"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 30th 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: Asnok Dharmalingam, Angela Baker, Gavin Sullivan, Tom Martin, David Cottee, Eugene McKernan, Richard Burstall, Ross Kerridge, Paul Healey, Fiona Merrit

TOPIC 1: Unexplained Neutrophilia

A 51 year old patient for C4/5 neck surgery for pain had initially been assessed 3 months previously, and was noted at that time to have a raised white cell count (22000) with a mixed picture, but was otherwise reasonably well. It was presumed that he may have some acute pathology developing at that time and was postponed for reassessment. Since then the GP had noted that the patient also had a reactive neutrophilia 3 years previously, also unexplained. No particular cause was found then. The white cell count is now 13000, again with no symptoms. CRP is normal. Should we go ahead?

Discussion: - Probably. In the first instance Haematologists would wish to exclude a myeloproliferative neoplasm (e.g. CML) which should be discussed with them re appropriate tests (JAK2 mutation et al). It is worth clarifying that these were done three years ago. The effluxion of time is also reassuring – if the patient was developing CML the WCC would have climbed higher by now. If appropriate tests were done then, it seems this is a patient who may be unusually neutrophilic, but otherwise normal and it is reasonable to proceed.

TOPIC 2: Whipples in an 84 year old

Patient with pancreatic head carcinoma was seen at the request of surgeons on the ward after treatment of jaundice with an ERCP and stent. At the time of the ward consult it became clear that the patient was not yet aware of the diagnosis (!) He was "reasonably healthy":- T2DM, hypertension, possible OSA. Independent for ADLs - mows lawns etc. Currently on treatment for cardiac arrhythmias (ectopics?) with Flecainide and Atenolol long term. He has been on Plavix for primary prevention for stroke for 15 years. Haemoglobin on presentation was 77. P-POSSUM indicated 30% mortality. Recent loss of weight of about 20 kilos presumably due to cancer (now 80kgs). What advice?

Discussion: - P-POSSUM significantly over-predicts risk from surgery, particularly at the 'higher end'. The low haemoglobin in this patient has a profound influence on predicted risk, but it is not clear how the risk changes with correction of anaemia by transfusion. (i.e. the dataset used to develop the calibration was based on initial haemoglobin). This is not currently incorporated in risk production models. P-POSSUM is probably outdated for evaluation such as this.

Before making any decision re advice it is important to clarify with the surgeons what their expectations are, and, particularly, what alternatives to complete Whipples resection may be contemplated, such as palliative surgery (gastrojejunostamy). Given the patient's comorbidities Whipples resection seems inappropriate but discussion with the surgeons may clarify if they wish to consider a more limited procedure. There needs to be a frank discussion of risks and formulation of an advanced care directive with the patient and family.

Follow Up – Discussion with surgeons after the PIG Meeting founds that the surgeons were not expecting anaesthetists agreement with offering the patient a Whipples procedure. A palliative (non-surgical) approach was agreed.

TOPIC 3: Fit patients may not be so fit

A 64 year old fit & active patient booked for a laparoscopic hysterectomy (TAHBSO) had recently travelled around Europe and was "fit". Further discussion found that in fact HBA1C was elevated (8.8), and ECG showed abnormalities (left axis deviation and poor r-wave progression). At the GP's initiative, (independent of anaesthetist's opinion) a stress echocardiogram was performed on the basis of the ECG findings which had demonstrated an abnormality – this had now lead on to cardiac catheterisation (pending). The patient had recently been started on Bydurion.

Discussion:-

1. The cardiac investigations may have been excessive however the surgery is entirely elective. There is little choice but to postpone to await results of the angiogram.
2. Bydurion is an injectable GLP-1 receptor antagonist exenatide, recently marketed in Australia. Exenatide can be given by daily, twice daily, or weekly injections. It is showing some success in improving glycaemic control and inducing weight loss, partly because of appetite suppression and slowing gastric emptying. It will probably become much more frequently encountered in Australia. It is unlikely to induce hypoglycaemia but gastric slowing may be a reason to withhold perioperatively.
3. Raised HBA1C as an indication for intervention in diabetes management has been reviewed recently. Local diabetes services accept that a patient with a HBA1C less than 8.5 may proceed to surgery unless there are other reasons to use the surgical episode as a reason to intervene in diabetes management. Non urgent surgery is best managed through the general practitioners.

Reference New diabetes therapies & Perioperative implications attached