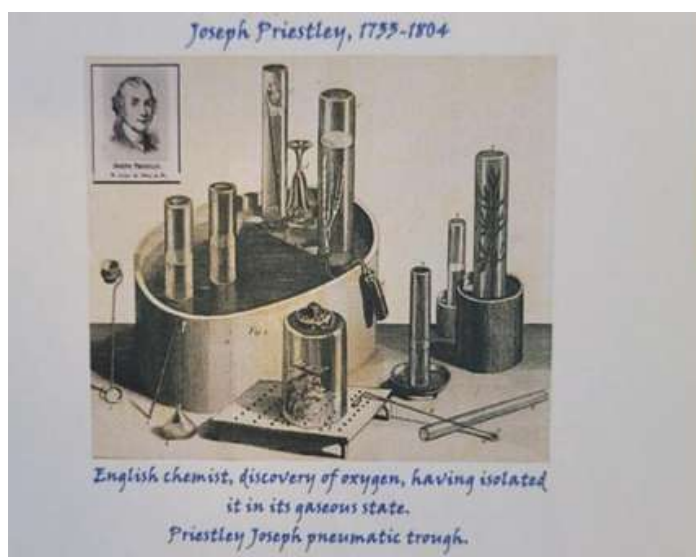
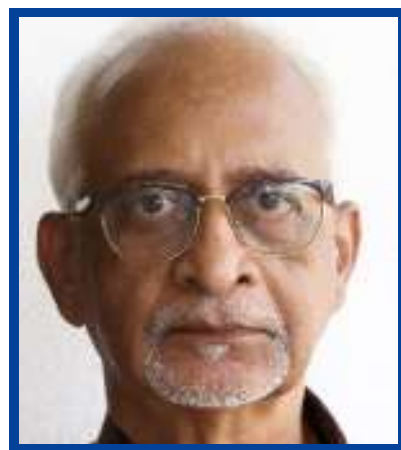


DR. MUHAMMED ASLAM NASIR

- Inventor and Consultant Anaesthesiologist on R&D of i-Gel (www.i-gel.com) & v-gel
- President, DocsInnovent, United Kingdom
- Managing Director, Talria Limited DMCC, Dubai

ARCHIVES OF 'A THEMATIC PHILATELIST & ANAESTHESIOLOGIST'

Dr. Chandrasekhar Krishnamurti,
Retired Professor in Anaesthesiology, NRIIMS, Visakhapatnam
ISA No. S0468



JOSEPH PRIESTLY

Priestley was an English chemist who focused the sun's rays on a sample of mercuric oxide in a bell jar containing mice. They survived for much longer than with common air. He then inhaled the gas himself, writing that it was "five or six times better than common air for the purpose of respiration, inflammation, and, I believe, every other use of common atmospherical air".

He had discovered oxygen in 1774, but called it dephlogisticated air having isolated it in 1774. He also discovered "nitrous air" (nitric oxide, NO); "vapor of spirit of salt", later called "acid air" or "marine acid air" (anhydrous hydrochloric acid, HCl); "alkaline air" (ammonia, NH₃); "diminished" or "dephlogisticated nitrous air" (nitrous oxide, N₂O) and vitriolic acid air (sulphur dioxide).

He also demonstrated that plants revitalised enclosed volumes of air, a discovery that would eventually lead to the discovery of photosynthesis.

References

1. Fruton JS. Methods and Styles in the Development of Chemistry. Philadelphia: American Philosophical Society, 2002.

WORKPLACE COMFORT

Dr. Vidya Mohanram G

Fortis Malar Hospital, Chennai

ISA No. G0333

An average person spends one third of the life working. For anaesthesiologists, the proportion is probably much higher. Workplace comfort therefore deserves to be given a high priority. In this article, I will be discussing some simple ways in which each of us can make our workplace a little more comfortable.

Managing our workload and schedule is extremely important to enjoy and be comfortable at work. When we are organised, we can be proactive, motivated, do our work with more confidence and derive satisfaction from a job well done. In contrast, an overwhelming chaotic workload may bring in more money, but is likely to increase the chances of errors, take a toll on our health and eventually leave us dissatisfied.

In this era of social media and constant communication, the lines between work and personal life are almost erased. To focus and be productive at work, we need to learn to compartmentalise our personal and professional lives. We need to put in adequate support systems in place, so that we can leave our personal worries at home and concentrate and be happy at work.

Commuting is an essential part of our work day. Having to travel long distances in heavy traffic can make us arrive stressed and tired at work. It is worthwhile working closer to home, even if the job pays a little less. Other



options are moving closer to work or hiring a driver even if it costs more money. Taking time off periodically, say one day a week and may be two weeks a year is very important to reduce the monotony of work. These breaks help rejuvenate us and make us enjoy our work more.

We anaesthesiologists, stand or sometimes sit for prolonged periods in the operating room. Comfortable scrubs, footwear, caps and masks are therefore essential. Adding personal touches to our attire makes us feel special and helps reflect our personality. Walking around, observing the surgery, interacting with the operating room staff and helping with some of the chores is better for our health than standing or sitting and also helps to build rapport, improve patient safety and raise our profile.

We are all used to the endless cups of tea and coffee along with the samosas during our day's work. Replacing some of the cups of tea and coffee with water, and the snacks with fruits, salads and nuts could make a big difference to our energy, attitude and health. Rather than eating meals at odd hours or skipping them altogether, we should make it a practice to relieve each other so that we can all eat reasonably on time. However, there is something to be said about sitting together after the list is over and sharing and enjoying food with co-workers.

When we join a new organisation, we need to find coworkers who share our values and interests. We should look beyond the customary circle of fellow anaesthesiologists and surgeons. We could find like-minded people among doctors from non-surgical specialities, nurses, technicians or even administrative personnel with whom we could create a support system. These people are great to hang out with and share our feelings and concerns. Having people around who listen and understand in a non-judgemental way goes a long way in reducing stress at work and increases happiness.

A simple way of making the workplace happy is acknowledging people, especially junior and non-medical staff. Being generous with compliments for jobs well done is a great way to raise morale. Team outings give an opportunity for people to get to know each other and improve camaraderie. When mistakes are made, constructive feedback should be given in private instead of criticising the person openly. Except for unsafe practices and gross violations of protocols, it is not worth trying to change our co-workers. When confronted with an annoying co-worker or a micro-managing boss, we need to learn to look at the facts beyond the behaviour and not let their actions affect us personally.

We enjoy our work more when we feel valued at our workplace. Conducting CME programmes, training medical and paramedical staff, taking the lead in Quality and Safety initiatives and being a member of various hospital committees are great ways to earn the respect and appreciation of co-workers and the Hospital Management. Participating in cultural programmes and marketing initiatives can help us stand out and be recognised.

A very important point for workplace comfort is zero tolerance for any form of

abuse. We should neither indulge in nor tolerate any form of abuse- be it verbal, physical or sexual. As far as possible, we should avoid uncomfortable situations and resolve conflicts amicably. A robust system should be put in place that deters potential abusers and makes victims feel comfortable to report abuse.

Two important things that can make life easy at work are, "Asking for Help" and "Saying NO". We assume that asking for help makes us look incompetent or not confident. Nothing could be further from the truth. Getting timely help reduces our stress and improves patient safety. Giving and taking help improves team bonding and makes the workspace more comfortable. We often do not say NO to requests even when we really do not have the time or energy or have medical or ethical concerns. We are worried about offending the person asking for a favour or appearing to be difficult. When we have a valid reason for refusing, we should put our points across politely and say NO without feeling guilty.

Lastly, we should learn to focus on the positives at our workplace. Not every day will be a great day at work and obsessing over the negatives will only lead to burnout. We should look for the things that bring us joy at work- it could be a brand-new work station, a block that worked well, an appreciative patient, a caring colleague, a tasty snack in the cafeteria or a great view from the top floor.

