MATERIAL AND METHODS
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The present work was carried out on the patients admitted in M.L.B. Medical College Hospital, Jhansi, scheduled for elective major or minor surgery requiring general anaesthesia and tracheal intubation. The patients of ASA grade I or II were all screened clinically and biochemically in their pre-anaesthetic visits and any patient with clinical features of some cardiovascular disease including an arterial blood pressure higher than 150/90 mm Hg were excluded from the study. Patients receiving sedative, antihypertensive, beta-blocking or other medication likely to interfere with this study and patients in whom a difficult intubation was anticipated were excluded from the study.

Informed consent was obtained from all patients. Premedication consisted of diazepam 10 mg by mouth on the evening before surgery at bed time and atropine 0.6 mg i.v., 5 minutes before induction.

In the O.T. room a Venflon i.v. cannula was inserted into a vein on the dorsum of the hand and infusion commenced with 5% dextrose. Non-invasive
blood pressure monitoring was done using an electronic digital (Marshall 1987) sphygmomanometer. All patients had continuous E.K.G. monitoring.

Pre-oxygenation was done with 100% oxygen by face mask delivered through a Magill circuit for 3 minutes. Anaesthesia was induced with a sleep dose of thiopentone (4-7 mg/kg) followed by suxamethonium 1.5 mg/kg to facilitate the tracheal intubation and ventilated with 100% oxygen for another 2 minutes. Orotracheal intubation with Macintosh laryngoscope was done with an appropriate sized plane or cuffed tube, by the same experienced anaesthetist. In case of a cuffed tube, the cuff was inflated only after all the serial recordings were completed. Surgeons were requested not to clean, drape or position the patients till 5 minutes after intubation, so as to avoid any stimuli, likely to interfere with the findings.

Serial heart rate and arterial pressure measurements were obtained before and after induction, immediately and 1, 3 and 5 minutes following laryngoscopy and intubation. After intubation, patients were ventilated with 67% nitrous oxide in oxygen.

Depending on the drug/drugs used for the study, patients were divided into 7 groups as follows:
**Group I** : (n=10) Control group, received none of the drugs from the study groups.

**Group II** : (n=7) Received laryngotracheal topical spray with 4% lignocaine 3-4 ml 1 minute before laryngoscopy using a Macintosh laryngeal spray.

**Group III** : (n=10) Received Inj. buprenorphine 2.5 µg/kg i.v. 8 minutes before laryngoscopy.

**Group IV** : (n=10) Received nifedipine 10 mg sublingual 10 minutes before laryngoscopy.

**Group V** : (n=10) Received buprenorphine 2.5 µg/kg i.v 8 minutes before and laryngotracheal spray with 4% lignocaine, 3-4 ml, 1 minute before the start of laryngoscopy.

**Group VI** : (n=10) Received nifedipine 10 mg sublingual 10 minutes before and laryngotracheal spray of 4% lignocaine (3-4 ml.) 1 minute before the start of laryngoscopy.

**Group VII** : (n=10) Received nifedipine 10 mg sublingual 10 minutes before and buprenorphine 2.5 µg/kg i.v. 8 minutes before the start of laryngoscopy.

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