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INSIDE THIS ISSUE

	Pg. no
From the Editor's Desk - Dr. Vibhavari Naik and Editorial Team	2
Reflections from My IAPA Journey: Eight Years of Growth and Gratitude - Dr. Aavula Muralidhar	3
Airway Topicalisation in Children – When, What, How and How Much? - Dr. R. Jayanthi	5
My Child is on the Spectrum – Managing the Neurodiverse Pediatric Surgical Patient - Dr Nisha Sara M Jacob	7
Safety Standards in Paediatric Anaesthesia - What is Different From Adults? - Dr Dishank Rawat, Dr Sapna Bathla	10
Holding Tiny Hands with Steady Hearts - My Journey Through Pediatric Anaesthesia at Rainbow - Dr. Sanya Arora	12
Anaesthesia Considerations in High Frequency Oscillatory Ventilation - Dr Sabbavarapu Mohan, Dr Gita Nath	13
Anaesthetic Management of a Case of Gorlin-Goltz Syndrome: Unique Challenges to the Anaesthesiologist - Dr Lella Sireesha, Dr Aavula Muralidhar	16
IAPA ASPA PPLS Workshop at PGI, Chandigarh - Dr Indu Sen	18
Redefining Paediatric Pain: A CME on Paediatric Pain Awareness at KEM Hospital, Mumbai - Dr Raylene Dias	20
Report On Children's Day Celebration by Chacha Nehru Bal Chikitsalay, Delhi in Collaboration with IAPA Delhi and Rotaract club of Delhi - Dr Kavita Sharma, Dr Sapna Bathla, Dr Aikta Gupta	21
Paediatric and Neonatal Anaesthesia Workshop and IAPA session in ISACON 2025, Raipur - Dr Sunidhara Reddy, Dr Shephali	22
IAPA Delhi Midterm Meet 2025	24
Crossword - Dr Ekta Rai	25
Crossword Answers	14



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IAPA FEB 2026 NEWSLETTER EDITORIAL



DR VIBHAVARI NAIK

Greetings, dear friends!

We are delighted to celebrate the decade-long odyssey (Jan 2016 – Jan 2026) of IAPA newsletter that has showcased the growth of IAPA, member voices, achievements, milestones and memories. This journey is a testament to the unwavering dedication and seamless continuity of our editorial teams, skillfully guided by Dr. Elsa, Dr. Ekta, and handed over to us. Today, we proudly unveil this 20th edition of the IAPA newsletter capturing the essence of events, academic insights, reflections, and shared experiences.

This issue features reflections of Dr. Muralidhar as he steps down from his role as IAPA National Secretary. Dr. Jayanthi has masterfully unravelled the art and science of the ‘topicalization of pediatric airway’, delving into diverse techniques, with a clear focus on safety. While every patient holds a special place, some require unique attention, and Dr. Nisha has brilliantly captured the intricacies of care of children with ‘Autistic Spectrum Disorder’ with striking infographics. Dr. Sapna and Dr. Dishank have compiled the safety standards in paediatric anaesthesia, underscoring it as the collective responsibility. Prepare to be captivated by Dr. Sanya as she narrates her fellowship experience as a deeply meaningful journey in learning paediatric anaesthesia. It is inspiring to witness the infusion of fresh, creative minds into our fraternity. Dr. Gita and Dr. Mohan present an informative overview on high-frequency oscillatory ventilation and its anaesthesia considerations. Case reports, though low in the evidence hierarchy, often have a significant impact by sharing real-world clinical experience. Dr. Murali and Dr. Sireesha share a case of Gorlin Goltz syndrome and its airway management. For crossword enthusiasts, we have one crafted by Dr. Ekta on impactful trials in paediatric anaesthesia. Check if you are up-to-date with the trials that matter the most!

In this newsletter you will also see a kaleidoscope of IAPA activities across the country including the IAPA-ASPA PPLS course at PGI Chandigarh, the Paediatric Pain CME at KEM Hospital in Mumbai, and the Children's Day celebration by CNBC by IAPA Delhi. Additionally, we have summaries of IAPA meetings, including the IAPA Mid-term meeting in Delhi and IAPA's participation at ISACON 2026, featuring a paediatric anaesthesia workshop and a dedicated session. We hope you enjoy reading this newsletter. We warmly welcome your feedback as well as article submissions for the next edition. Looking forward to meeting you at Bangalore for IAPA 2026 and at Vellore for ASIAPACON 2026.

IAPA Editorial Team.

Dr Vibhavari Naik, Dr Sunidhara Reddy, Dr Ranju Singh, Dr Ekta Rai, Dr Gayatri Sasikumar and Dr Anisha De.

IAPA NEWSLETTER EDITORIAL TEAM



REFLECTIONS FROM MY IAPA JOURNEY: EIGHT YEARS OF GROWTH AND GRATITUDE

Dr. Aavula Muralidhar, Honorary Secretary (Outgoing), National IAPA

MY DEAR IAPA FAMILY MEMBERS,

“SHUBHA NAMASKARAM!”

Warm wishes to one and all for a happy, healthy, prosperous, and peaceful New Year! As I prepare to bid farewell to my role in the National Executive Committee (EC) and to warmly welcome the newly elected Secretary and other EC members. My eight-year journey in the IAPA National EC has been nothing short of extraordinary—a beautiful blend of learning, growth, friendship, and unforgettable memories. When I look back, I see a journey filled with milestones that shaped not only my professional path but also my personal connections with our wonderful IAPA family. It has been my privilege to meet, learn from, and work alongside paediatric anaesthesiologists from across the country—seniors whose wisdom inspired me, and juniors whose enthusiasm kept me motivated. Truly, it feels like a divine blessing to have shared this journey with all of you.

**2018 – Beginning of the Journey with IAPA National**

My journey with the IAPA National EC began in 2018 as “EC Member” during our National Conference at Hyderabad, when Dr. M. Subrahmanyam (then Secretary and now President) encouraged me to take up a role in the National Executive Committee. I was elected as an EC Member in the General Body Meeting and proposed the formation of “state chapters”—a vision that was warmly supported by then President Dr. Pradnya Sawant and Secretary Dr. Subrahmanyam.

Though many wondered whether the idea would succeed with just 400 members nationwide, our collective enthusiasm proved otherwise. In 2019, we launched the first state chapter in Telangana, and since then, we have proudly established nine state chapters, with several more in progress, achieved through continuous dialogue with senior members of each state. Each chapter has grown into a vibrant hub of academic activity, driven by passionate local teams. To all the EC members of our state chapters—thank you for your energy, vision, and commitment.

2019–2023 – A New Phase as Treasurer

In 2019, at the Delhi National Conference, I was elected as National Treasurer, joining hands with Dr. Elsa Varghese (President), Dr. Neerja (Vice President), and Dr. M.S.R.C. Murthy (Secretary). This marked the beginning of a new journey, supported wholeheartedly by our senior colleagues, especially Dr. M. Subrahmanyam.

All the new EC members were extremely encouraging and supportive, particularly Dr. Elsa Varghese, who selected me as one of the core faculty members for the ASPA PLS Training Programme, which began in 2019 at Bengaluru.

As Treasurer, I worked closely with Dr. M.S.R.C. Murthy, and together, we introduced several reforms within IAPA:

- Conducted online elections and set eligibility criteria for nominations.
- Streamlined the IAPA Fellowship Programme.
- Launched online IAPA National Academic Sessions for fellowship students.

During the COVID period, we organized the first online CME on the anaesthetic management of COVID cases. Despite the challenges, we also conducted paediatric and neonatal crisis management workshops, both offline and online. Notably, in 2020, we organised the first hybrid workshop (offline & online) on paediatric/neonatal crisis management in Hyderabad—a pioneering effort in India. These initiatives proved that even in the toughest times, the spirit of IAPA remained unshaken.

2023–2025 – In the Role of Secretary

In 2023, during the first-ever online elections, I was unanimously elected as “National Secretary” – a responsibility I accepted with humility and determination along with Dr. Dinesh Kumar as Treasurer and new EC members.

We focused on the initiation of new state chapters, strengthening our foundation through structured committees of three-year duration, renewed academic energy, and stronger engagement with our members.

We also focused on improving the “IAPA Fellowship Examination” pattern, in collaboration with the examination committee. The theory examination format was modified in February 2024 to better assess candidates’ knowledge and its application in paediatric anaesthesia practice. This was approved in the GBM with full support from all National EC members.

In 2024, a new gold medal in the name of Late Dr. Indrani Mitra from Kolkata was instituted, joining the existing Dr. Rajani Sundar Gold Medal. Both are awarded to the highest-scoring candidates during each fellowship exit examination conducted every six months.

To honour members who have made significant contributions to the association, we once again awarded the IAPA Honorary Fellowship Certificate at the Pune national conference in February 2025, to senior members with a minimum of 10 years of experience in paediatric anaesthesia. It was a proud and emotional moment, celebrating those whose dedication continues to inspire us all.

Academic Growth and Innovation

To promote knowledge dissemination and foster discussion among fellows, online IAPA academics was launched in 2022. Regular online academic sessions are held twice a month—on the second and fourth Fridays—moderated by an experienced senior. Faculty from across India became the cornerstone of our fellows’ examination preparations. In response to their needs, we redesigned the sessions into interactive formats including case discussions and journal reviews, promoting active engagement and deeper understanding.

