

Authors' reply

Sir,

We are happy to read the views and the opinion expressed by the reader^[1] about some aspect of our article.^[2] Our response to some of the concerned issues is as below:

Regarding hemodynamic monitoring, the heart rate and blood pressure were measured every minute, starting just before induction until surgical incision and 10 minutes thereafter till completion of surgery. It was removed from the final manuscript as it was a relatively lengthy table. In propofol group, though the heart rate was >20% below baseline, there was lesser variation in heart rate intraoperatively than in the

isoflurane group. Hemodynamic profile in propofol group was thus better than the isoflurane group.

Regarding comparison of emergence, we compared the time for eye opening and time taken to reach an Aldrete score of 9. Aldrete score contains parameters like consciousness and motor activity. So, eye opening, consciousness, and motor activity are reasonably enough parameters to compare emergence.

We used a single isoflurane vaporizer for all cases in control group. Isoflurane consumed per case was calculated by dividing total isoflurane used in the vaporizer with total number of cases anesthetized. Indeed, it was a rough estimate, but we could not find any better and more practical method to calculate the isoflurane dose. The surgery was performed by same neurosurgical team, time required was nearly identical (as shown in the relevant observations in the manuscript) in most cases. In propofol group, we calculated the cost of the propofol used. We did not consider the amount of propofol that remained in the syringe after operation, because that was used in next patient, after changing the connecting tubing to avoid wastage of the drug. We routinely use midazolam 30 mcg/kg intravenous 3 minutes before starting administration of propofol in all cases. We titrated the infusion dose of propofol according to bispectral index scores, which were kept in a range of 40 to 60.

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