MATERIAL AND METHODS
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This study was conducted in the department of Anaesthesiology, M.L.B. Medical College, Hospital, Jhansi in 90 patients of age group between 19-30 years. All patients undergoing emergency caesarean section were included in the study. They were operated under general anaesthesia or spinal anaesthesia. Patients having systolic blood pressure above 140 mm Hg and diastolic above 90 mm Hg were included in the study. An informed consent was obtained from all patients.

All parturients who were undergo emergency caesarean section were subjected to detailed pre-anaesthetic check up half an hour before surgery. All patients were asked the history of oral intake, if the patient was starving and if time permits half an hour before surgery 0.6 mg Atropine sulphate was given intramuscularly. If there was history of oral intake then gastric tube was passed and gastric suction was done.

On arrival in operation theatre, blood pressure & heart rate were recorded in each patient.

Depending on the drugs used for the study the total number of 90 patients were divided into three groups.

GROUP I

This group consisted of 40 patients who were given sedation 10 mg diazepam intramuscularly half an
hour before the induction of anaesthesia.

GROUP II
This group also consisted of 40 patients who were given Nifedipine 10 mg sublingually half an hour before induction of anaesthesia.

Group I and II were further divided into group Ia & Ib and IIa & IIb as per the technique of anaesthesia applied. In group Ia and IIa general anaesthesia was given and in Ib and IIb spinal anaesthesia was given.

GROUP III
This group comprised of 10 patients who had severe hypertension with oedema and albuminuria. These were given diazepam 10 mg intramuscularly and Nifedipine 10 mg sublingually.

The patients of this group were operated under general anaesthesia (Nifedipine) capsule was cut at one end and the drug was administered sublingually half an hour before induction of anaesthesia.

MONITORING
Pulse rate, respiratory rate, blood pressure were recorded at:
1. the time of administration of Nifedipine.
2. 10 minutes after Nifedipine.
3. 20 minutes after Nifedipine.
4. 30 minutes after Nifedipine.
5. Just after endotracheal intubation.
6. 45 minutes after Nifedipine.
7. at the time of extubation.

TECHNIQUE OF ANAESTHESIA

Detailed of technique in each group is as follows:

I. General Anaesthesia with controlled Ventilation

All patients were in supine position on an operation table with a pillow under the occiput blood pressure and pulse rate were recorded. Intravenous drip of 5% dextrose or isotonic solution was started.

Pre-oxygenation was done for 3-4 minutes to all patients and during this time skin preparation and drapping was completed by obstetrician. Induction was done with a dose of thiopentone sodium 2.5% solution in doses of 4-5 mg/kg body weight. This was followed by suxamethonium in doses of 1.5 mg to 2.0 mg/kg body weight about 100 mg was loaded and given intubation with a cuffed endotracheal tube was smoothly and swiftly carried out following which the operation started. The cuff of the endotracheal tube was then promptly inflated ensuring the aeration chest expansion equal on both sides. Anaesthesia was maintained with Nitrous oxide and oxygen (5.5 litre per minutes) and intermittent positive pressure ventilation using M. W. Gills circuit. In most of
the patients the initial dose of suxamethonium provided sufficient relaxation till the foetus was delivered. Once the spontaneous ventilation starts suxamethonium was used in doses of 10 mg subsequently till the surgery was over. After a delivery of the infant fortwin 10-20 mg and phenargan 25 mg intravenously was used to elevate pain and awareness.

II. Subarachnoid Block

Blood pressure and pulse rate were recorded before the start of the procedure. Intravenous drip started with fast infusion of 5% dextrose followed by normal saline/Ringerlactate 540 ml. Patient was put on left lateral position with spines flexed. Area was cleaned thoroughly and a skin wheal raised with the injection of lignocaine 1% solution in L₃-L₄ interspinous space. For spinal injection a 20 S.W.G. needle was mostly used. When tip of needle enters into the subarachanoid space a free flow of C.S.F. is observed. Bupivacaine (Sensorcaine heavy) in doses 1.5-2.0 ml (10 mg) was injected or 5% lignocaine (0.8 to 1.0 ml). Then patient was made supine. Another 900 ml of Ringer lactate or 540 ml of normal saline was infused rapidly. After the injection of spinal block and lateral tilt of table the surgeon was asked to commence the operation. Pulse rate and blood pressure were recorded till the delivery of the infant and also after delivery. Injection
ergometrine was given intravenously after delivery of the foetus along with oxytocin in infusion bottle.