At the Pune conference in 2025, it was my privilege to present “Certificates of Appreciation” to all faculty members who had contributed tirelessly to these national academic sessions. Their commitment truly embodies the heart of IAPA.

IAPA SNAC – A Dream Ignited

Neonates represent a unique and vulnerable group that we, as paediatric anaesthesiologists, are dedicated to caring for. In 2023, recognising the absence of a structured course addressing the complexities of perioperative management for this sensitive group, I suggested that IAPA initiate its own national-level neonatal training course - IAPA SNAC (Safe Neonatal Anaesthesia Course). A project born from our vision to train anaesthesiologists in smaller towns in neonatal resuscitation and stabilisation. Although initially shelved for unknown reasons, I am thrilled that in 2025 we revived this initiative, forming a dedicated core team with the support of our new President and Vice President. We aim to launch this landmark programme by 2027, empowering our community to lead neonatal anaesthesia education with pride and self-reliance.

“We must believe in our own strengths”—India performs more neonatal cases and has more neonatal anaesthesiologists than any other country and our expertise deserves global recognition.

Encouraging Knowledge and Connection

We also extended the Paediatric Anaesthesia journal membership to IAPA members at a subsidised rate, and to encourage academic engagement, offered free subscriptions to new members. I urge everyone to make the most of this invaluable resource to stay updated and inspired.

Looking Back with Gratitude

As I step down, my heart is full of appreciation—for every colleague, mentor, and friend who stood beside me. The past eight years have been a journey of friendship, learning, innovation, and unity.

I am proud of what we have achieved together—and even more excited for what lies ahead. I feel assured that the new Executive Committee will carry forward this legacy and take IAPA to even greater heights.

With gratitude and love,

Dr. Aavula Muralidhar

MD, IAPA Honorary Fellowship in Paediatric Anaesthesia

Outgoing IAPA National Secretary

Indian Association of Paediatric Anaesthesiologists (IAPA)





DR. R. JAYANTHI
CHENNAI

AIRWAY TOPICALISATION IN CHILDREN – WHEN, WHAT, HOW AND HOW MUCH?

Topicalisation of the airway is a common technique used during procedures that involve airway manipulation. It is the process of anaesthetising the mucous membranes of the respiratory tract with local anaesthetic (LA) to suppress gag and cough reflexes. Topical lignocaine is commonly used and helps reduce the incidence of undesirable airway reflexes such as laryngospasm, desaturation, and sore throat in children undergoing airway manipulations and procedures [1].

Topicalisation can be done using different techniques, sometimes in combination. One of the technique for topicalisation is spray-as-you-go (SAYGO). In this technique the nasal and oral mucosa is topicalised with lignocaine jelly and the fiberoptic bronchoscope (FOB) is introduced. A small-bore catheter (like an epidural catheter) is introduced through the working channel of the scope to deliver a spray of local anaesthetic – lignocaine directly on to the larynx and trachea. Forceful injection via the bronchoscope without a catheter and flushing with air filled syringe is alternatively used. This deposits the local anaesthetic directly onto the cords and spreads in the subglottic region as well.

Alternative techniques include -

Nebulisation: The patient inhales aerosolised local anaesthetic often 2-4% lignocaine via a face mask for 15 -30 min. The drug is inhaled as a fine mist and can reach the distal airways. It is an effective method of topicalisation especially in children where we cannot give airway blocks.

Atomisation: A device known as the mucosal atomization device (MAD) converts the local anaesthetic into a fine spray to be delivered via the nose to the airways. These techniques are well tolerated and easy to perform.

Pledgets: Pledgets or swabs soaked in local anaesthetic can be used to pack the nasal cavity.

Gargle: The older child can be made to gargle with the solution of lignocaine to numb the oropharynx.

The concern here is that given the variable absorption with each delivery method, there is a risk for local anaesthetic systemic toxicity. Also, there is insufficient evidence to recommend one technique being superior to the others [2]. The preference then goes to simple, convenient and effective techniques. Most endoscopists prefer the SAYGO technique. Lignocaine 2–4% applied to mucous membranes produces superficial anaesthesia in about one minute [3]. The peak effect occurs within two to five minutes, and the duration of action is 30–45 minutes [3].

A more favourable cardiovascular and systemic toxicity risk profile makes lignocaine a better option as opposed to bupivacaine or ropivacaine. Clinical levels of toxicity have been shown with lignocaine doses greater than 6.0-9.3 mg/kg lean body weight [2]. The total dose of local anaesthetics must be considered, including regional anaesthesia and surgical infiltration. Although lower concentrations may be just as effective, more rapid onset of anaesthesia is associated with higher concentrations [2]. The volume or dose of lignocaine that can be safely used in children is not clearly defined, though most paediatric anaesthesiologists would adhere to the dose of 5 mg/kg. The recommended dose of lignocaine is calculated and diluted to required volume making a 1-2% solution. Need for additional doses due to prolonged procedure or the sharing of the drug with the surgeon who also uses it via the endoscope makes it challenging to decide how much to give. Many of these questions have been addressed in a recently published consensus guideline.

Key recommendations from the guideline [4] include -

1. The age and weight of the child, the concentration of solution and the volume required should be taken into account when considering dosing of topical lignocaine for airway procedures.
2. Preoperative discussion between anaesthesiologists and surgeons is recommended at the team brief where both parties plan to use lignocaine. The maximum dose should be identified and divided appropriately according to the need.

3. A maximum dose of 5 mg/kg (ideal body weight) is recommended as a safe dose for procedures up to 2 hours; however, lesser doses are often deemed to be clinically effective, and a conservative approach is advised.
4. Ideal body weight should be used for dosing calculations in obese children.
5. Lignocaine solutions > 4% should not be used in children.
6. Patients should be routinely fasted for at least 1 h after airway topicalisation with lignocaine. If the child is deemed to be at significant risk of aspiration, this time may need to be extended.
7. Timing of all topicalisation and total dose of lignocaine used should be documented clearly.
8. Intravenous lipid emulsion 20% should be immediately available in departments where lignocaine topicalisation takes place.

Given the elimination half-life of lignocaine as 90–120 min, it appears appropriate for a single additional (reduced) dose of lignocaine to be given beyond this point, assuming no additional local anaesthetic has been administered by any other routes. Particular caution is advised when calculating the dose in children who are underweight, have comorbidities (e.g. hepatic disease) or are aged < 6 months, with lower doses (4mg/kg) warranted in these groups. Hypertensive crises and cardiac arrest have been reported in children where solutions containing vasoconstrictors have been used and hence must be avoided.

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“MY CHILD IS ON THE SPECTRUM” – MANAGING THE NEURODIVERSE PEDIATRIC SURGICAL PATIENT



**DR NISHA SARA M
JACOB
MANIPAL**

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that affects social, behavioral, intellectual, and communication aspects to varying degrees. Often labelled as ‘difficult’ or ‘combative’, these neurodiverse children present with unique, repetitive or inflexible behavioral patterns that may baffle the unsuspecting anaesthesiologist. In India, 1 in 68 children are estimated to be on the spectrum, with numbers increasing owing to improved awareness and diagnostics. Autistic children require anesthesia more frequently than other children; procedures range from simple diagnostic or dental interventions that are usually well tolerated by their neurotypical peers, to more complex surgeries.

Flexibility, adaptability and creativeness within the boundaries of safety are key to managing autistic children in the perioperative period. Anesthesia necessitates a deviation from the norm to an unfamiliar environment, which can trigger or augment atypical behavior; this may be colored by previous unpleasant anesthetic experiences. The autistic SPACE framework, which addresses the Sensory needs, ensures Predictability, Acceptance, Communication and Empathy, helps understand and accommodate the needs of autistic children.

The preanesthetic evaluation must be tailored to the needs and comfort of the child without compromising the quality of clinical information elicited (Fig:1). Engage caregivers to assist the evaluation (e.g. assess the child’s weight at home). Planned theater visits, and educational and behavioral interventions through social stories or visual aids may be initiated following the preanesthetic assessment to familiarize the child with the theater environment.

