"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 17th May 2018.
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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.

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TOPIC 1: Back surgery in a nonagenarian

A 91 year old female scheduled for a laminectomy due to severe back pain associated with numbness in her legs, weakness and loss of balance but is still "active" (with her daughters support at home). Pain is very postural i.e. increases within minutes of standing and there is associated weakness, both typical of a lumbar canal stenosis syndrome. But there are significant comorbidities: - ischemic heart disease with two long stents (DES) inserted 10 months ago. Still gets angina despite lack of effort, but this is stable. T2DM, hypertension, hypercholesterolemia, TIAs in the past but no recent symptoms. Chronic renal failure (Creatinine 130). Iron deficiency. Recently seen by a cardiologist who feels she is "as good as she can be". The patient is disabled by the pain and keen to have surgery, but is particularly concerned about avoiding postoperative nursing home admission or dependency. Is it worth the risk?
Discussion: - Discussed for some time: - it appears that her medical risk can't be minimised; the risk is significant, however the patient's life is becoming miserable without surgery, and the trajectory without intervention is painful dependency. The most appropriate next step is to clarify surgical decision-making. (i.e. Was the patient assessed by consultant, had they considered risks, is there a clear indication for surgery with a realistic expectation that the symptoms will be improved by surgery. Are there non-surgical interventions possible?) If this is the case then it is appropriate to proceed with risks. (After meeting the case was discussed with the surgeon. It was clarified that the consultant surgeon had indeed seen the patient and remembered the details well. He is confident that the symptoms are indeed due to cord compression and should improve with surgery to at least reduce her numbness, weakness, and instability, although some pain will remain. Therefore proceed.

TOPIC 2: Uninvestigated "Drop Attacks" and colonoscopy

An 82 year old very independent, fit, and well (no regular medications) patient is scheduled for a colonoscopy to investigate a positive FOB. The procedure is scheduled for 4 days' time. The patient reports 'drop attacks' in the last 18 months. There is no prodrome:- immediate loss of consciousness. Incontinence on one occasion. The patient reports that she "felt dreadful for a day afterwards". The patient has been investigated from a cardiological point of view, with a normal echocardiogram and a normal Holter. She has stopped driving and stopped aquarobics of her own initiative. Discussed at Perioperative/Cardiology meeting:- cardiologist suggests that although although there are investigations involving more prolonged recordings than Holter test, and a tilt test could investigate for autonomic dysfunction, this is very unlikely to find anything leading to interventions, and would only delay the investigation. There is no great urgency for the colonoscopy, but arrangements are in place and scheduled. How to manage?
Discussion:- A neurological assessment is needed and a CT scan is the most urgent investigation:- if this is normal further investigation of drop attacks can wait. The colonoscopy may be associated with profound vagal stimulation: a bowel prep may have its own adverse effects, particularly it may precipitate further 'drop attacks'. Bowel preparation should thus be done as an inpatient, particularly as the patient lives alone. Therefore plan go ahead with the colonoscopy as initially scheduled, but admit the patient for inpatient bowel preparation, and obtain a CT brain scan afternoon prior to colonoscopy, as well as a general medical consultation.

TOPIC 3: **Surgery in a situation of cognitive disability**

A 65 year old patient from a group home with severe developmental delay (non-verbal) has severe pain on standing or moving of hips, and this is consistent with X-ray findings of severe osteoarthritis. Patient is non-verbal and normally "friendly" and co-operative but cries with pain when made to stand. His function is deteriorating as a result. The surgery is indicated; consent through guardianship is obtained. What is the appropriate perioperative management?

Discussion:-

- Temazepam pre-med may assist, but can be unpredictable (the friendly personality with reassuring familiar staff is more important)
- General anaesthesia with spinal (after induction) for intrathecal morphine to give prolonged analgesia.
- Either single-shot FIB lock or local infiltration to the wound for postop analgesia. Not a local anaesthesia catheter which may confuse the issue, could be a source of infection, and would probably add little in this situation anyway. 8mg of dexamethasone to augment the effect of a local anaesthetic.
- Best timing was discussed extensively:- initially considered it would be best to be first on the list; however, after some consideration it was felt that scheduling in the early afternoon would enable the patient to be given an very early light breakfast, followed by fasting for solids but with free fluids given until 2 hours before surgery. This may be preferable in terms of fasting management, and would have the advantage of enabling the analgesia to be from the intrathecal morphine to be effective overnight, which would minimise the nursing challenges during the night. Patient will need to be specialled overnight either by a nurse or by a carer from the group home's staff.
- The care plan needs to be documented for all staff to be able to refer to easily.

TOPIC 4: **Syndrome with multiple enablers – perioperative management.**

(Details of this case have been profoundly edited).

A patient is scheduled for abdominal surgery to remove a possibly malignant mass. This would normally be relatively straight forward. The surgeon has requested early review to ascertain that the patient could be managed perioperatively safely. The patient has an extremely long medical history with multiple diagnoses of severe disorders involving cardiac, respiratory, endocrine, haematological and metabolic aspects. There is ongoing treatment of these conditions that generates multiple perioperative management complexities, although these can be planned for. During assessment it became apparent that for at least some of the conditions the diagnosis was somewhat uncertain; some involved 'over-diagnosis'; others appeared to be (perhaps) inappropriately aggressive treatments of minor findings. There may be elements of inappropriate illness behaviour such as hysteria, Munchausen's, and 'la belle indifference'. It was clear that both the patient, the patient's family, the carers, and some multiple specialists were invested as enablers in this situation. Should the perioperative period be used as a way of trying to 'break the cycle' by 'proving' that some of these conditions were in appropriated diagnosed or treated?

Discussion:- Discussed at some length with a variety of opinions. Experienced Liaison Psychiatric/ethics advice was then sought. The general experience with patients such as these is that if there is a stable belief in the diagnoses no matter how bizarre, supported by investment from enablers, then there is virtually no prospect of resolving the situation by confrontation with 'facts' and clinical evidence. It is tempting to buy into trying to 'cure' the situation, (Note that the patient's personality may be very successful at drawing new medical staff in:- that is a manifestation of their psycho-pathology.) However, there is virtually no prospect of success in this regard. If surgery is genuinely needed (i.e. by defined 'hard' pathology as in this situation) then it must be managed within the context of the patient's beliefs, whilst trying to avoid exacerbating the situation further.