"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 23rd May 2019.
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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: Ross Kerridge, Paul Healey, Ashok Darmalingham, Ange Baker, Others.

TOPIC 1: **Subclinical Hypothyroidism**

A 53 year old female for a laparoscopic fundoplication. Various comorbidities including obesity, OSA, smoker, type 2 diabetes on insulin/metformin/SGLT2i. Hypothyroidism on thyroxine replacement. TSH recently 50 and GP had increased thyroxine 2 weeks before. TSH two weeks later (in the clinic) 34 and T4 low normal. Not clinically hypothyroid. Her regular specialist physician advised that surgery should be postponed for 4 weeks and patient maintained on the same increased dose to normalise thyroid status.
Discussion: - Differing views. Some agreed with delay, others thought it was reasonable to proceed carefully, (in a patient not clinically hypothyroid), accepting that the patient may be mildly hypothyroid. It was understood that part of the motivation from the endocrinologist to postpone surgery was to reinforce to the patient the necessity for compliance with medication. (Addit:- ten days later the patient had become biochemically hyperthyroid – confirming that patient non-compliance had been an issue for this patient). No clear answers.

TOPIC 2: **Timing of Surgery after NSTEMI**

87 year old with a positive FOBT leading to endoscopy revealing a caecal cancer. Patient had become unwell over the last few months with symptomatic angina and then a NSTEMI (troponin 1000 approximately). Anaemic (Hb72). Normal GFR. History of a LAD stent in 2000 followed by treatment with aspirin and statins, but no further symptoms of IHD until this event. He is otherwise feeling well after a transfusion of 3 units of blood. A TTE shows EF of 47%. The surgeons want to do a right hemicolectomy. What is the appropriate timing?
Discussion:- Some felt it was reasonable to go ahead immediately – that the NSTEMI has been precipitated by anaemia (now cured), so proceed. The clopidogrel started after the NTEMI can be stopped. The more conventional recommendation is to wait for (either) 6 weeks or 3 months after a NSTEMI, although there is no 'evidence' to justify this. The patient's life expectancy should be considered. Based on John Carlisle's risk model (using British data) an 87 year old with a NSTEMI has a life expectancy of less than 3 years. Population-based average life expectancy data is available for Australia – this needs to be more generally incorporated into shared decision making. Consensus was that it was reasonable to proceed with this 'relatively small' operation, if only to prevent a recurrence of the bleeding causing cardiac complications. Undertaking more extensive colorectal or other surgery would be a different matter. Regarding timing of surgery, although there was no 'evidence' that this was optimal, it seems reasonable not to operate 'immediately' after a NSTEMI and transfusion. Pragmatically, the logistics of scheduling mean it would be a few weeks post NSTEMI until surgery was undertaken, and this is probably a good thing, even after a NSTEMI. After a STEMI there may be more justification to delay due to implied endothelial instability and myocardial injury, although (again) this is not based on high-level evidence.

(See attached) LIFE EXPECTANCY TABLES FROM ABS DATA

TOPIC 3: Multiple Sclerosis and Spinals

A 62 year old for a total knee replacement. Background history (as reported) of Guillarn-Barre and Multiple Sclerosis. (latter is reasonably 'good' at present). Smokes 20 a day, ethanol reported as 60 grams a day. No medication for MS. Previous HCV but cleared. Biochemistry shows mildly raised transaminases, mildly decreased platelets (94), and normal album and coags.

Discussion:- MS and spinals:- there is no evidence that spinal anaesthesia exacerbates MS, however exacerbation of MS may happen coincidently, and be attributed to anaesthesia. A well-documented discussion of this needs to be had before surgery. Platelet count of 94 in someone who is otherwise asymptomatic (and therefore presumed to have good platelet function) is not a contraindication to spinal anaesthesia. There may be value in 'vigorous' discussion with the patient on the need to stop/cut down alcohol for 2 to 3 weeks prior to surgery to improve liver function and platelet activity.

TOPIC 4: SupraVentricular Tachycardia in Surgery

A 68 year old female with past history of SVT, for unicompartmental knee replacement. Patient has had a long history of SVT. Two episodes needing treatment with Adenosine 17 years ago, and was offered ablation then but did not go ahead (by choice). Since then she has had short episodes of self-limiting SVT, but no further severe episodes and is on no medical treatment. Echo in 2013 was normal. She is on treatment with thyroxine.

Discussion: - Consensus was that it would be appropriate to repeat the echo preoperatively. Her thyroid levels need to be checked. There was consensus regarding starting prophylactic therapy preoperatively. (i.e. Should beta-blocker be given preoperatively?) It was suggested to discuss with cardiologist regarding prophylactic treatment and best interventional treatment at the time of surgery if SVT recurs.