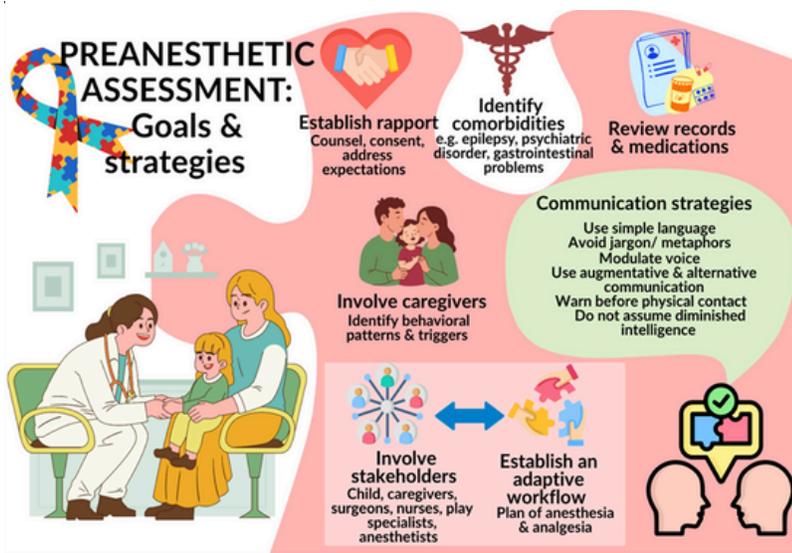


Figure 1: Preanesthetic assessment in children with ASD – goals and strategies

Strategies to ensure a comfortable preoperative period include caregiver presence, avoiding excessive fasting, reducing waiting times, decreasing sensory overload, and use of comfort items (noise cancelling headphones, toys, blanket). Assistance from a play specialist may be invaluable. Distraction using videos or games, and gentle, deep pressure help some patients. Despite the above non-pharmacological interventions, individualized sedative premedication is often required to facilitate anesthetic induction (Table 1). In rare instances where untraditional sites for premedication administration are considered (e.g. en route to hospital or at home), logistic and safety concerns must be addressed. If a child remains uncooperative despite adequate preparation and premedication, postponement of the non-emergent surgery may be contemplated.

IAPA-Bye-Laws

As members of the association, it is essential to familiarize ourselves with the Bye-laws that govern its operations. These Bye-laws serve as the foundational legal and procedural framework that outlines members' rights, responsibilities, and the overall structure and functioning of the association. Understanding them ensures that members can actively participate in decision-making processes, comply with requirements, and contribute effectively to the association's objectives. - <https://iapaindia.com/images/downloads/IAPA-Bye-Laws.pdf>

Table 1: Premedication for children with ASD

General principles

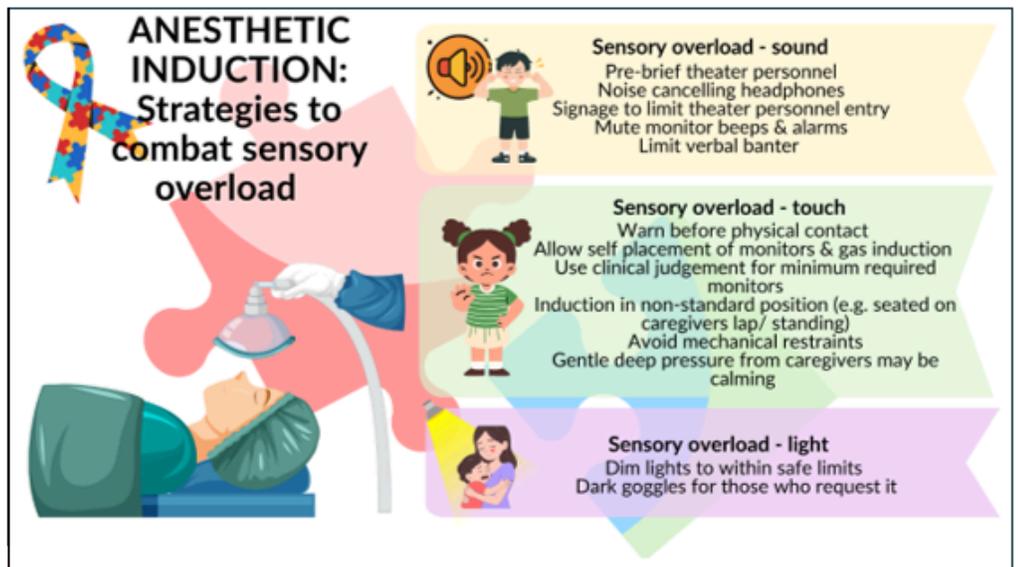
- Review medical records for previous premedication doses and effect, & plan accordingly
- Use oral route where possible
- Individualize for each child based on medical condition, acceptability & previous premedication experience.
- Consider the pros and cons of individual drugs before choosing.
- Involve caregivers with administration – e.g. discuss imitating routine of medication administration when at home, disguise taste with favorite drink or give the medication in a favorite cup
- If administering more than one drug, administer the tasteless one first (e.g. clonidine) followed 15 min later by others (e.g. midazolam- bitter taste for oral and burning sensation for intranasal administration respectively)

Drug	Route	Dose	Onset	Pros	Cons
Midazolam	P.O. Intranasal	0.25-1 mg/kg (max. 20 mg) 0.2-0.3 mg/kg	20-30 min	Rapid onset, short duration	Dysphoria in some patients Burning sensation
Ketamine	P.O.	3-5 mg/kg	15-25 min	Rapid onset, less risk for respiratory depression. Useful in extremely agitated patients	Vivid dreams, hyper salivation, long duration
	I.M.*	1-2 mg/kg	3-5 min		
Clonidine	P.O.	2-4 mcg/kg	45-60 min	Tasteless, no psychotropic effects, relatively short half-life	Prolonged onset, enhances memory, oxygen supplementation may be needed
Dexmedetomidine	P.O.	5 mcg/kg	30-45 min	Few side effects	Limited clinical experience
	Intranasal	1-2 mcg/kg	20-45 min		

Abbreviations: P.O. – per oral, I.M. – intramuscular

* I.M. – not ideally suited due to need for restraint. Use only if all other options are exhausted.

The art of induction is often tested while anesthetizing an autistic child. In addition to the principles of communication (Fig:1), and premedication (Table 1), specific strategies such as caregiver presence during induction, and approaches to combat sensory overload may be adopted (Fig:2). Due to sensitiveness to touch, topical anesthetics for intravenous line placement are objectionable to many children.



ANESTHETIC INDUCTION: Strategies to combat sensory overload

- Sensory overload - sound**
 - Pre-brief theater personnel
 - Noise cancelling headphones
 - Signage to limit theater personnel entry
 - Mute monitor beeps & alarms
 - Limit verbal banter
- Sensory overload - touch**
 - Warn before physical contact
 - Allow self placement of monitors & gas induction
 - Use clinical judgement for minimum required monitors
 - Induction in non-standard position (e.g. seated on caregivers lap/ standing)
 - Avoid mechanical restraints
 - Gentle deep pressure from caregivers may be calming
- Sensory overload - light**
 - Dim lights to within safe limits
 - Dark goggles for those who request it

Figure 2: Strategies to combat sensory overload during anesthetic induction in children with ASD.



The technique, rather than choice of anesthetic agents, affects postoperative outcomes. The overarching goals of intraoperative management are adequate analgesia (multimodal with liberal local anesthetic techniques), optimal hydration, prevention of postoperative nausea and vomiting, avoiding oxidative stress, and preventing emergence agitation. Drug interactions with routine medications must be considered. Additional sedation may be required for a smooth postoperative recovery.

Postoperatively, aim to restore normalcy at the earliest. Caregiver presence along with comfort items before the child awakens in a dim and quiet space eases anesthetic emergence and postoperative recovery. Secure or camouflage lines and tubes. Numbed areas should be protected from harm. Where feasible, early removal of intravenous lines, reduced vital sign checks, and early discharge from recovery are advocated. Physical restraints are best avoided. Pain assessment relies on behavioral pain rating scales with the help of the caregivers to understand non-verbal cues. Parent/nurse-controlled analgesia is often required following major surgeries.

Dr. Stephen Shore famously remarked, “When you meet one person with autism, you’ve met one person with autism” – underscoring the importance of an individualized approach to managing children on the spectrum. While anesthesia for autistic children certainly poses a challenge, favorable outcomes are possible with careful planning that actively engages all stakeholders.

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SAFETY STANDARDS IN PAEDIATRIC ANAESTHESIA - WHAT IS DIFFERENT FROM ADULTS?

DR DISHANK RAWAT
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The practice of paediatric anaesthesia is a high stakes endeavour that demands exceptional precision due to the limited physiological reserves and developmental variability. This article outlines critical safety standards distinguishing paediatric from adult practice, emphasizing on physiological differences, pharmacological precision, specialized equipment, and systemic safeguards.

Physiological and Anatomical Vulnerabilities

Children tolerate physiological stress poorly. The paediatric airway—anatomically and physiologically distinct with high metabolic demands and low functional residual capacity, is at risk for rapid desaturation [1]. Immediate access to size-appropriate equipment (uncuffed/cuffed endotracheal tubes, straight blades) is mandatory. Apnoeic oxygenation, preoxygenation, and video laryngoscopy enhance first-pass intubation success, minimizing hypoxic episodes.

Cardiac output depends primarily on heart rate due to limited stroke volume adjustment [1]. Vigilant heart rate monitoring and anticholinergic prophylaxis against vagal stimulation are essential. High surface area-to-volume ratios accelerate heat loss, necessitating active warming (theatre temperature control, warmed fluids, forced-air devices) [1]. However, care should be taken to avoid iatrogenic hyperthermia. Fluid management demands vigilance in both volume and composition—hypotonic fluids risk hyponatremia while improper volumes cause dehydration or overload.