Here is wishing you all a happy day at work!

ISA NATIONAL SPONSORED CMEs & WORKSHOPS

NATIONAL CME AT BOKARO (7TH MAY 2023)



CME AT BAREILLY (13TH - 14TH MAY 2023)



CME AT PRAYAGRAJ (18TH JUNE 2023)





WORLD ENVIRONMENT DAY CELEBRATIONS

ISA National announced the celebration of the 'World Environment Day' on 5th June 2023. The Programme Heads Dr. Manoj Kumar, Dr. Rekha Das and Dr. Manisha Katikar appealed to all the ISA members and the ISA state and the city branch office bearers to plant a tree in their vicinity or at home.

Participation was seen all through the country with a lot of zeal and zest. Pictures and videos were received and the results of the best slogan will be announced soon with the help of the ISA cultural group. Best slogan of the event will be adopted by the ISA National and the videos will be played during any zonal, state or city academic event all through the year.

This event supported the "Go Green and Clean Air" initiative of the Government of India.

It was a way forward towards green anaesthesia and a green lifestyle.....

WORLD MUSIC DAY

21st June is celebrated as the ' WORLD MUSIC DAY ' and to mark this very special day, ISA Cultural Club released a video of Indian folk songs sung by our ISA members.

Music is an expression of our emotions. It not only has an entertainment value but also has a calming effect and can reduce stress and anxiety. This video was created keeping the stressful lives of anaesthesiologists in mind and the songs in it are a treat to listen to.

It was launched by Dr. Manoj Kumar, Dr. Rekha Das and Dr. Manisha Katikar who are heading the ISA Cultural Club. The purpose of the video was to acknowledge and appreciate the talent of our members and to promote happiness and bonding in the ISA family.

Dr. Sailaja Ganti, Dr. Sudheesh Kannan, Dr. Murali Warriar, Dr. Archana Deshpande, Dr. Meenal Chauhan, Dr. Girish Mallar, Dr. Payal Berawala, Dr. Shruti, Dr. Sri Vidhya and Dr. Chetana Agarwal made their contribution to this melodious music compilation sung in various languages.



100th ISA NATIONAL PG ONLINE CLASS CELEBRATIONS

On 26th June 2023, the Indian Society of Anaesthesiologists (ISA) National celebrated the 100th class of PG online class series with great enthusiasm. This was an academic milestone in the history of ISA.

On this occasion, an online webinar was organised. Dr. Sukhminder Bajwa, Hon. Secretary ISA National delivered an inspiring talk on 'Vision of ISA Academics: Shaping the academic attitude of young anaesthesiologists'. The session was chaired by Dr. Venkatagiri K, Prof. J.V. Divatia and Prof. Naveen Malhotra. On this occasion, a video was presented which showed the journey of the PG online classes. The coordinators shared their experiences and expressed how these classes have helped them in their professional growth. Several postgraduate students and faculty gave their feedbacks. They said that entering the Zoom meeting room on Monday evenings had now become a routine for them & that they also viewed the topics again whenever they had the time or had doubts and before facing exams. These classes now have a live viewership of more than 500. Till date, YouTube views have touched an impressive 2 lakhs.



Celebrations by ISA National on the 100th PG online class.

Zoom Link : <https://us02web.zoom.us/j/84935475122?pwd=emNQNRgrSFNscmlvZlB1cE1COEkUT09>
Id: 260 347 9911 | Password: ISANHQ

26th June 2023, Monday, 6:30 to 7:30 pm

TIME	EVENT	FACULTY/SPEAKER
6.30 - 6.32pm	Welcome speech	Dr Sukhminder Bajwa Hon. Secretary ISA National
6.32-6.34 pm	Address by Chief Guest	Dr. MV Bhimeshwar President, ISA National
6.34-6.36pm	Address by Guest of Honour	Dr Mahesh Sinha Vice president, ISA National
6.36-6.38pm	Address by Chairman Academic Committee ISA National	Dr Venkatagiri K
6.38-6.40pm	Address by President Elect ISA National	Dr JV Divatia
6.40-6.42pm	Address by Immed. Past Secretary ISA National	Dr Naveen Malhotra
6.42-6.45pm	Video show: The teaching faculty of India & their journey through 99 PG online classes	Dr Madhuri Kurdi & Dr Nishant Sahay
6.45-6.47pm	Introduction of chairpersons	
6.47-7.15pm	Talk on 'Vision of ISA Academics: Shaping the academic attitude of young anaesthesiologists'	Dr Sukhminder Bajwa Hon. Secretary ISA National
7.15 -7.28pm	Feedback, Suggestions, discussion on PG classes	All faculty, students
7.28-7.30pm	Vote of Thanks	Dr Manoj Kumar Hon. Treasurer ISA National

HONORARY SECRETARY ISA NATIONAL
ISA NATIONAL HEAD QUARTERS
 27-A, Rattan Nagar, Tripura/Patella- 147004, Punjab, India.
 Email: isanhq@gmail.com / Secretaryisanhq@gmail.com
 Mob: +91 9801252237 / +91 9910252438
 Website: www.isanetb.in

100 ISA ONLINE PG CLASSES



Dr. M.V. BHIMESHWAR
 Dr. MURALIDHAR JOSHI
 Dr. VENKATAGIRI K
 Dr. NAVEEN MALHOTRA
 Dr. SUKMINDER J.S. BAJWA

THE CO-ORDINATORS



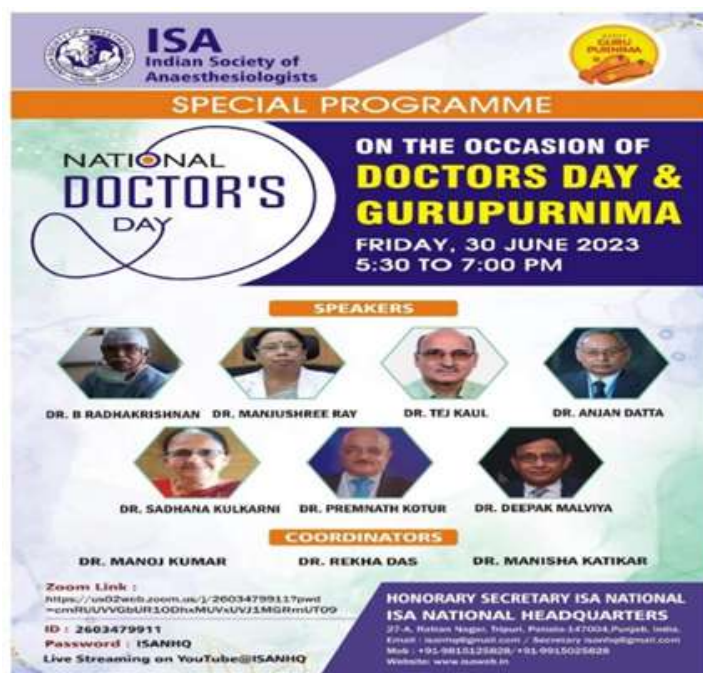
MADHURI KURDI NISHANT SAHAY PARUL JINDAL ANKUR KHANDLWAL JYOTSANA JAIN MONICA CHHIKARA RIDHIMA SHARMA



Celebration of 100th Online PG Class
www.youtube.com

'DOCTORS DAY' & 'GURUPURNIMA' CELEBRATIONS

ISA National celebrated 'DOCTORS DAY' & 'GURUPURNIMA' online on 30th June 2023 between 5.30 to 7.30pm. Senior teachers of ISA viz-Dr Tej Kaul, Dr Deepak Malviya, Dr Premnath Kotur, Dr Manjushree Ray, Dr B Radhakrishnan, Dr Anjan Datta & Dr. Sadhana Kulkarni spoke on the occasion. The coordinators for the event were Dr Manoj Kumar, Dr Rekha Das & Dr Manisha Katikar.



