

- To use air traps if possible.
- To inject drugs through IV cannula by keeping the syringe vertical to keep air afloat.
- To avoid nitrous oxide in cases of suspicion of embolisation.

SpO₂, ECG and NIBP were the monitors used. 500 ml of Ringer's lactate was cohydrated. In the right lateral position, L3-4 interspace was identified and 2.5 mg of bupivacaine and 50 µg of fentanyl was injected into the intrathecal space. Two pillows were kept under the legs to facilitate venous return. The onset of adequate anaesthesia was 4 minutes and the level of analgesia was T6. The surgery was completed in 40 minutes and was uneventful. There was neither bradycardia nor hypotension after the block. The systolic blood pressure was between 130 to 140 mm Hg throughout the procedure. The SpO₂ was between 85 – 90% without oxygen which increased to 95-97% with 40 % oxygen. The post operative period was uneventful and was discharged in the fourth day.

Discussion

Management of anaesthesia of TOF requires a thorough understanding of the haemodynamics and the possible alterations of the same by administered drugs. For any cardiac patient coming for non cardiac surgery³, the maintenance of the cardiac grid pertinent to the particular disease is essential.

Table 1 showing the ideal grid in TOF patients.

	Preload	PVR	SVR	HR	contractility
TOF	N or ↑	↓	↑	↓ or N	↓ or N

N: normal

↑: increased

↓: decreased

With an ideal preload in mind, we gave the patient 500 ml of oral fluids and 500 ml of crystalloids. A decrease in pulmonary vascular resistance (PVR) and an increased systemic vascular resistance (SVR) will allow decreased shunt and hence a better oxygenation. General anaesthesia with ketamine supplements without inhalational agents has been described for patients with TOF coming for non cardiac surgery⁴. An epidural catheter and boluses of local anaesthetics in bursts are reported for caesarean section with TOF⁵. We adopted the technique of spinal fentanyl and minimal bupivacaine with optimal preload and elevation of legs to have minimal hemodynamic imbalance and maintenance of SVR. As there are MAPCAs, the possibility of a cyanotic spell is unlikely. We had kept Inj. Phenyl ephrine ready to tackle a drastic fall in blood pressure which did not happen. Our patient has lived up to 21 years

with acceptable symptoms. Hence an anaesthetic technique which does not have major haemodynamic disturbance is enough. We opted to go for intrathecal narcotics especially fentanyl which gives adequate anaesthesia with minimal effects on cardiovascular system. As the estimated time of surgery was short, this was possible. Intrathecal fentanyl⁶ have been used in many settings with better hemodynamic balance and minimal use of vasopressors which prompted us to use the technique of intrathecal fentanyl. We did not allow a fall in SVR and maintained the necessary cardiac grid. The perioperative period was totally uneventful and the patient was discharged on the fourth day. To conclude, intrathecal fentanyl and minimal bupivacaine is an acceptable anaesthetic method where we just need to avoid severe hypotension in compensated cases of TOF coming for noncardiac surgery.

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