Pharmacological Precision

Immature hepatic and renal function alter drug pharmacokinetics. Infants have a higher percentage of total body water, which increases the volume of distribution for water-soluble drugs thus requiring higher loading doses. Delayed clearance risks drug accumulation and toxicity [2]. The narrow therapeutic index of anaesthetic agents—particularly local anaesthetics, makes children susceptible to Local Anaesthetic Systemic Toxicity (LAST) at lower doses. Paradoxical drug reactions (e.g., benzodiazepine-induced excitability) necessitate judicious selection. Decimal point errors risk fatal overdoses, making precise calculations essential. Precision TIVA pumps with paediatric algorithms enhance dosing accuracy.

Specialized Equipment and Monitoring

Safe anaesthesia mandates size appropriate equipment availability: "Right size, right place, right now" [3]. Every facility must maintain a standardized paediatric difficult airway trolley. Standard monitoring (Electrocardiography, pulse oximetry, non-invasive blood pressure monitoring, capnography, temperature) is universal, but interpretation differs [4]. Continuous capnography is non-negotiable for all general anaesthetics. High-risk cases require invasive monitoring, quantitative neuromuscular monitoring (NMT), and processed EEG for depth assessment [5]. Ultrasound guidance for vascular access and regional anaesthesia improves safety and reduces complications [3]. Safety standards must remain uncompromised irrespective of location of care (e.g. Non-Operating Room Anaesthesia) [4].

Organizational and Human Factors

Safety is a systemic responsibility—organizations must cultivate a safety culture through institutional commitment and rigorous protocols. Risk mitigation begins with comprehensive preoperative assessment evaluating developmental stage, comorbidities, previous anaesthetic exposure, and family history of complications (e.g., malignant hyperthermia). Multidisciplinary consultation optimizes care for high-risk patients with tailored anaesthesia plans. Parental presence during induction may reduce anxiety in selected cases, though institutional protocols vary. Postoperative pain management and emergence delirium prevention are critical—multimodal analgesia and regional techniques minimize opioid requirements and adverse events.

Institutions must define their paediatric service scope and establish referral pathways to specialized centres [6]. Layered clinical privileges ensure competency—routine cases for general anaesthesiologists, complex cases for those with advanced paediatric training. Standardized processes (pre-procedure checklists, team time-outs, structured handovers) reduce errors. Simulation training for rare but critical situations, critical incident reporting with root cause analysis, and participation in quality initiatives (e.g. “Wake Up Safe”) further strengthen perioperative safety [7].

Conclusion

Paediatric anaesthesia safety demands multi-layered defences: recognizing physiological vulnerabilities, ensuring pharmacological precision, providing specialized equipment, and implementing rigorous process controls. Institutional specialization, credentialing, checklists, simulation, and quality reporting form the foundation of safe practice [Figure 1].

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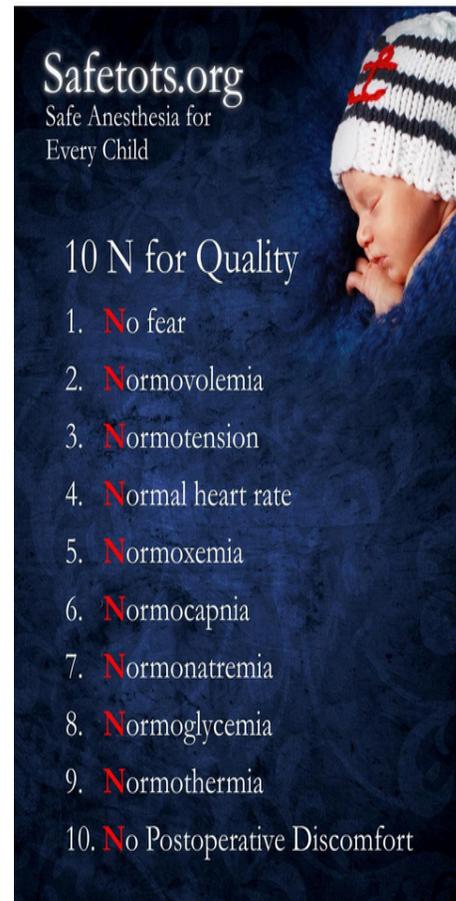


Figure 1: The ten key principles of maintaining physiological homeostasis for safe administration of anesthesia in pediatric patients [8]

IAPA COMMITTEES (2023-2026)

The work carried out by IAPA is fundamentally driven by the collective efforts of its various committees, each dedicated to specific domains essential for the organization's functioning and growth. These committees focus on critical areas such as accreditation, guidelines development, examination processes, research initiatives, newsletter publication, website management, and the coordination of state branches. Some committees are dedicated to implement IAPA collaborative programs, including ASPA PPLS course, SAFE Paediatrics and the Wake Up Safe India. We thank everyone who is part of these committees for their tireless work and commitment to advancing paediatric care and safety across India.

<https://iapaindia.com/images/committees-2023-2026.pdf>

HOLDING TINY HANDS WITH STEADY HEARTS - MY JOURNEY THROUGH PEDIATRIC ANAESTHESIA AT RAINBOW

My journey as a 'Paediatric Anaesthesia' fellow at Rainbow Children's Hospital, Marathahalli, has been one of the most transformative and enriching experiences of my professional life. Entering the fellowship, I knew paediatric anaesthesia demanded precision, sensitivity, and unwavering focus—but I never anticipated how deeply the program would shape me, both as a clinician and as a person.

From the very beginning, the fellowship created an atmosphere where learning felt dynamic and purposeful. The teaching style—calm, structured, and clinically focused—made every day academically stimulating. Whether it was a complex airway, a neonate with fragile physiology, or a high-risk child requiring

meticulous pre-operative optimisation, I was constantly encouraged to think deeper, anticipate complications, and approach every case with confidence, vigilance, and empathy. I learned that every anaesthetic plan is more than just pharmacology or technique—it represents a profound responsibility for a child's safety and a family's trust.

The days were filled with challenges that transformed me. Paediatric anaesthesia is a delicate interplay of physiology, anticipation, and intuition. I vividly remember securing difficult IV access in dehydrated infants, stabilising neonates for emergency surgeries, and managing children with complex comorbidities where every drug and decision mattered. Over time, I handled a wide spectrum of cases—neonatal emergencies, paediatric laparotomies, thoracotomies, airway reconstructions, orthopaedic corrections, neurosurgical procedures, and day-care surgeries. Each case brought its own lessons, reinforcing the importance of preparation, teamwork, and calm decision-making.

There is a unique moment in paediatric anaesthesia that stays with you forever—the moment when a child wakes up comfortably, safely, and pain-free. I will always remember the relieved smiles of parents when they saw their child in recovery, breathing well, stable, and comfortable. Their gratitude, often expressed silently through moist eyes or a whispered thank you, reminded me why this specialty carries such profound meaning. Those moments made even the most exhausting days feel worthwhile.

The collaborative culture at the hospital strengthened everything I learned. Surgeons, nurses, technicians, and fellows worked together seamlessly, turning every case into a shared learning experience. Pre-operative discussions, intraoperative coordination, and structured debriefs created an environment where patient care was truly a team effort, and every voice mattered. This culture transformed high-pressure situations into opportunities for growth.

Amidst the academic intensity, I also learned the importance of maintaining my emotional well-being. Paediatric anaesthesia carries a unique emotional weight—we care for the smallest, most vulnerable patients, while absorbing the unspoken anxieties of families. During this fellowship, I realised the value of small rituals that helped me stay grounded: a quiet dinner at home, a call to my family after a long shift, or a few moments of stillness before entering a challenging case. These little practices kept my mind centered and reminded me to take care of myself so I could better care for my patients.

Looking back, my fellowship was far more than a training program—it was a deeply human journey. It strengthened my foundations, refined my judgment, taught me humility, and reminded me of the immense privilege of providing anaesthesia to children. This chapter will remain one of the most meaningful parts of my career—a journey that shaped me into a more capable clinician and a more empathetic person.



**DR. SANYA ARORA
BENGALURU**



Call for articles

We invite academic articles and non-academic writeups for the upcoming edition of IAPA Newsletter.

Feel free to write back to
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ANAESTHESIA CONSIDERATIONS IN HIGH FREQUENCY OSCILLATORY VENTILATION

**DR SABBAVARAPU MOHAN
HYDERABAD**

**DR GITA NATH
HYDERABAD**



Introduction:

High-frequency ventilation delivers small tidal volumes at a rapid rate with sustained mean airway pressure (MAP). It offers more lung protection, particularly when high settings are needed in conventional mechanical ventilation (CMV) for gas exchange, which could result in ventilator-induced lung injury. Among the two major forms of high-frequency ventilation, High-Frequency Oscillatory Ventilation (HFOV) and High-Frequency Jet Ventilation, HFOV is used more commonly.

In HFOV, a ventilatory piston creates negative and positive pressure oscillations to deliver small tidal volumes on a set MAP. Expiration is active with HFOV (unlike CMV, where expiration is passive). The frequencies used are typically in the range of 480 to 900 breaths per minute (Figure 1). Recent large-scale randomised controlled trials, namely OSCAR and OSCILLATE [1,2], have not demonstrated any mortality benefit of HFOV in adults. However, HFOV remains a justifiable mode to consider for limiting lung stress and strain, particularly in patients with severe paediatric acute respiratory distress syndrome, neonatal respiratory distress, congenital diaphragmatic hernia, congenital lobar emphysema, and for postoperative lung protection in neonates. Understanding the physiological alterations with HFOV is important for anaesthesiologists to anaesthetise a baby receiving HFOV for surgical procedures.

