"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 2nd November 2017. Publication date 13th November 2017.
Website: www.perioptalk.org

The imperfect opinions in these reports are only meant to stimulate discussion: - they should not be considered a definitive statement of appropriate standards of care.

Attendance: Libby Freihaut, Mark Davies, Nick Roberts, Simon Gomes-Veira, Kim Rackemann, Paul Healey, Patrick Farrell, plus others

TOPIC 1: *Large Goitre, plus non-specific symptoms*

KM 58yo woman for removal of a large retrosternal multinodular goitre in under one week's time. Euthyroid. Thyroid imaging was not available on CAP.

Relevant Hx: BMI 43, Heavy smoker (100 py) currently not smoking; COPD - FEV1 52% of predicted; Exercise tolerance 30 metres on the flat; Probable OSA awaiting sleep studies, scheduled for post thyroidectomy. Chronic hip pain- has a referral to chronic pain specialists (HIPS) but hasn't attended. Previous accidental overdose at home with prescribed opiates; depression and anxiety; migraines; Takes oxycodone, tapentadol, quetiapine, meloxicam, diazepam, Ipratropium, Ellipta, Sumatriptan.

Previously presented for surgery at Maitland Hospital in January 2017 but was cancelled due to poor respiratory function and exacerbation of COPD. (SP02 on room air at that time 89%). Now 'recovered'.

The current issue of concern: - She has been having unexplained 'syncopal' episodes with an associated aura in the last 6 months. CT angio of neck vessels was normal. She had been seen by a respected neurologist whose provisional diagnosis was postural hypotension (which she exhibited on examination). She has a normal baseline ECG. Neurologist had requested an EEG, Echocardiography, sleep study, Holter monitor and tilt-table test when seen two months ago. He also ordered blood tests for diabetes, adrenal dysfunction, and thyroid function. With the exception of bloods (which were essentially normal), none of these tests have been done.

Prior to PIG meeting she had been discussed at the perioperative cardiology meeting. The cardiologist felt that with a normal ECG, further cardiac investigations were not likely to yield much and that it was appropriate to proceed.

Discussion: - The group had a general feeling that a Holter monitor was indicated +/- a TTE. However the opinion of a respected cardiologist trumped our nervous desire to investigate further and it was concluded it was acceptable to proceed with surgery without further cardiac investigations…..

TOPIC 2: *Non-Malignant Thyroidectomy in the elderly*

89yo man for left sided hemithyroidectomy in less than a week's time. Ultrasound shows large left large cystic thyroid mass. 2 x FNA cytology has shown no malignant cells but this doesn't rule out possible malignancy (as per ENT surgeon).

The only symptom associated with thyroid is possible voice change. No compressive symptoms. Euthyroid. Mass is 6x5x8cm on CT July 2016

Past History: Ex heavy smoker (nil for 20yrs.) with COPD but no respiratory admissions, HT, ETOH 40g/day. He lives alone but receives many services, still driving a car.

R/V by Respiratory Physician Oct 16 and again April 17- went on to have respiratory prehabilitation with initial improvement in his PFTs. The spirometry performed at periop clinic Nov 2017 is now back to his poor baseline: 0.88/2.35.

Cardiac Echo: Moderate Pulmonary Hypertension, LVEF 75% otherwise minor abnormalities. Normal Nasendoscopy May 2017

Group question: Why is he being done at all?

CON:- He is euthyroid and there are no compressive symptoms (yet). Although this could be a malignancy, there is no evidence that it is. He is an old man with significant lung pathology which is likely to limit his life in the next 5 years….possibly before any thyroid malignancy has a chance to develop.

PRO:- Compressive symptoms may eventuate and perhaps it is better to operate now rather than when he is 95yo. Thyroid surgery is reasonably low perioperative stress physiologically (compared to a laparotomy, thoracotomy or joint replacement.) Prognosis of decline of chronic lung disease varies widely.

Consensus was to proceed. HDU review in PARU requested

TOPIC 3: *High-Risk Colon Cancer surgery*

75yo woman was referred by surgeons to clinic for assessment for appropriateness for surgery. Possible laparotomy for bowel cancer. Consulting anaesthetist requested the group's consideration of the decision.

Past History: - Previous laparotomy and Hartmann's procedure for unrelated bowel cancer. Paroxysmal atrial fibrillation; IHD – 2x AMIs 2015, stents, currently gets angina 2-3 times/week. Past DVTs and PEs- on apixaban. Asthma. Obesity: BMI 43

Exercise tolerance limited to walks around the house with a walking frame.

Predicted 13% mortality using NSQIP. Surgeon subjectively felt it would be higher, as surgery anticipated to be very long and difficult. Cardiologist commented she was 'very high risk'.

The group concurred with the assessing anaesthetist that she was not fit enough for surgery.

(Other cases were also discussed)