Yuva Parnika (Youth Zone)



SOLUTIONS TO CROSSWORD

ON USG (Page 36 May 2023 issue of VAPOUR)

DOWN

1. Property of sound waves acts like the principle of ultrasound: Reflection and(10)

REFRACTION

2. A full bladder required for an abdominal ultrasound is to have a goodwindow (8)

ACOUSTIC

3. A piezoelectric crystal is used to convert..... waves into ultrasound waves (8)

PRESSURE

4. Potential side effects of interscalene blocks (10) **HOARSENESS**

5. With ultrasonography, all the following structures for upper extremity blocks are hypoechoic: Inferior trunk, Phrenic nerve and C7 root EXCEPTcord (6) **MEDIAL**

6. The erector spinae comprises of group of muscles including longissimus, spinalis and (12) **ILIOCOSTALIS**

7. One of the nerves blocked during TAP Block is (15) **ILIOHYPOGASTRIC**

8. On sonoanatomy, a bilateral sacral cornua reveals aeye sign (4) **FROG**

ACROSS

9. Medical imaging modality other than ultrasound that does not use any form of radiation (3) **MRI**

10. Ultrasound can be taken of this area for an infant but not for an adult (7) **CRANIUM**

11. Red dot on the probe helps to detect probe.....(11) **ORIENTATION**

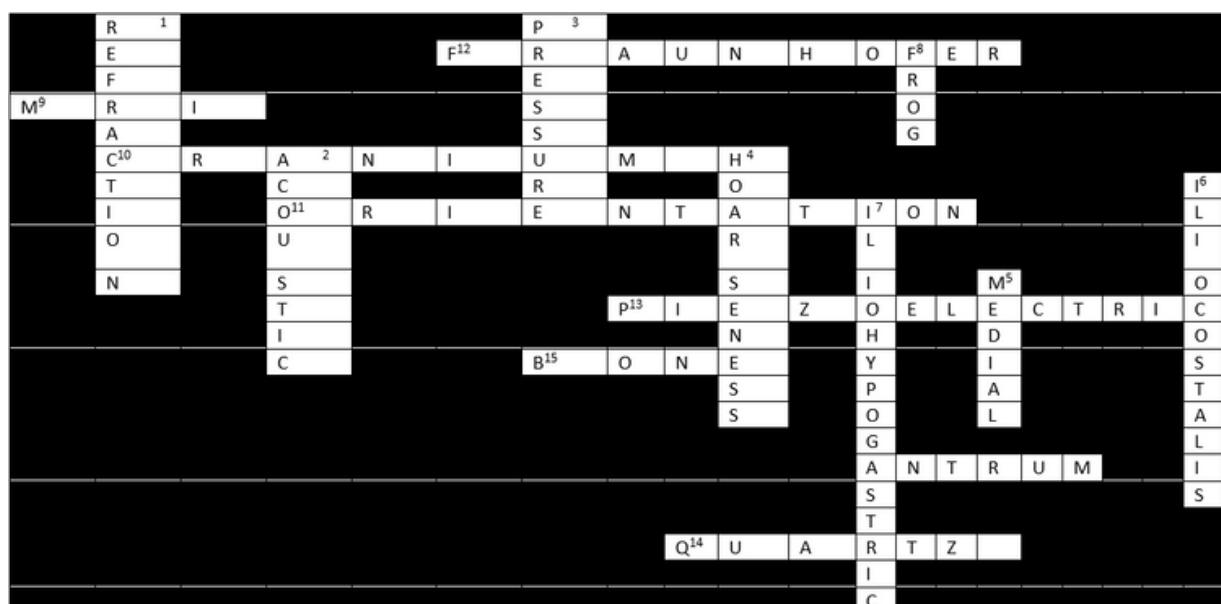
12. Far field is thezone (10) **FRAUNHOFER**

13. The fundamental operating principle of medical ultrasound transducers is (13) **PIEZOELECTRIC**

14. Piezoelectric crystal may be made of (6) **QUARTZ**

15. In which of the following materials is the speed of ultrasound greatest ? (4) **BONE**

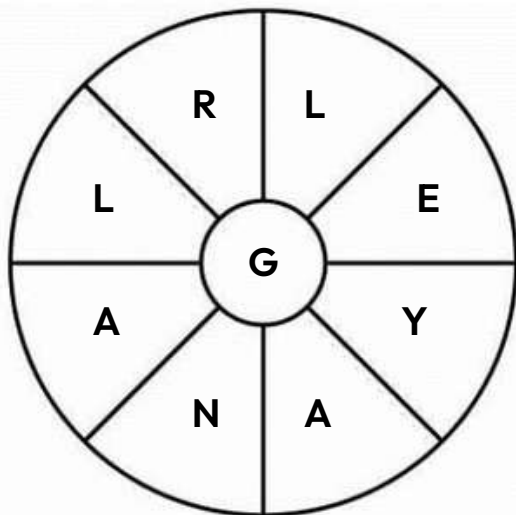
16. Sonographic presentation of emptyis flat , collapsed or round bull's eye (6) **ANTRUM**



SPIN THE WORD WHEEL

Dr. Parul Jindal

Professor, Department of Anaesthesiology, HIMS, SRHU, Dehradun
ISA No. P1190



The centre letter has to be used in all the words.
Only 6 to 9 letters words are acceptable

INTERPRETATION

>25 words: Conscious oriented
18-25: Emergence delirium
12-18: BIS is 40
<12: Need a caffeine shot

WCA



18th World Congress
of Anaesthesiologists
3 - 7 March 2024 SINGAPORE

Together We Can



WFSA
WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS



Save
The
Date

3 - 7 March 2024

18th World Congress
of Anaesthesiologists

Call for Abstracts opens in **May 2023!**



Be updated
Join the mailing list
Scan QR Code

www.wca2024.org

CROSSWORD

SUPRAGLOTTIC AIRWAY DEVICES (SGADs)

Dr. Parul Jindal

Professor, Department of Anaesthesiology, HIMs, SRHU, Dehradun
ISA No. P1190

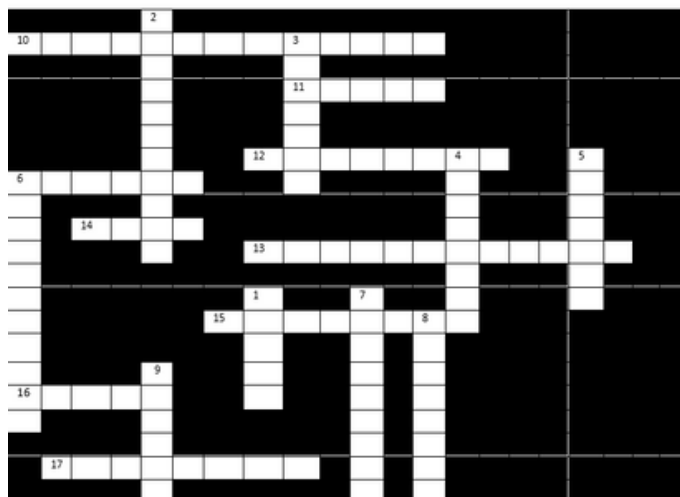


DOWN

1. _____, a Canadian anaesthesiologist, devised the Pharyngeal Bulb Gasway in 1935. (5)
2. Innovation of LMA Unique came at a critical time with rising clinician concern over the transmission of life-threatening prion protein diseases, such as _____ disease. (11)
3. Sir Archie Brain based his supraglottic airway on the _____ dental mask. (7)
4. _____ bars were present in the original classic LMA to prevent the epiglottic infolding. (8)
5. Ambu AuraGain was manufactured in _____. (7)
6. Soft Parker pen tip endotracheal tube is used to intubate with _____ type of LMA. (11)
7. Ambu AuraGain was previously made of _____-free material. (9)
8. Gastro LMA was devised by _____. (7)
9. Combitube is available in various sizes, measured in _____ units. (6)