Physiology-Driven Approach Relevant for Anesthesia

a. Gas Exchange

Compared to CMV, HFOV minimises lung stress and strain as compared to CMV [3]. High pressure can result in barotrauma, such as pneumothorax, subcutaneous, or mediastinal emphysema. Alveolar overdistension leads to volutrauma, characterised by the release of inflammatory mediators, influx of neutrophils, and further tissue damage, particularly in the remaining normal lung areas. Repeated alveolar opening and closing cause atelectotrauma due to shear stress. Preventing these injuries involves opening the lung by maintaining a sustained positive airway pressure and then delivering the smallest distending pressure necessary for adequate gas exchange. Oxygenation primarily depends on MAP and Fraction of Inspired Oxygen (FiO_2), with a target SpO_2 of greater than 87%. Ventilation, or carbon dioxide (CO_2) removal, is controlled by the frequency of oscillations and tidal volume (cycle volume). A decrease in frequency leads to larger tidal volumes and increased CO_2 clearance, unlike that in CMV. The ventilatory goal is to allow some degree of hypercapnia while maintaining a pH of > 7.2 . It should be noted that capnography is not useful in HFOV.

Emergency Scenarios Related to Increased PaCO_2

Progressive hypercapnia may result from endotracheal tube obstruction and can be detected by the loss of the chest wiggle factor (CWF), visible movement of the patient's chest and torso generated by HFOV oscillations, and changes in the observed amplitude. Closed suction should be performed along with an increase in bias flow during suctioning to prevent a decrease in MAP and derecruitment. If total obstruction is suspected, the ET tube should be changed while manually hyperventilating the child, and HFOV should be recommenced at the lowest frequency and highest cycle volume. Pneumothorax requires a high clinical suspicion and is detected by a change in amplitude, loss of oscillations on the side of the pneumothorax, hypoxia, hypotension, and an abrupt rise in PaCO_2 [4].

b. Lung Recruitment and Risk of De-recruitment

HFOV necessitates a high MAP to maintain lung expansion. Even a brief loss of MAP can cause rapid alveolar collapse and profound desaturation.

c. Hemodynamic Effects

High MAP can reduce venous return and cardiac output, which is exacerbated by coexisting hypovolaemia. Therefore, a close assessment of the fluid status is necessary.

Anaesthetic Considerations

Pre-Anaesthesia Considerations

Multidisciplinary discussions with neonatology/ICU teams about goals to be achieved regarding the current ventilator settings (MAP, Hz, amplitude, FiO₂), recent arterial blood gas (ABG) trends, haemodynamic status, and inotropes used should be conducted. The continuation of HFOV or planning for a safe transition to pressure-controlled ventilation is recommended. Good communication with relatives is required because of the unfamiliar appearance of patients receiving HFOV.

Intraoperative Anaesthetic Goals

Avoid de-recruitment - HFOV should be continued during induction, whenever possible. If switching to conventional ventilation, use low tidal volumes, high PEEP, gentle pressure control modes [5].

Maintain adequate oxygenation and CO₂ clearance - SpO₂, CO₂ clearance (ETCO₂ often unreliable hence use ABG), and CWF should be closely monitored.

Protect the lungs - bag-mask ventilation, high peak pressures, and overinflation should be avoided. Humidified inspired gases should be used to prevent necrotising tracheobronchitis (NT). Nebulisers are unreliable when using HFOV; therefore, bronchodilators should be administered intravenously.

Haemodynamic stability - Induction agents should be carefully titrated. Avoid sudden hypotension, which may worsen V/Q mismatch. Carefully assess the fluid status to determine whether additional fluid boluses and/or vasopressors are required. In the event of cardiac arrest, HFOV should be discontinued, and manual ventilation should be commenced with the help of the Jackson Rees circuit (using a PEEP-equipped bag).

Anaesthetic Technique

Intravenous induction is preferred, either ketamine or fentanyl-based, while ensuring spontaneous breathing. If HFOV must be paused, pre-oxygenate and limit the apnoea time. Opioid-based anaesthesia with propofol/ketamine is often preferred because inhalational agents cannot be administered. Pulse oximetry, ABG, ETCO₂ (often inaccurate), CWF, continuous ECG, NIBP or IBP and temperature monitoring should be performed.

Postoperative Considerations

Resume HFOV immediately after surgery if indicated and check ABG to confirm post-procedure ventilation status.

Series of cases done in our hospital

Case 1: An 8-month-old infant, 5 kg (Figure 2) with congenital lobar emphysema on oxygen support with HFNC upgraded to HFOV underwent thoracotomy and lobectomy. Intraoperatively, the child was maintained on HFOV for lung isolation. Postoperatively, HFOV was converted to low-pressure ventilation along with chest tube drainage, pain control, and air-leak surveillance.

Case 2: A 2-day-old, 4 kg neonate with a large cervical teratoma underwent an ex-utero intrapartum procedure for airway stabilisation, during which tracheostomy was performed. Owing to extreme airway distortion causing severe respiratory compromise, the infant required HFOV on the first postoperative day. Surgical excision of the mass was performed on the same day, and HFOV was continued in the perioperative period until airway patency and lung compliance improved.

Case 3: A 1-month-old neonate with congenital diaphragmatic hernia (CDH) was optimised preoperatively with HFOV and iNO (Figure 3). Diaphragmatic hernia repair was performed under HFOV which continued postoperatively along with titrated iNO, analgesia, and monitoring for complications.

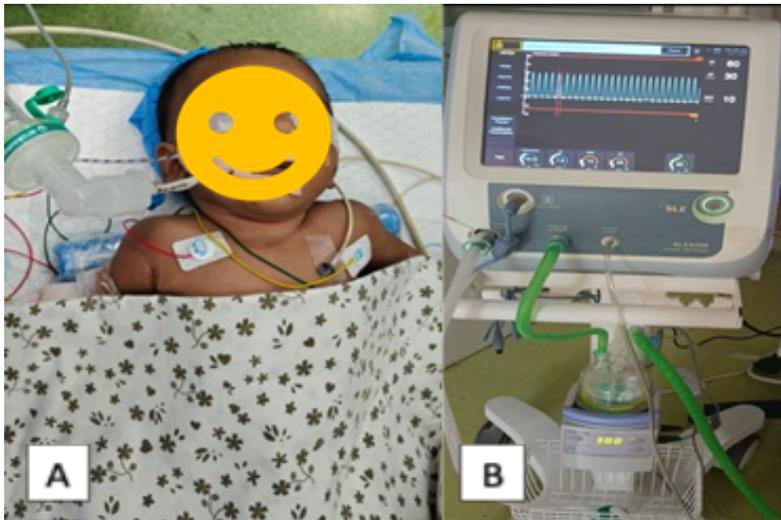
Conclusion:

HFOV, a lung-protective ventilatory mode, uses small tidal volumes at high oscillatory rates to achieve adequate gas exchange and is being increasingly used. Infants on HFOV may require surgical intervention. Anaesthesiologists need to be aware of the physiological differences and limitations of HFOV to ensure its safe perioperative use.

ACROSS
DOWN
1. KIDSBLONG 2. TREX 3. BIGAPPLE 4. JPEDIA 5. BEEPAINFREE 9. FEAST 10. MASK
2. TAXICAB 6. PROPPR 7. NECTARINE 8. PANDA 11. APRICOT 12. PEACH 13. MAGIC 14. EUROFAST 15. HAMSTER

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**Figure 1: HFOV machine****Figure 2: Baby connected to HFOV machine****Figure 3: Inhaled nitric oxide (iNO) equipment****HOW TO BECOME IAPA MEMBER?**

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DR LELLA SIREESHA
HYDERABAD

ANAESTHETIC MANAGEMENT OF A CASE OF GORLIN-GOLTZ SYNDROME: UNIQUE CHALLENGES TO THE ANAESTHESIOLOGIST



DR AAVULA MURALIDHAR
HYDERABAD

INTRODUCTION:

Gorlin-Goltz syndrome is a rare autosomal dominant ectodermal disorder with an incidence of 1 in 50000 - 1,50,000, characterised by mutation of PORCN gene, affecting multiple organ systems [1]. The primary clinical manifestations include basal cell carcinomas, odontogenic keratocysts, palmar or plantar pits, and ectopic calcifications of the falx cerebri. Additional features include - short stature, frontal bossing, facial asymmetry, cleft or high arched palate, macrocephaly, mandibular prognathia, hypoplastic skin patches, kyphoscoliosis, renal anomalies, polydactyly, ocular abnormalities, and cardiac or ovarian fibromas [2]. Airway challenges for an anaesthesiologist include restricted neck movements, difficulty in performing laryngoscopy due to reduced interincisor distance [3] secondary to mandibular cysts and malocclusion or impacted teeth, and difficulty in ventilation and intubation due to oral or laryngeal papillomas. We present a case of one such patient posted for excision biopsy of soft palate and right tonsillar fossa growth.

