



## “From the Trough”

### Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 13<sup>th</sup> February 2020. Publication date 21<sup>st</sup> February 2020.

Website: [www.perioptalk.org](http://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:** Paul Healey, Ross Kerridge, Blair Munford, Simon Ellis, David Cottee, Gabrielle Papeix, B Bartlett, Tim Webb, Lucy Andersen, Lauren Paton, Nick Stewart

#### **TOPIC 1:           Complicated EVAR**

Female patient aged 70 referred for anaesthetic consultation for high risk complicated EVAR. 4.8cm juxta-renal AAA found on imaging for respiratory symptoms.

Previous medical history:

1. Ischaemic heart disease
  - AMI 2009
  - 2 x BMS at time
  - No angina since. On appropriate medical therapy
2. COPD
  - Smoker > 50 pack years
  - No hospital admissions
  - FEV1 1.1 L (approx. 65% predicted)
  - Managed on inhaled therapies.
3. Schizophrenia
  - Well managed and stable. No recent hospitalisations, however admits to taking additional Risperidone when she has increased delusions.

Medications

- Risperidone, anastrozole, aspirin, irbesartan, metoprolol, tiotropium, symbicort, amlodipine, atorvastatin.

Further history

- Lives with son – he helps her with most activities. She is able to hang out washing if he takes out the basket.
- DAS1 score of 4.7 METS. Uncertain when compared with history!

Examination

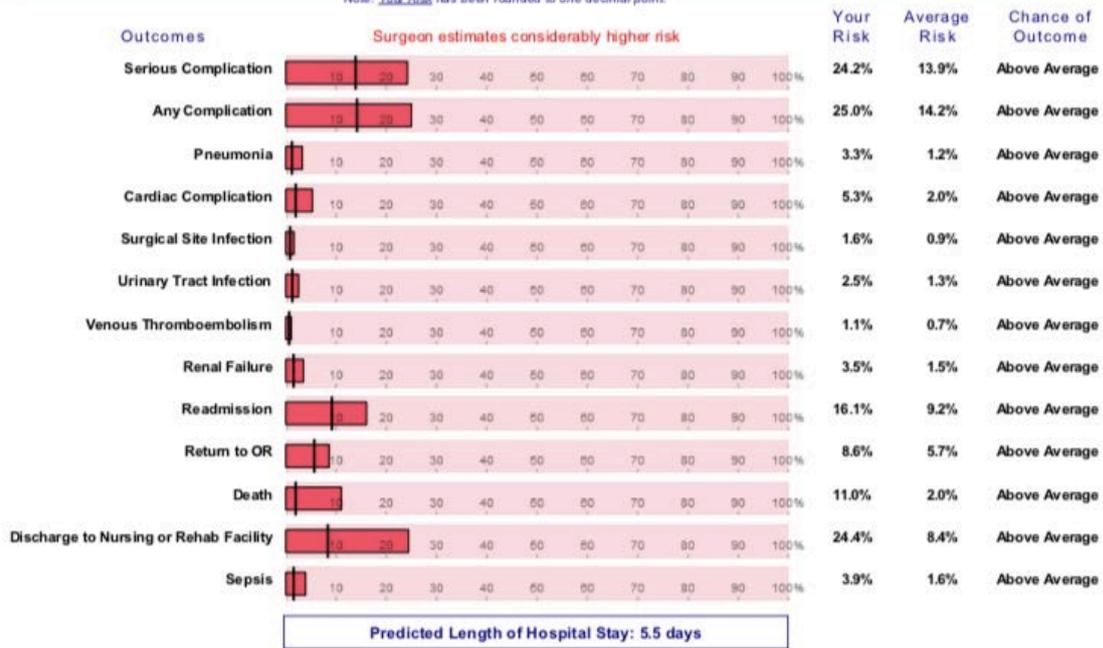
- No wheeze, patient sleeps on 2 pillows as sleeps better, no orthopnea or PND.

Risk scoring via NSQIP

Procedure: 0078T - Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal artery(s))

Risk Factors: 65-74 years, Severe systemic disease/constant threat to life, Diabetes (Oral), HTN, Dyspnea with moderate exertion, Smoker, COPD, Class I Obese

Note: Your Risk has been rounded to one decimal point.



Risk was discussed with the patient – she reports a desire for quality of life over quantity. She is not eager to proceed to surgery. A phone hook-up with her son took place and the advantages vs disadvantages was discussed. All agreed that surgery less desirable option.