ACROSS

6. The placement of a LMA following endotracheal extubation during emergence is called _____ manoeuvre. (6)
10. i-Gel was launched by _____ Company. (13)
11. Full form of SLIPA is Streamlined _____ of the Pharynx Airway. (5)
12. Inventor of i-Gel is from which country? (8)
13. Other name for 'Brimacombe bounce' is _____. (12)



14. Mnemonic used for risk factors for difficult "rescue" with supraglottic device is _____. (4)
15. 'Chandy manoeuvre' is a manoeuvre that is crucial in maximising the chances of successful intubation via the ILMA and was first described by Chandy _____. (8)
16. _____ Laryngeal airway is an earlier device which had an elongated tube approximately 34 cm long, made of plastic. (5)
17. For LMA C Trach, the _____ concept of LCD is used for best visualisation. (8)

PRIZE WINNING ESSAYS

of **VAPOUR ESSAY COMPETITION** (JUNE 2023)

Category A: Postgraduates in Anaesthesia

Category B: Senior Residents & Consultants (in Anaesthesia) less than 40 years age

Our Esteemed Judges



Dr. Chandrasekhar Krishnamurti,
Retired Professor in Anaesthesiology, NRIIMS,
Visakhapatnam



Dr. Arunangshu Chakraborty
Senior Consultant, Anaesthesia, Critical Care
and Pain, Tata Medical Centre, Kolkata

Congratulations

CATEGORY A

FIRST PRIZE



Dr. Ananya Mishra
MD Anaesthesia Resident, Raipur Institute of
Medical Sciences, Raipur, Chattisgarh

SECOND PRIZE



Dr. Ankita Saini
DNB Resident (Primary) in Anaesthesiology, Max
Super Speciality Hospital, Shalimar Bagh, Delhi
ISA No: A5124/A

THIRD PRIZE



Dr. Palak Sharma
Third Year Resident, Department of Anaesthesia,
Gandhi Medical College, Bhopal, Madhya Pradesh
ISA No: P3691/A

CATEGORY B

FIRST PRIZE



Dr. Suchetana
Senior Resident in Anaesthesia, Bangalore Medical
College, Bengaluru, ISA No: S6328/A

SECOND PRIZE



Dr. Priyanka Pavithran
Consultant Anaesthesiologist,
Aster MIMS, Calicut
ISA No: P1973

THIRD PRIZE



Dr. Bhavna Gupta
Assistant Professor, Department of Anaesthesia
AIIMS Rishikesh
ISA No: B1501

My Favourite Supraglottic Airway Device

Dr. Ananya Mishra

MD Anaesthesia Resident, Raipur Institute of
Medical Sciences, Raipur, Chattisgarh



Introduction:

Airway management is a critical aspect of anaesthesia and emergency medicine, aiming to ensure adequate oxygenation and ventilation during various surgical procedures. The laryngeal mask airway (LMA) has revolutionised airway management since its introduction, and the LMA Protector represents a significant advancement in this field. This essay explores the LMA Protector's features, benefits, and clinical applications, highlighting its importance in modern medical practice.

Overview of the LMA Protector:

The LMA Protector is an innovative supraglottic airway device designed to secure and maintain a patent airway during routine and challenging airway situations. It builds upon the success of its predecessors, incorporating enhanced features to optimise airway management. Developed by Teleflex, the LMA Protector exemplifies the evolution of LMA technology, providing improved patient safety and procedural efficiency.

Features and Design:

Cuff Technology: The LMA Protector incorporates an anatomically shaped, inflatable cuff made of medical-grade silicone. This cuff adapts to the patient's

airway anatomy, minimising leakage and optimising seal pressure. The elliptical shape of the cuff facilitates easy insertion and proper placement, reducing the risk of complications.

Integrated Drain Tube: The LMA Protector features a built-in drain tube, allowing the passage of fluids and gases from the patient's oropharynx to a collection bag. This feature prevents the pooling of secretions or regurgitated material, minimising the risk of aspiration and enhancing patient safety.

Bite Protection Shield: The device includes a bite protection shield, reducing the risk of tube occlusion due to patient biting. This feature enhances the durability and longevity of the LMA Protector during lengthy procedures.

Integrated Pilot Tube: The LMA Protector integrates a pilot tube for cuff inflation, making it easier for healthcare providers to monitor cuff pressure during ventilation. Maintaining optimal cuff pressure is crucial for minimising complications such as sore throat, hoarseness or nerve injury.

Benefits and Clinical Applications:

-Ease of Insertion: The LMA Protector's ergonomic design and elliptical cuff shape allow for easier and faster insertion, improving overall procedural efficiency. This feature is especially valuable in emergencies where prompt airway management is crucial.

-Enhanced Seal and Ventilation: The anatomically shaped cuff of the LMA Protector provides a superior seal, minimising the risk of airway leakage and optimising ventilation. The device's cuff design also reduces the likelihood of postoperative complications, such as sore throat or laryngeal oedema.

-Versatility: The LMA Protector is suitable for a wide range of clinical applications, including general anaesthesia, procedural sedation, and emergency airway management. Its versatility makes it a valuable tool in various healthcare settings, including operating rooms, emergency departments and outpatient clinics.

-Patient Comfort: The LMA Protector's integrated bite protection shield and soft cuff material enhance patient comfort during airway management. The reduced risk of tube occlusion and improved seal pressure contribute to a smoother, less intrusive experience for the patient.

Conclusion:

The LMA Protector represents a significant advancement in airway management, providing healthcare professionals with an improved supraglottic airway device. Its unique features, such as the anatomically shaped cuff, integrated drain tube, bite protection shield and pilot tube enhance patient safety, procedural efficiency, and overall airway management outcomes. As medical technology continues to evolve, innovations like the LMA Protector are vital in optimising patient care and improving clinical outcomes in anaesthesia and emergency medicine.

FIRST PRIZE

When A Supraglottic Device Saved My Day!

Dr. Suchetana

Senior Resident in Anaesthesia,
Bangalore Medical College, Bengaluru
ISA No: S6328/A



In the realm of medical emergencies, every second counts, especially when it comes to securing a patient's airway. The timely intervention of a supraglottic airway device (SGAD) has repeatedly proven to be a life-saving measure. By swiftly establishing a patent airway and ensuring adequate oxygenation, these devices have become indispensable in critical situations.

SGADs are medical instruments designed to establish an artificial airway without the need for direct visualisation of the vocal cords. They are inserted into the upper airway, sealing off the glottis facilitating effective oxygenation and ventilation. These devices typically consist of a tube, an inflatable cuff, and an opening to connect to a breathing circuit or bag-valve-mask system. During emergencies, time is of the essence, and quick and reliable airway management is crucial. These devices excel in this aspect, allowing healthcare providers to promptly establish a secure airway, particularly when tracheal intubation may not be feasible or practical.

The use of these devices offers several advantages in terms of patient safety. The seal created by the inflatable cuff helps to prevent aspiration of gastric contents, reducing the risk of pulmonary complications. Furthermore, these devices minimise the potential for trauma to delicate structures within the airway, decreasing the likelihood of complications associated with traditional intubation methods. Another notable advantage is their accessibility and ease of use. Unlike complex intubation procedures, the insertion of these devices can be rapidly taught to healthcare professionals across various levels of training.

This wider accessibility enables more healthcare providers to be proficient in their use, ultimately increasing the chances of timely intervention during critical situations.

When I was in my second year of residency, we had a patient with carcinoma of the glottis posted for direct laryngoscopy and biopsy. A thorough pre-anaesthetic checkup was done in which radiological imaging showed an infiltrative true vocal cord mass with extension to the supraglottis. In anticipation of a difficult airway, I had prepared the intubation cart and kept ready all the required instruments and drugs as per instructions of the anaesthesia faculty.