CASE REPORT:

A 5-year-old girl presented with difficulty swallowing solids and liquids, nasal regurgitation, cough after liquids, and excessive salivation for 5 days. Diagnosed with Goltz syndrome at 11 days of age, she had hypoplastic patches over her body, facial asymmetry, depressed nasal bridge, right eye coloboma, left microcornea, fused eyelid, V-shaped philtrum, bilateral parietal bone depression with global developmental delay, syndactyly, polydactyly, thoracolumbar scoliosis, and crossed-fused ectopic right kidney. Diagnosis was confirmed by skin biopsy showing atrophied adipose tissue in dermal regions and increased papillary dermal blood vessels.

On examination, the patient was anaemic and malnourished, weighing 10 kg, with short stature of 110 cm. Airway examination revealed adequate mouth opening, skin lesions around lips, sharp serrated crowns, normal neck movements, and proliferative growth involving soft palate and uvula extending to both tonsillar fossae. Blood tests showed haemoglobin of 5.5 g/dL, with other investigations normal. CT revealed bilateral lobulated soft tissue density lesions in tonsillar fossa extending to laryngeal inlet, partially occluding it. Ultrasound showed crossed-fused ectopic right kidney. 2D echocardiography and brain CT were normal.

Preoperatively, the patient received blood transfusion, supplemental iron, zinc, multivitamins, vitamin E, A, D3, calcium drops, and intravenous fluids. After preoperative counselling, high-risk consent was obtained and adequate blood reserved.

We anticipated challenges with laryngoscopy and intubation due to the presence of bilateral tonsillar lesions in the oropharynx. Nevertheless, we assessed that ventilation would remain feasible through the available space in the oropharynx. Our airway management strategy involved performing fiberoptic intubation under anesthesia to prevent contact between the laryngoscope blade and the lesions, which could potentially lead to complications such as bleeding in the airway. A difficult airway cart was kept ready with provisions for a surgical airway in case of failure to intubate and ventilate. The patient was shifted to the operating theatre after adequate fasting. All standard monitors were connected, and the baseline values were recorded. An intravenous (IV) cannula was sited, and the child was premedicated with injection midazolam 0.5 mg IV and glycopyrrolate 0.1 mg IV. Anaesthesia was induced with intravenous (IV) propofol (20 mg), fentanyl (20 mcg), and sevoflurane 2-4% while maintaining spontaneous ventilation as well as affirming the ability to ventilate. Fiberoptic intubation through the right nostril was attempted with paroxygenation. Thick secretions were noted orally which could not be suctioned through the fiberoptic bronchoscope suction channel. So we decided to perform a hybrid technique of introducing laryngoscope under FOB vision to avoid injury to the lesions. A direct laryngoscopy blade was inserted, and oral suctioning was done to clear secretions. Growth was observed in the bilateral tonsillar fossa, extending to the level of the vocal cords, and the laryngoscopic view was Cormack and Lehane grade 3 with external laryngeal manipulation. FOB guidance was used to further advance a 5 mm cuffed flexometallic endotracheal tube through

the vocal cords without injuring the lesions. Child remained hemodynamically stable and saturating well due to paraoxygenation. Bilateral air entry was checked, and neuromuscular blockade was achieved using atracurium (5 mg IV).

Anaesthesia was maintained with oxygen (1 L/min) and nitrous oxide (2 L/min) with sevoflurane (2 %). Hydrocortisone (40 mg IV) was administered to decrease airway oedema, and tranexamic acid (150 mg IV) was administered to minimise blood loss. The surgical procedure was completed without any major adverse events and with minimal blood loss. The duration of the surgery was 1 h. Extubation was performed in the lateral position after achieving adequate recovery and reversing the neuromuscular blockade with 0.1 mg IV glycopyrrolate and 0.6 mg IV neostigmine. The patient was shifted to the postoperative care unit for further monitoring and was discharged on postoperative day 3 without any complications.

Discussion:

With this case we share our experience of using hybrid intubation for airway management in a case of Gorlin Goltz syndrome. Gorlin Goltz syndrome poses significant challenges to the anaesthesiologist. Craniofacial abnormalities and papillomatous growths in the airway can make mask ventilation difficult, which has been earlier reported in literature [4]. In our case, CT allowed us to assess the ventilation adequacy. The hybrid approach of airway management has been documented in the literature related to paediatric difficult intubations [5]. However, the available literature is limited, and there is a lack of guidance on the safe execution of this technique. The dissemination of case reports such as this can contribute to the expansion of this body of literature.

Conclusion:

Gorlin-Goltz syndrome is rare and requires a comprehensive approach with detailed history taking, thorough clinical and radiological assessment to formulate an airway management plan. Awake fiberoptic intubation remains the gold standard because direct laryngoscopic intubation carries the risk of airway trauma, bleeding, and laryngeal oedema. Hybrid intubation could be a useful consideration in such cases.

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Figures:



Figure 1A and B. Child with Gorlin-Goltz syndrome having hypoplastic skin lesions, kyphoscoliosis (1A) and polydactyly (1B).

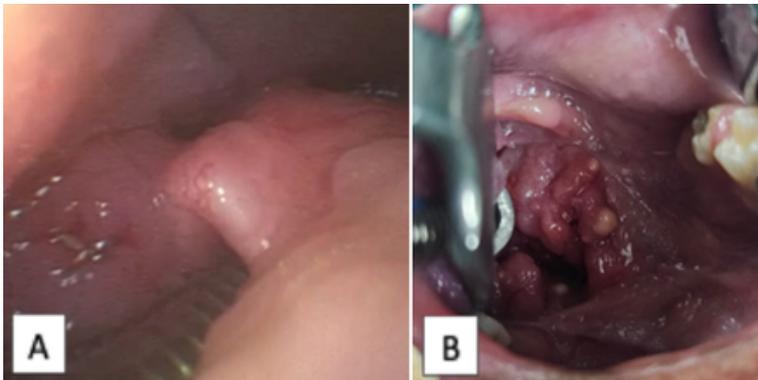


Figure 2A and B. Intraoral image showing left tonsillar lesion, epiglottis and flexometallic tube (2A) and right tonsillar lesion after surgical exposure (2B).





IAPA-ASPA PPLS WORKSHOP (Paediatric Perioperative Life Support) 10th August, 2025

Venue: APC Auditorium, PGIMER, Chandigarh



(COMPILED BY DR INDU SEN)



We trained twenty-two post MD, middle to senior level anaesthesiologists from north India. The scientific proceedings followed ASPA, PPLS template. An online pre-briefing and post-briefing meeting was held on 9th & 15th August, 2025.

Dr Indu Sen, Professor, Anaesthesia & Intensive Care was the course coordinator from PGIMER, Chandigarh under the able guidance of Prof Sandhya Yadanapudi. Prof YK Batra, Prof Neerja Bhardwaj (Former Department Heads), Prof RK Ratho (Dean Academics) and Prof Kajal Jain (Current HOD) inaugurated this one-day workshop.

Faculty included Drs Sandhya Yadanapudi (Chandigarh), Indu Sen (PGIMER, Chandigarh), Sapna Bathla (VMMC& SJH New Delhi), Anju Gupta (AIIMS, New Delhi), Col Amit Rai (Command Hospital, Chadi Mandir Cantonment, Panchkula, Haryana), Shubhdeep Kaur (SGRD, Amritsar, Punjab) and Anudeep Jafra (PGIMER, Chandigarh). Dr Aakriti Gupta & Dr Aditi Jain were silent observers and ensured that all sessions are held in time.

Programme started with introduction of the PPLS course followed by the pretest. All five talks and breaking bad news session was held in APC auditorium. Nine interactive sessions were done in three different halls with seven to eight participants in each room along with two moderators. All these sessions witnessed very active participation and discussion. In addition, PPLS ppts & videos provided relevant information and focus for discussion or teaching of skills.

Programme ended with a post-test and feedback from the participants. Average pretest score was 14.57 and average posttest score was 17.26. Nineteen participants eligible for PPLS certification include: Drs, Divya Jain, Avneet Singh, Preethy J Mathew, Shreya Shah, Vaishali Gupta, Subhasish Patnaik, Ritu Gupta, Akansha Bhanwa, Sarath Kumar, Anita Yadav, Nimish Singh, Tanya Singh, Gurwinder Kaur, Sabina Khanal, Guru Dutt Sharma, Mukta Singla, Rajinder Kaur, Harshita G & Maheshwaran.

The feedback rated the workshop very high and the majority mentioned that they found PPLS, a very practical and meaningful course and appreciated the efforts of the faculty. Venue and food scored highest rating from participants & guest faculty.

Faculty feedback included having high-technology manikins at the stations to add realism. Dr Sapna and all faculty suggested that new references & guidelines can be added in the PPLS manual and presentations. Dr Anju Gupta suggested that arrhythmias talk can be done before paediatric resuscitation to avoid repetition. Prof Sandhya explained the logic of having resuscitation first. Dr Indu Sen felt that we can have two courses; Essential PPLS course followed by an Advanced PPLS course where we can have sessions on complex craniospinal, cardiac, pulmonary, organ transplantation & neonatal emergencies. Advanced PPLS is expected to be useful to those exclusively pursuing paediatric anaesthesia.