On the day of surgery, after confirming the nil per oral status and a quick review in the pre-operative holding room, the patient was wheeled into the theatre. Since it was a shared airway between the anaesthesiologist and the head and neck onco-surgeon, we preferred to establish a definitive airway with controlled ventilation. The patient was induced intravenously with a weight-based calculated dose of opioid and the induction agent, propofol was titrated to effect. Since we were able to mask ventilate the patient after giving propofol, we decided to give succinylcholine and intubate with an appropriate sized cuffed endotracheal tube. On direct laryngoscopy, I was unable to visualise the anatomy due to tumour distortion. Sensing the imminent difficulty, I alerted my faculty and in the hurry to remove the scope from the vallecula, the tip of the flange hit a part of the tumour which then started to bleed torrentially.

As a novice, I started to panic seeing the gush of blood from the oral cavity, but my professor maintained his cool and immediately suctioned the oral cavity while attempting to secure the airway. With limited time to spare and the patient's oxygen saturation rapidly declining, I handed over the I-gel which he skillfully inserted to form a secure seal, ensuring that the patient's airway remained patent and enabling the delivery of oxygen. The patient's saturation improved immediately with bag-and-I-gel ventilation. After the bleeder was localised and had effectively stopped, we attempted the second time to pass an endotracheal tube, this time with success. The surgical team successfully completed the biopsy, and the patient's condition gradually stabilised. In this instance, the prompt use of a SGAD in the operating theatre played a crucial role in saving the patient's life. By ensuring continuous oxygenation in the midst of an emergent airway obstruction, the device provided a temporary but essential solution that allowed us to address the complication effectively.

Difficult airway guidelines recommend considering the use of a SGAD in various situations, such as when intubation is unsuccessful, or when there is an anticipated difficult intubation. In specific circumstances, a SGAD may be utilised as a primary airway device, especially in situations where intubation is contraindicated or not feasible. This could include cases of facial trauma, limited mouth opening, or anatomical abnormalities that make traditional intubation challenging. However, it is important to note that the specific recommendations and protocols for the use of a SGAD in difficult airway management can vary depending on the guidelines followed by the medical institution or professional organisation. As the medical field continues to evolve, SGADs will undoubtedly remain invaluable in critical situations, ensuring that patients receive the immediate and effective care that they need to survive and recover.

SECOND PRIZE

My Favourite Supraglottic Airway Device

Dr. Ankita Saini

DNB Resident (Primary) in Anaesthesiology, Max
Super Speciality Hospital, Shalimar Bagh, Delhi
ISA No: A5124/A



Introduction:

The I-Gel (Intersurgical Ltd), an exceptional supraglottic airway device (SAD), has transformed the field of airway management. With its groundbreaking features, reliable functionality and user-friendly design, the I-Gel stands out as a true hero in securing and maintaining a patent airway.

Love at First Insertion:

Upon my first encounter with the I-Gel, it was love at first insertion. This single-use, latex-free SAD boasts of a unique design that includes a soft, gel-like cuff and an anatomically shaped airway tube. This tailored construction ensures effective ventilation while securely positioning the device within the pharynx.

Seamless Seal, No Drama:

The I-Gel's ability to create a flawless seal with the airway eliminates the struggle of achieving an airtight fit or dealing with leaks. Its non-inflatable cuff, made of a thermoplastic elastomer gel material, adapts to the patient's anatomical contours, providing a secure and effective seal while minimising the risk of pressure-related complications.

User-Friendly Wonder:

The I-Gel's user-friendly design makes it a breath of fresh air in airway management. It finds extensive application in various clinical scenarios, including general anaesthesia as an alternative to endotracheal intubation, allowing for controlled and spontaneous ventilation. It is also suitable for emergency airway management, rapid sequence induction, and cardiopulmonary resuscitation (CPR).

Anatomic Superstar:

The I-Gel's impeccable anatomical design sets it apart from other devices. It effortlessly adapts to the contours of the airway, ensuring a secure fit while minimising trauma to surrounding tissues. Its soft and flexible structure prioritises patient comfort. Compared to traditional airway management techniques, the I-Gel offers straightforward and rapid insertion, requiring minimal training and expertise. The integral bite block provides additional stability, preventing device displacement.

Versatility for the Win:

The I-Gel shines as a true champion in terms of versatility. Its wide range of sizes accommodates patients of all ages, from paediatrics to adults. Whether used in the operating room, emergency department, or pre-hospital settings, the I-Gel effortlessly adapts to any clinical scenario. Its ability to deliver reliable ventilation and facilitate procedures makes it a go-to device for airway management enthusiasts like myself during residency.

Limitations:

While the I-Gel offers numerous advantages, it is crucial to recognise its limitations. Patients with known hypersensitivity to the materials used or those with distorted oropharyngeal anatomy may not be suitable candidates for the device. Additionally, caution should be exercised in cases of regurgitation or a high risk of aspiration. Proper training and appropriate patient selection are vital for optimal outcomes, as with any airway management device.

Conclusion:

In a world where airway management plays a pivotal role in patient care, the I-Gel stands out as a beacon of excellence and reliability. Its seamless seal, user-friendly design, anatomical prowess, and remarkable versatility make it my undisputed favourite SAD. More than just a medical device, the I-Gel is a game changer that enhances patient outcomes while providing convenience and confidence to healthcare professionals. It has revolutionised airway management, offering a safe, efficient, and reliable alternative to traditional intubation methods. Ongoing research and technological advancements continue to enhance the capabilities of the I-Gel, promising a brighter future for airway management.

SECOND PRIZE

When A Supraglottic Device Saved My Day!

Dr. Priyanka Pavithran

Consultant Anaesthesiologist,
Aster MIMS, Calicut
ISA No: P1973



A thirty-year-old mentally challenged lady was posted for tracheal resection and anastomosis. She had developed tracheal stenosis following tracheostomy done for prolonged ventilation for the treatment of pneumonia. She had undergone bronchoscopic dilatation twice, but the tissue had regrown and she required surgery. Her imaging had showed a tracheal stenosis at the level of C7 with a luminal diameter of 5 mm. The pulmonologist who was treating her informed us that we would be able to pass a 5mm endotracheal tube and he was kept ready as back-up in case of any difficulty in intubation. The difficult airway cart was set with all necessary gadgets. We did not plan awake technique as she was not cooperative. After attaching the standard monitors, she was preoxygenated and was induced with propofol and fentanyl. As her mask ventilation was easy, we decided to intubate after giving atracurium. Laryngoscopy revealed a Cormack Lehane grade I. But we were not able to pass either a cuffed or an uncuffed 5mm size endotracheal tube. The stenotic area was very high up and there was no option of placing the tube above the obstruction and ventilating her. We quickly made a plan to place a size 4 I-gel which had a good seal even after positioning her in the extended neck position for surgery. We completed the surgery till the resection of the stenotic area with the I-gel and later placed a micro laryngeal surgery(MLS) tube under vision into the trachea so that the surgeons could anastomose the trachea around the Microlaryngeal Surgery tube. Retrospectively, we realised that the pulmonologist had miscalculated that we would be able to pass a 5mm endotracheal tube as her luminal diameter was 5 mm. Fortunately, the I-gel saved my day and we were able to complete the case uneventfully without any airway compromise.

This incident is only one of the several occasions when a supraglottic airway has acted as a rescue device in my experience. Very often we find situations where intubation is expected to be difficult, but a supraglottic device(SGD) could be placed very easily. SGD saves a lot of time, risk and effort required to secure the airway in patients with anticipated difficult intubation. The wide availability, ease of use and fast learning curves have made SGDs a popular choice for airway management.

THIRD PRIZE

My Favourite Supraglottic Airway Device

Dr. Palak Sharma

Third Year Resident, Department of Anaesthesia,
Gandhi Medical College, Bhopal, Madhya Pradesh
ISA No: P3691/A



In the most critical situations, supraglottic devices have revolutionised patient care. When the clock is ticking and the monitor sounds are diminishing, having the confidence to handle the situation easily with a reliable and handy instrument is the perfect description of how imperative these devices are in today's world. All the supraglottic devices have special features, merits, and a few demerits, but the one that caught my eye for emergency intubation and the last-minute hustle was "Elisha", a triple lumen 3rd generation supraglottic airway device. Despite the plethora of new devices, it has a combination of features that aid intubation and ventilation in optimum ways.

Its uniqueness consists of its ability to combine the triad of ventilation, intubation without interruption of ventilation, and gastric tube insertion and this is what one desires when the patient's clinical status is at stake.

Maintaining ventilation while preventing aspiration by deflating the stomach and simultaneously attempting to establish a definitive airway saves us time and maintains oxygenation until the goals are achieved. The Elisha airway device is made of latex-free medical-grade silicone. The ventilation and the intubating channels have a partitioned wall between them. However, they join at the ventilation outlet situated in front of the laryngeal inlet. The ventilation channel has a standard 15-mm connector located at the proximal end of the device. The intubating port allows passage of an 8.0-mm ID endotracheal tube (ET) for intubation which can be blind or fiberoptic-guided. The device is inserted blindly and has two high-volume, low-pressure balloons - a proximal balloon sealing the oropharynx and a distal balloon sealing the oesophagus.

Both balloons are inflated through a single pilot port with 50 mL of air, resulting in an intra balloon pressure of approximately 70 cm H₂O.

Supraglottic airways have a vital role to play during the induction of a patient who is otherwise properly optimised for an elective procedure. However, the clinician faces unexpected difficulties in maintaining a patent airway during laryngoscopy and intubation. This mandates proper and uncompromised operation theatre preparation considering every intubation as an unanticipated difficult one. It also requires ticking the checklist associated with a difficult airway cart. Nevertheless, some concerns with these devices remain, including failure to adequately ventilate, and causing airway damage. Careful patient selection and excellent technical skills are necessary for successful use. Deep knowledge of when not to use is equally important to avoid iatrogenic complications, especially in an emergency if a patient with restricted mouth opening, or distorted upper airway anatomy is encountered.

Preventing complications due to a supraglottic airway is just as important as saving patients in an emergency; the most common being aspiration followed by soft tissue oedema, trauma, and nerve trauma. However, with well-designed supraglottic airway devices such as the Elisha, the risk of aspiration is reduced and it also helps in positive pressure ventilation with minimal risks.

I have not yet used the device clinically and am not sure about its current availability in the market. However, such a wonderfully designed supraglottic device deserves a special place in the difficult airway trolley of all medical institutes in and outside operation theatres. Being a resident of the anaesthesiology department and encountering ELISHA in airway workshops, I still aspire to use it on my patients when in need and make it available at institutional levels.

I am very sure that researchers are still trying to make airway devices that are advanced yet easy to use.

THIRD PRIZE

When A Supraglottic Device Saved My Day!

Dr. Bhavna Gupta

Assistant Professor, Department of Anaesthesia,
AIIMS Rishikesh
ISA No. B1501



We anaesthesiologists often find ourselves in the majority of difficult airway management situations. The problem becomes even more complicated in challenging airway conditions characterised by reduced mouth opening. Supraglottic airway devices (SGDs), particularly my preferred I-gel, have proven to be "life savers" in such situations. Herein I share insights into managing one of those challenging and unique cases.

It was a cold winter morning, and we had a listed case of post-burn facial contracture, which we had reviewed the night before surgery. Our elderly lady had accidentally sustained massive burn injuries over her face and chest, a few years back, resulting in microstomia, characterised by limited mouth opening, just slightly more than the width of her finger. Furthermore, both her nostrils were halfway obliterated, and she had restricted neck movement, with fixed flexion deformity. Presently, she had been posted for a surgical procedure aimed at cutting and revising the contractures with the goal of enhancing her neck extension, restoring her neck extension and facilitating proper oral intake.

What were the available options for me?

As I thought about the situation, I realised that her limited mouth opening would be a considerable challenge during airway management. I recognised (with limited mouth opening) that the conventional intubation approach might not be possible. The patient's emotional journey deeply touched our hearts, and her apprehension towards the surgical procedure was completely understandable. After having endured suffering over the past years, marked by severe inhalational burns, a tracheostomy,

and extended stay in the intensive care unit, she now wished for no further scars over her neck. Witnessing her emotional struggle, we empathised with her and approached the situation with utmost sensitivity and care.

Awake fibreoptic intubation?

This realisation prompted me to explore alternative approaches, one of which was awake fibreoptic intubation. However, we encountered an issue with our damaged fibrescope, resulting in sub-optimal image quality. Additionally, intubation through the same method can pose challenges in cases involving deformed nostrils and distorted airway anatomy.

Tracheostomy?

In the hunt for an appropriate airway management strategy for a patient with limited mouth opening due to substantial pan-facial injuries and resultant contractures, I realised that the only option was to perform a tracheostomy. This invasive technique, on the other hand, would include making a surgical incision in the patient's neck to provide an alternate conduit for getting the case done; however, this would result in a visible scar on the patient's neck, adding another layer of emotional and physical stress to her recovery.

Supraglottic airway device

With this knowledge weighing heavily on my mind, I was even more determined to explore non-invasive options, ultimately leading me to the remarkable solution provided by I-gel, and I chose a size smaller than the conventional size that would fit the limited space in her mouth and at the same time would also ensure that her ventilation was adequate.

How we did it?

After careful consideration and discussion with the surgeon and patient regarding our plan of airway management, we made the necessary preparations for the challenging task that lay ahead in the operation theatre. Monitors were fitted to ensure vital signs monitoring. Recognising the importance of maintaining spontaneous ventilation, we attached nasal prongs and provided oxygen @ 2L/minute. We diligently prepared the patient for the procedure, using lidocaine nebulisation, mouth gargles, and carefully selected drugs (sedatives and analgesics-midazolam and ketamine) to optimise the conditions for successful SGD insertion.

The patient maintained spontaneous ventilation, mask ventilation was effectively managed, and I precisely positioned a smaller-than-expected I-gel SGD, size 2.0, to ensure a secure and comfortable fit.

The smaller-than-usual-sized SGD proved to be a great saviour when the surgery began. It delivered consistent ventilation throughout the procedure, allowing the surgical team to work with precision and care. We constantly monitored the patient's vitals and respiratory parameters as needed to optimise ventilation. With its secure insertion and dependable performance, the I-gel SGD enabled us to deliver anaesthetic gases securely and effectively, minimising the dangers associated with difficult airways.

Sigh of relief!