 IAPA-ASPA PLS WORKSHOP (Paediatric Perioperative Life Support) 10th August, 2025 Venue: APC Auditorium, PGIMER, Chandigarh		
Faculty: Dr Sandhya Yaddanapudi, Dr Indu Sen, Dr Sapna Bathla, Dr Anju Gupta, Dr Shubhdeep, Dr Amit Rai, Dr Anudeep Jafra.		
0745-0800	Registration and Tea	Observer and Time Management
0810-0820	Introduction to the course: Dr Sandhya	
0825-0835	Pretest: Dr Amit Rai	
TALKS		
0840-0900 0905-0925	I. Common causes of peri-operative cardiac arrest: Dr Sandhya II. Recognition of critically ill child: Dr Indu	
INTERACTIVE CASE DISCUSSIONS		
0930-1050 30 minutes each rotation. 25 minutes for each topic	1. Recognition of the airway at risk: Dr Indu / Dr Amit 2. Fluid resuscitation in hypovolemia / blood loss during major surgery: Dr Sapna / Dr Anudeep 3. Desaturation in recovery room: Dr Sandhya / Dr Shubhdeep	Dr Anju Dr Aakriti
1100-1145 Inauguration, Group Photo followed by High Tea		
TALKS		
1150-1210 1215-1235	III. Updates on Paediatric Resuscitation : Dr Sapna IV. Recognition and management of arrhythmias : Dr Anju	
INTERACTIVE CASE DISCUSSIONS		
1240-1405 30 minutes each rotation. 25 minutes for each topic	1. Tight bag? Dr Sandhya / Dr Amit 2. Unexpected cardiac arrest in an infant after a caudal: Dr Anju / Dr Shubhdeep 3. Sudden fall in ETCO ₂ in an infant during surgery: Dr Indu / Dr Anudeep	Dr Sapna Dr Aditi
1405-1430 Lunch		
TALK		
1435-1455	V. Effective teamwork during crisis: Dr Indu Sen	
SKILLS STATIONS		
1500-1630 30 minutes each rotation. 25 minutes for each station	1. Recognition and management of arrhythmias: Dr Sandhya / Dr Anju 2. Effective CPR skills and teamwork: Dr Anudeep / Dr Shubhdeep 3. IV/IO access station: Dr Sapna / Dr Amit	Dr. Aakriti Dr Aditi
1630-1645	VI. Breaking bad news including role play (with participants): Dr. Anudeep/Dr Amit Rai/ Dr Indu	
1655-1710 Post-test: Dr Shubhdeep		
1715-1730 Q and A : Feedback (All faculty)		
1730 onwards Tea		



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State chapter executive committee should be limited and in odd number, One President, One Vice president, One general secretary, one treasurer and three EC Members.

State has to get separate PAN from income tax department. After getting their PAN Card, they should apply for BANK ACCOUNT in any nationalised bank.

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INDIAN ASSOCIATION OF PAEDIATRIC ANAESTHESIOLOGISTS

REDEFINING PAEDIATRIC PAIN- A CME ON PAEDIATRIC PAIN AWARENESS ON 31 OCTOBER 2025 AT KEM HOSPITAL, MUMBAI (COMPILED BY DR RAYLENE DIAS)

The department of paediatric anaesthesia Seth GS Medical College KEM Hospital Mumbai in association with IAPA Maharashtra State Chapter organized a CME on **Redefining Paediatric Pain** to commemorate the centenary year of the institute and pain awareness month of October. The main objective of the program was to “Make Children’s Pain Known and Matter and Better.” Sixty faculty and students from various specialities like paediatric anaesthesia, anaesthesia, paediatric surgery, paediatric medicine, orthopaedics, occupational therapy, pain physicians and haematology attended the event.

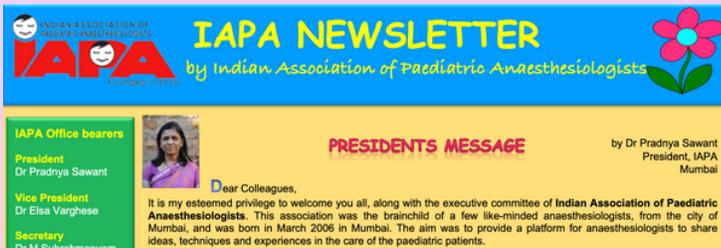


The CME was inaugurated by Dr Sandesh Parelkar, professor & head of paediatric surgery and dean of the hospital. He delivered the welcome address and felicitated the eminent speakers – Dr Lakshmi Vas, senior paediatric anaesthesiologist and chronic pain specialist; and Monica Santos, a professional healthcare clown from Spain. Dr Indrani Hemant Kumar Chincholi, president of IAPA Maharashtra set the pace for the academic programme and gave everyone a brief overview and peek into the paediatric pain clinic at KEM Hospital and the services offered. Dr Raylene Dias, associate professor & head of department explained why paediatric pain matters and the methods to make pain understood and better. Dr Gayathri P, assistant professor touched upon the cycle of chronic pain in kids and how to tame the beast. This was followed by a very comprehensive lecture by Dr Lakshmi Vas on common paediatric pain conditions and her approach to management of these children. This encompassed all the different types of paediatric pain like headaches, abdominal pain and children with spastic lesions like cerebral palsy etc. She touched upon her multidisciplinary approach to these children like physiotherapy, lifestyle and diet modification, behavioural therapy and the miracle worker - dry needling techniques and botulinum toxin injections. Dr Lakshmi Vas also took an informative session on how to set up a paediatric pain clinic and all the equipment and personnel one would be need. This was followed by a humorous session by Monica Santos a professional healthcare clown from Spain. She spoke on the gentle touch of humour and healthcare clowning on pain. Monica also got all delegates and faculty on their feet to perform a wonderful game cum tap dance which released endorphins and brought about stress relief and lightened everyone’s mood.



The sessions were well received by delegates and all were given feedback on how to deal with or refer children to us for acute and chronic pain management. The question-answer session at the end helped delegates to clear their doubts and get a good overview on basic principles of pain management in children. The vote of thanks was delivered by the organizing secretary of the event Dr Raylene Dias and this was followed by high tea. The CME was accredited by the State Medical Council.

IAPA NEWSLETTER JOURNEY



This was the first IAPA newsletter published in Jan 2016 under the Editorialship of Dr Elsa Varghese.

Completed 10 years and strongly rolling on. Celebrating this 20th IAPA newsletter edition.

Across ten years, these pages have carried voices, visions, and values—quietly weaving the story of a society in motion.

REPORT ON CHILDREN'S DAY CELEBRATION BY CHACHA NEHRU BAL CHIKITSALAY, DELHI IN COLLABORATION WITH IAPA DELHI AND ROTARACT CLUB OF DELHI

Dr. Kavita Sharma, Dr. Sapna Bathla, Dr. Aikta Gupta, IAPA DELHI

Children's Day, 14th November, was celebrated with great enthusiasm and warmth in collaboration with the IAPA Delhi and Rotaract Club, Delhi with the aim of bringing joy, learning, and smiles to children.

The program began with an inaugural session highlighting the importance of Children's Day and the role of nurturing young minds. The voluntary blood donation camp was organised at Chacha Nehru Bal Chikitsalya along with four blood donation centres as a part of the event. The camp witnessed enthusiastic participation from staff members, students and many volunteers. The activity stressed upon the spirit of social responsibility and community service along with the importance of volunteer blood donation in saving lives. The presence of esteemed Principal Secretary, DGHS and many other guests made the event a grand success. Senior members and Director of CNBC addressed the gathering and encouraged children to dream big and believe in themselves.

Various engaging activities were organized for the children. A storytelling session was conducted, which captured the children's attention and conveyed important moral values in an interactive manner. This was followed by fun-filled activities and games, ensuring active participation and enjoyment for all children.

As part of the celebration, goodies and gifts were distributed to the children, which brought immense happiness and excitement. The club members and students actively participated in the distribution and interacted warmly with the children, making the event more memorable.



The celebration concluded on a joyful note, with smiles on every child's face. The event was a great success and reflected the spirit of Children's Day by creating a cheerful, inclusive, and caring environment for children. The organizers Paediatric Anaesthesia department of CNBC expressed gratitude to the IAPA Delhi and Rotaract Club for their valuable support and cooperation in making the event meaningful and successful.



PAEDIATRIC AND NEONATAL ANAESTHESIA WORKSHOP – ISACON 2025, RAIPUR (COMPILED BY DR SUNIDHARA REDDY AND DR SHEPHALI)

The Paediatric and Neonatal Anaesthesia Workshop was successfully conducted under the aegis of ISACON 2025 on 26th November 2025 at DKS Super Speciality Hospital, Raipur. The workshop received an encouraging response with 32 registered delegates, reflecting the growing interest in structured training in paediatric anaesthesia.



The program commenced with registration and group formation, followed by a welcome address and an introductory lecture on “Children are not small adults and neonates are not small children.” The academic sessions were systematically structured into thematic modules covering basic principles, special conditions, and management of sick neonates and children. Basic principle topics included anxiety reduction and premedication, peri-operative fasting and fluid management, blood loss assessment, temperature monitoring, and common peri-operative complications. Special condition sessions addressed anaesthetic management for cleft lip and palate, inhaled foreign body and airway endoscopies, paediatric laparoscopic surgery, and NORA. The sick child module included focused case discussions on hydrocephalus, meningomyelocele repair, NEC/perforation, congenital diaphragmatic hernia, and tracheoesophageal fistula. A dedicated lecture on trauma and head injury in children further enriched the program.