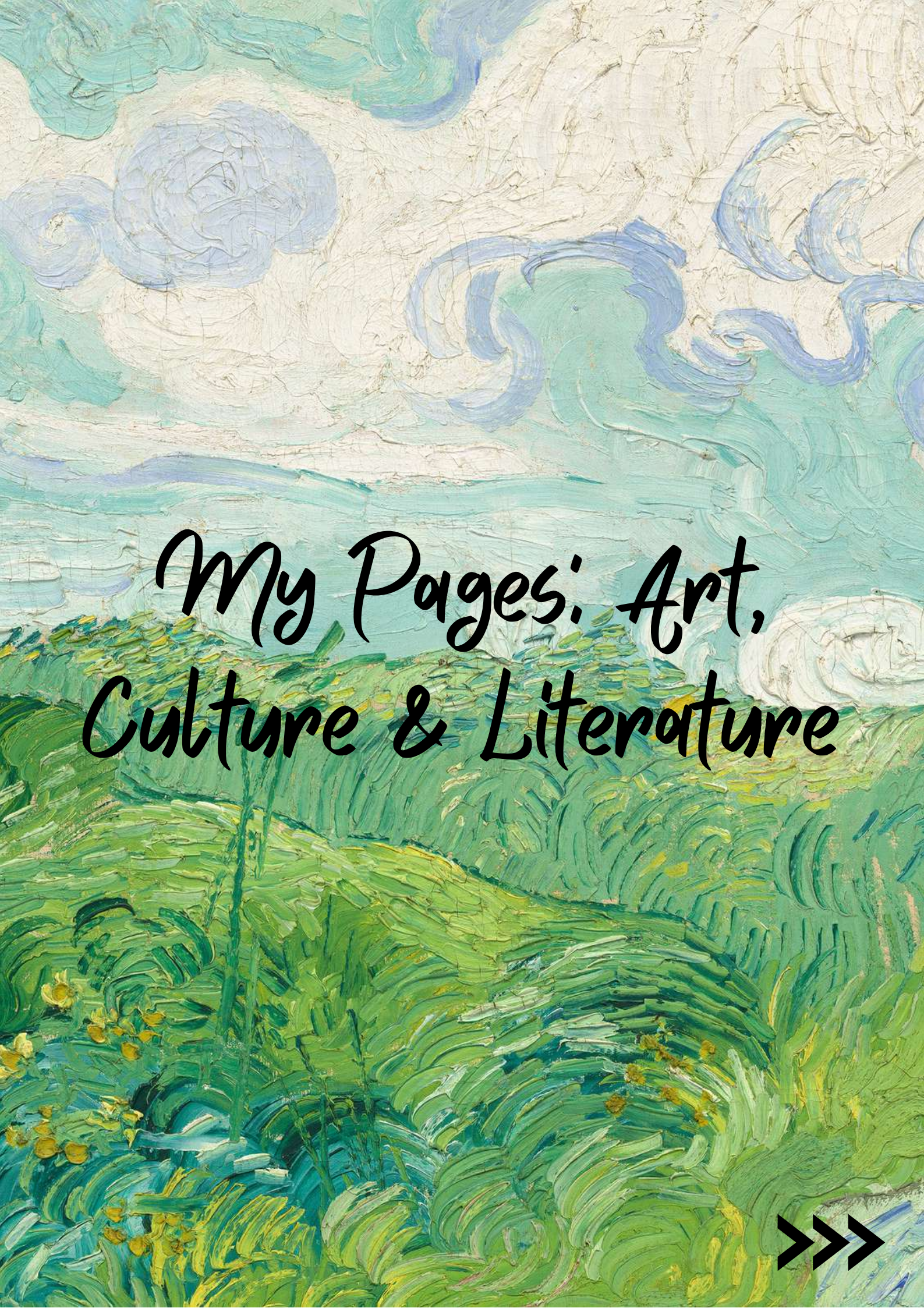
After the surgery was completed, the I-gel was removed, and the patient was transferred to the post-operative area with utmost care. The SGD demonstrated its utility by facilitating surgery and assuring the patient's well-being and a smooth and uninterrupted anaesthetic experience. Its effectiveness in handling difficult airways

has been imprinted in my mind, forever influencing my approach as an anaesthesiologist.

I gel -My superstar

I-gel as an SGD had genuinely rescued the tracheostomy, allowing me to handle a challenging scenario with confidence and success. After this life-changing experience, I changed my practice of managing difficult airways by keeping SGDs as an important airway management option. Nonetheless, I have encountered numerous similar challenging airway situations where the utilization of smaller SGDs proved to be remarkably successful, solidifying their role as invaluable lifesavers.

I have humbly presented to you my approach to managing an airway situation, while you may have envisioned alternative methods with your valuable knowledge, expertise and experience. I assure you that I have exerted my utmost efforts in handling this situation. Considering the limited availability of airway gadgets, the non-functionality of equipment (fiberoptic bronchoscope), the well-being of my patient, her considerations and wishes, and the surgeon's comfort in completing the surgery, I strived to provide the best possible care.

An impressionistic landscape painting. The foreground is a lush green field with a path leading into the distance. The sky is filled with soft, swirling clouds in shades of blue, green, and white. The overall style is reminiscent of J.M.W. Turner's work.

My Pages: Art, Culture & Literature



THE PRECIPICE OF MADNESS

By Dr. Bhagirath. S. Naganath
Associate Consultant in Anaesthetics
Sakra World Hospital, Bengaluru
ISA No. B1247



The radiance of a sun beam
the warmth of the morning ray
the endless rush of the glistening stream
what do they all want to say
sometimes they whisper,
sometimes they roar
ever so softly, ever so gently
those eternal truths
that we must remember ever so fervently.

What can be more truthful than truth
perhaps a lie bespoken with glee
pieces bitten off the forbidden fruit
to run, to hide, to flee
guilt, it seems, is remorseless
ever watchful, ever scathing
without mercy, without kindness
like a bewitched bee

A flowing stream, flows forth unhindered
rustle, its bustle, ever so comforting
calms us, puts us at peace,
of thoughts, emotions, feelings
must they not stream forth unhindered
must they not be comforted
conscious thoughts, sub-conscious ones
mingle, as one, never as two
the mind, it seems is the stream that streams forth
from you

Death is not the problem, life is
Joyful are the oblivious,
Joyful are the dead
As they watch us from the heavens above
Funerals, they are for the living
To grieve, to give or to retrieve life
The maker who createth us all
to the one who taketh all
Again, I say, death is not the problem, life is

Love, eternal, love, sublime
Gleaming jewels in the chest
glistening forth from the rest
Everything to nothing in Time

Of suppressed thoughts and hidden
remembrances,
Of raging rage, of uncontrollable passion
blinding light that illuminates us
Where does it emanate from.?
Of hidden chasms deep, stories belied
Of untold tales, many lie
blinding light that illuminates us
Where does it emanate from..?

The precipice beckons now,
The chasm looks inviting,
The abyss is warm,
The Darkness light,
The Cries mellow
The Songs so yellow
Must I plunge or must I not.?
That indeed is the question

ANAESTHESIOLOGIST- A SILENT HERO OF THE OPERATION THEATRE



By Prof. Manpreet Singh

Department of Anaesthesia and Intensive Care

Govt. Medical College and Hospital, Sector 32, Chandigarh, India

ISA No. M 1435

Email: manpreetdawar@gmail.com , Ph.: +91-9646121503

In the room with bright OT light,
Where fear and worry take their flight,
The patient becomes still and calm,
This is beauty of touch of anaesthesia's balm,
The hands move with gentle care,
As the patient slips into a world that is rare,
Where the dreams and reality intertwine,
And time stands still, suspended in time,
The body is free from pain,
And the surgeons start their operations
The heart beats at its own speed,
And though the mind is not aware,
But the body is in safe anaesthetist's care
In the realm of shadows and whispers, where silence reigns supreme,
The anaesthesiologist makes the patients dream,
Guarding the patient from pain and death,
Their vigilant eyes never waver, watching every spike,
Adjusting the anaesthesia, keeps the journey light,
They are in the midst of monitors,
With full alertness and full zeal,
They witness moments of triumph, as surgeons work w
Repairing what is broken using full sight,
The presence of anaesthetist is silent and profound,
He brings tranquillity and peace around
As the surgery is over, the surgeon is happy
And the patient will again come out of dreams,
The whole journey is of silent care,
The anaesthetist is always there
Do not take his work as Zero
No doubt- Anaesthesiologist is OT's silent hero!

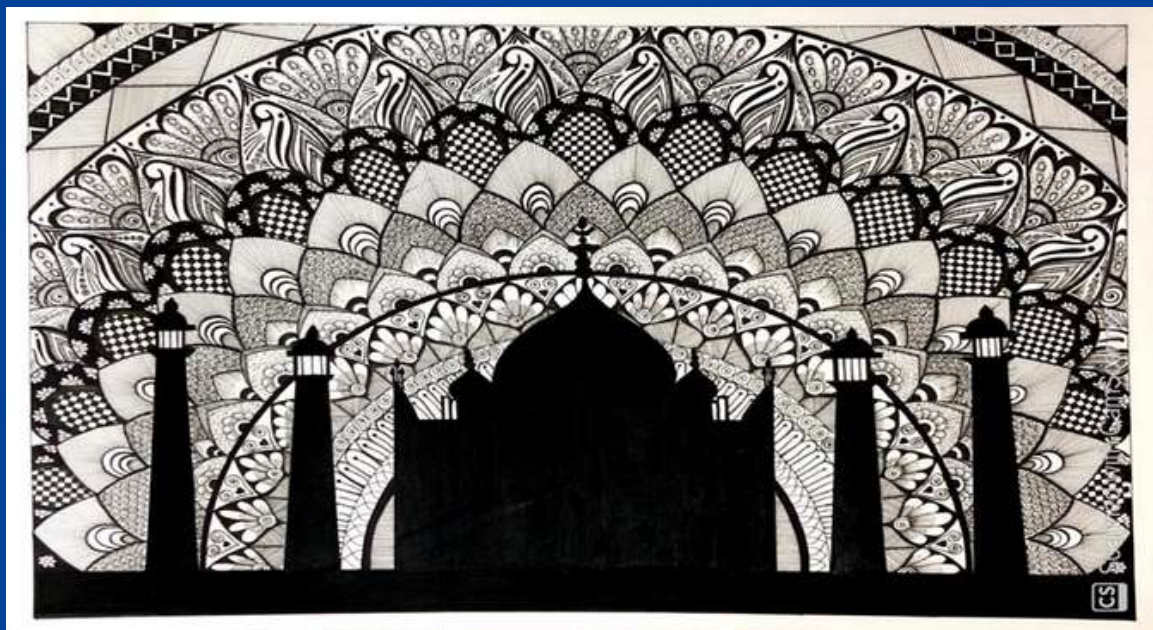


ARTWORK BY ANAESTHESIOLOGISTS

By Dr. Ayushma Jejani Padia

Consultant in GI & Transplant Anaesthesia, Nagpur, Maharashtra

ISA no. A3080



Combination of Mandala & Zentangle Art Form
(Hand-sketched, no stencils used)

ARTWORK BY ANAESTHESIOLOGISTS

By Dr. Somnath Shaha

Senior Consultant & Head, Department of Anaesthesiology & Critical Care,
Indian Railways Health Services Central Hospital, Guwahati, Northeast Frontier Railway
ISA No: S-1935

" Soar on eagle wings, high above the madness of the world....
May the sky test your limits and the sun be your aim....."



Art type: Illustration

Medium: Microtip ink pen, colour pencils on tinted art paper

A TRYST WITH DR. PANNAGA RAMESH

Anaesthesiologist

Member ISA Bangalore; ISA No. P1789

Special Interests:

Botanical illustration, Artwork and Calligraphy



Hello Dr. Pannaga!

Warm greetings from the editorial team of VAPOUR!

It is a very interesting hobby that you are pursuing. Please tell us something about your hobby.

1) What is Botanical Art?

Botanical art means drawing plants scientifically and in a way which is botanically correct but not necessarily complete. More emphasis is placed on the aesthetic value of the plant or flower but without the requirement for all the information required by the botanists. Artwork is frequently in colour (on a plain background). It may also include a record of the plant growing in its natural habitat. Botanical art may form part of a project and contribute to a flora - records made of plants in a geographical location or garden; whereas flower painting or floral portrait is much more about a pleasing painting and much less on the botanical accuracy.

2) How did you develop this hobby?

During my school days, I was very creative, participating in all the activities at school which required creative skills. Once I finished my school and entered pre-university, I very badly wanted to be a doctor (which I regret now), and I completely lived with books. The only way I showed my creativity was with my

biology records. I enjoyed drawing illustrations on the record books during my MBBS course too, and I was involved with writing names with calligraphy at most of the conferences that were held during that time. When I was doing my DNB Anaesthesiology at Narayana Hrudayalaya in 2014, on one night duty, I saw a patient who was almost dying. In that situation I began thinking what might be going on in his mind. I imagined myself in his position and thought whether I would be happy dying? The thought which first came to my mind is: I haven't done much of what I actually liked doing. That's when I decided to take this hobby seriously. I have been doing traditional art, water-colours and colour-pencil work. I have tried using oil painting, acrylic and other mediums since then. I started working on Botanical art very recently, viz in 2021. I love being with nature, observing, knowing about plants and illustrating nature.

3) Since when are you doing this?

I started pursuing botanical art since 2021, post coronavirus disease pandemic.

4) Which part of the plant do you like to sketch the most?

I like to sketch buds and drying, wilting flowers.

5) Did you undergo any formal training?

I did a basic one year art course in Hyderabad, where I learnt using most of the available mediums. In 2022, I enrolled for the distance learning diploma course by SOCIETY OF BOTANICAL ARTISTS, London. It is a 27 months course involving 12 assignments and three diploma portfolio pieces. I will be attending the graduation ceremony at London in May 2024. One more year to go for me to finish the course.

6) Which medium do you use: pencils, colour pens or water colours?

I use both colour-pencils and water-colours for botanical art.

7) Are you planning to pursue it as a second profession?

Yes, I am working towards making art as my second profession now! The one which started as a hobby, is on the verge of becoming my profession. Though I miss practising anaesthesia full time, the joy I receive from art is something which I cannot explain in words.

8) How much time do you devote for your passion?

I give about 2 to 4 hours daily for this, and more time on weekends.

9) Are you imparting training sessions to other people like botany students?

Yes, I give training sessions for both beginners and intermediate students in watercolours and colour pencils. Recently, a person requested me to teach botanical art, and I am working towards that, and hopefully will be starting from July 2023.

10) What is your message to our fellow anaesthesiologists?

My message to anaesthesiologists- When I look back at my life, I am very glad that I have cultivated a lot of hobbies, and I have seen many of colleagues who do not know anything other than anaesthesia/ medicine . Everyone should develop a hobby. One should know what to do in the free time.

We, as anaesthesiologists have learnt to save lives, but it is important that we save ourselves too! We can save ourselves by de-stressing and cultivating a hobby such as painting and drawing that requires detailing which is a kind of meditation. We must make time for our family. Our life and well-being is as important as developing our career. For the young anaesthesiologists, the age between 20 to 35 years is very important when they must maintain their health and give some time for themselves.

Thank You!

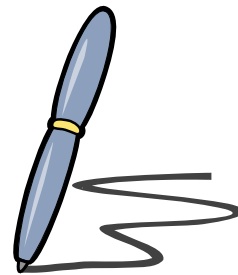
Editorial Team, VAPOUR

Botanical art



Dr. Pannaga H R

INVITATION TO CONTRIBUTE



‘Vapour’, the official newsletter of the Indian Society of Anaesthesiologists invites contribution of articles originally written by ISA members (Life and associate). The articles can be in the form of interesting case reports for discussion, articles on topics of current clinical relevance, photo-essays, articles on medicolegal /health/ financial/extracurricular issues of interest to the anaesthesiologists. Letter to the Editor/ Original literary works such as poems, funny cartoons or paintings on topics of anaesthesia are also welcome. Information about extraordinary achievements /experiences of ISA members, book publication can be sent.

The articles should be brief and written in font Times New Roman 12-14 size and presented in Microsoft office word document (rtf/doc files). Plagiarism and violation of copyrights should be strictly avoided. The articles should be e-mailed to isanhqvapour@yahoo.com with a covering letter addressed to the Honorary Secretary ISA National.

Dr Sukhminder Jit Singh Bajwa

Honorary Secretary ISA National & Editor-in-Chief

VAPOUR

(The official newsletter of the ISA National)

DISCLAIMER

The information and opinions presented in this newsletter reflect the views of the authors. The editorial team of the newsletter and the Indian Society of Anaesthesiologists (ISA) will not be responsible for the statements made by the authors. Publication does not mean endorsement by the ISA.