A major highlight of the workshop was the hands-on skill stations, which provided practical training in newborn, neonatal and paediatric resuscitation, difficult intravenous and intraosseous access, central neuraxial blocks, and difficult airway management. These stations encouraged active participation, case-based learning, and close interaction between faculty and delegates.

The workshop was led by an eminent faculty comprising Dr. M. Subrahmanyam (Course Director), Dr. Sunidhara Reddy, Dr. Vibhavari Naik, Dr. Sanjay Prabhu, Dr. Anisha De, Dr. Poonam Bhadlikar, Dr. S. K. Mohanty, Dr. Rakhee Goyal, Dr. Muralidhar, Dr. Madhavi, Dr. Shephali, and Dr. Siddharth, whose expertise and dedication greatly contributed to the academic success of the program.



The workshop concluded with an interactive feedback session and concluding remarks, with delegates expressing high satisfaction regarding the scientific content, practical exposure, and overall organization. The program effectively fulfilled its objective of enhancing knowledge and skills in paediatric and neonatal anaesthesia, reinforcing the importance of such focused educational initiatives.



IAPA Session in ISACON 2025 - RAIPUR



IAPA was also invited to participate in a dedicated 90 minute session at ISACON 2025, national conference at Raipur on 29th November.

This session featured 5 talks by eminent speakers like - IAPA President Dr M Subrahmanyam and senior IAPA faculty like Dr S Ramesh, Dr Nandini Dave, Dr Ekta Rai and Dr Poonam Motiani. This session was moderated by Dr HG Manjunath and Dr Pradeepika Gangwar. It was well attended and appreciated by attendees.

09:30 - 11:00 AM (15 Mins each)	Game changers (change in practice) in Pediatric Anaesthesia	Dr M Subrahmanyam	Dr H G Manjunath Dr Pradnya Sawant Dr Pradeepika Gangwar
	5 recent publications impacting Pediatric Anaesthesia	Dr Ekta Rai	
	Improving safety in pediatric Anaesthesia	Dr Nandini Dave	
	Post operative pain management	Dr Poonam Motiani	
	Tips for Private practitioners in low resource settings	Dr S Ramesh	
	Discussion		



DR. KAVITA RANI SHARMA
DELHI

IAPA DELHI MIDTERM MEET 2025



DR SAPNA BATHLA
DELHI

The IAPA Delhi Midterm Meet was held on 23rd–24th August 2025 at Lady Hardinge Medical College, New Delhi, under the aegis of the Indian Association of Paediatric Anaesthesiologists (IAPA), Delhi Chapter. The meet was attended by approximately 140 delegates, including paediatric anaesthesiologists, consultants, and postgraduate trainees.

Day 1 commenced with the IAPA Fellowship Examination, conducted as per standard guidelines, providing an important academic platform for fellowship candidates. This was followed by a faculty dinner, which offered an opportunity for informal interaction and strengthening of academic camaraderie among faculty members.



The meet was formally inaugurated in the august presence of the Additional Director General of Health Services, Dr Sujata Chaudhary and Additional Medical Superintendent, Lady Hardinge Medical College, Dr L.H.Ghotekar and Dr Harish Pemde, The inauguration was further graced by the IAPA National executive members; President Dr. M. Subrahmanyam, Vice President Dr. MSRC Murthy and Secretary Dr. Aavula Muralidhar underscoring the national importance of the event.

The scientific program included all academic formats, such as lectures, panel discussions, case-based discussions, and interactive sessions, focusing on contemporary and clinically relevant topics in paediatric anaesthesia. The sessions were well received and generated active participation and meaningful academic discussions. A competitive e-poster session was also conducted, which received an enthusiastic response. Prizes were awarded in various categories, encouraging academic participation and showcasing high-quality research and clinical work.

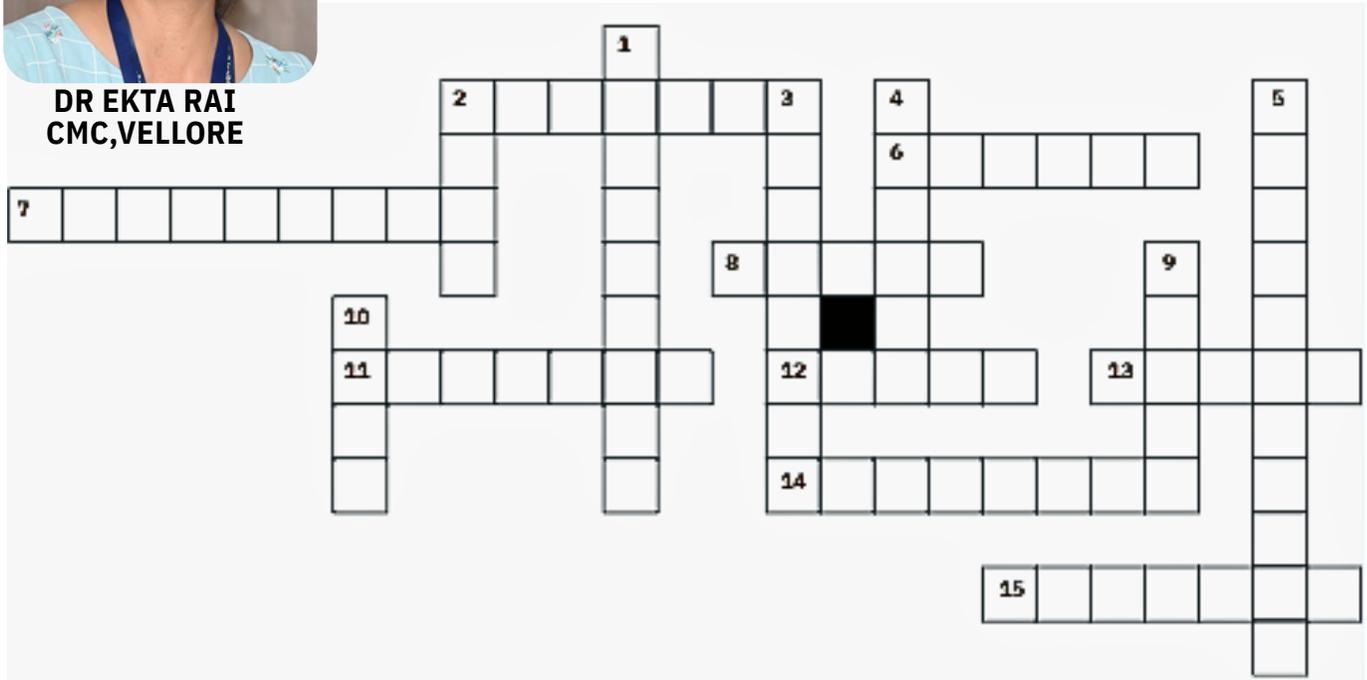
The IAPA Delhi Midterm Meet 2025 successfully met its academic objectives and reaffirmed IAPA's commitment to high-quality continuing medical education in paediatric anaesthesia.





DR EKTA RAI
CMC,VELLORE

THE IMPACTFUL TRIALS



Across

- 2.** A consensus statement in hemostasis, and plasma/platelet transfusion in critically ill infants and children.
- 6.** A trial to determine the effectiveness and safety of transfusing patients with severe trauma and major bleeding using plasma, platelets, and red blood cells in a 1:1:1 ratio compared with a 1:1:2 ratio.
- 7.** A Study which provides information on morbidity and mortality related to neonatal anaesthesia across Europe.
- 8.** A study aimed to examine children who were exposed to a single episode of GA during inguinal hernia surgery vs the siblings who were not.
- 11.** A prospective observational cohort study of children in Europe to identify perioperative severe critical events.
- 12.** A Protocol development and feasibility of perioperative anaesthetic morbidity in children in Asia.
- 13.** A trial showed the inferiority of melatonin as compared to midazolam in reducing pre-operative anxiety.
- 14.** A multicentric audit of the incidence of pulmonary aspiration with different fasting regimens.
- 15.** A multicentric trial investigating the role of high flow during paediatric upper airway surgery.

Down

- 1.** A multicentre study assessing the safety, efficacy, and pharmacokinetics of recombinant factor IX Fc fusion protein in children with severe haemophilia B.
- 2.** A trial aimed to determine whether low-dose sevo/dexmed/remifentani anaesthesia is superior to standard-dose sevoflurane anaesthesia towards terms of global cognitive function.
- 3.** An international observational study on the current practice of ventilation strategies in children undergoing GA and the occurrence of post-operative pulmonary complications.
- 4.** A prospective, multicenter, observational Japan Pediatric Difficult Airway in Anesthesia.
- 5.** A multicentre, double-blind, randomised controlled trial to show the impact of honey on post-tonsillectomy pain in children.
- 9.** A study investigating the effects of fluid boluses in the resuscitation of febrile children with evidence of poor perfusion.
- 10.** The study to test the effect of exposure highlighting the impact of multiple, but not single, procedures requiring GA before 3 yrs birthday is associated with adverse neurodevelopmental outcomes.