Patient was referred back to surgeon. She is to have a repeat abdominal vascular ultrasound to assess rate of growth of AAA.

**Discussion: -**

- Discussion re high risk EVAR vs standard EVAR and risks of later complications – should this impact on the risk for the patient
- Discussion in regards to respecting patient’s wish for independent quality of life over quantity of life.
- Note that rate of growth of aneurysm may alter risk vs benefit of surgery. Patient wishes to discuss with the referring surgeon.

## **TOPIC 2:      Clavicle Fracture**

A 51 year old fit male who has a fractured clavicle after a mountain bike accident.

Previous trauma (also secondary to MTB accident!) with fractured ribs and post injury PE. No pro-thrombotic conditions on testing.

During his last surgery at POW in Sydney he reports a cardiac arrest under GA, with no CPR. Surgery was abandoned. He described that his chest was not sore and he was kept on a Holter Monitor for a number of days with no further complications. He was seen by Cardiology at the time but has not seen a Cardiologist since.

Takes daily Karvezide and no other abnormalities on physical examination. Current ECG – sinus rhythm at 75 bpm.

Further information was requested from POW.

- On the anaesthetic record it was noted : Post induction, before airway manipulation, SVT then 8 VEBs followed by a flat line.
- Rhythm strip showed bradycardia with possible escape rhythm

### **Discussion:**

1. Does he need his clavicle done? Bike riders are notorious for wanting to get back out on the bike as soon as possible!! This may help that happen sooner. However it's unlikely even with ORIF of clavicle that he will be selected for the tour de France anyway!
2. Should we investigate further – noted that at 51 years old he is likely to have further surgery. His ECH and rhythm should be discussed with the Cardiologists. This will be done at the Cardiology meeting on Thursday mornings.

## **TOPIC 3:      Nephrectomy**

A 67 year old male for R laparoscopic nephrectomy for right renal cell cancer with metastasis to hepatorenal angle. Tumour has been under surveillance for 2 years due to treatment for other cancers.

He was seen in clinic and had his surgery postponed.

Previous medical history

1. Stage 4 Lung Cancer 2016
  - Treatment with chemo-radiotherapy and immunotherapy (Nivolumab).
  - Complicated by pneumonitis – requiring cessation of immunotherapy and high dose weaning steroids.
2. Colorectal cancer
  - Curative surgery 2016
3. Type 2 diabetes
4. Bipolar disorder
5. Ex smoker - 50 pack years

Recent admission to CMH with SOB due lower respiratory tract infection and anaemia (Hb 100g/L). Noted to have a BNP of 1800. Managed with IV antibiotics and discharged home for follow up with oncologist and Echocardiogram. Not was made of masses on chest CT - ? progression of lung cancer.

## Investigations

- DASI – 3.9 METS. Reports exercise tolerance 1 FOS.
- Spirometry : FEV1 1.7L (53% predicted), with no obstruction.
- No echocardiogram performed.

After discussion with procedural anaesthetist this patient was referred back to the oncologist for assessment of their multiple cancers and prognosis. He was also sent for an Echocardiogram to assess cardiac function in the setting of res

## Discussion:-

1. Should we do this operation? A discussion was had with his treating oncologist after review. They reported:
  - His colorectal cancer is cured after his surgery
  - His lung cancer is no longer active after immune therapy (masses remain on CT, however they are not active)
  - His renal cell cancer has been watched and is metastatic.
  - Surgery for nephrectomy is to increase life expectancy and reduce risks of local complications of cancer growth.
  - He is not for further immune therapies after side effects of previous treatment.
2. Cardiac optimisation – Echocardiogram demonstrated systolic dysfunction with an LVEF of 30%. There were no other abnormalities. He is currently on ACEi and oral hypoglycaemic agents. He will be discussed at the next perioperative Cardiology meeting.
3. Role of CPET testing. Suggested that it may help risk stratify patient for complications. Others suggested that he is high risk no matter CPET result! CPET may provide information on cardiac or respiratory limitation to exercise, and provide useful baseline information for further exercise training pre-operatively.

See attached BJA paper on the considerations for the anaesthetist of Immune checkpoint inhibitors.

## TOPIC 4:        **EUA**

An 86 year old female for a EUA and pessary due to recurrent UTIs that have resulted in delirium.

### Previous medical history

1. Hypertension
2. Cerebrovascular disease
  - Lacunar infarct 2012
  - Subcortical infarct Jan 2019
  - TIA May 2019
3. Recurrent UTIs
4. Traumatic subdural haemorrhage 2018
5. Rheumatoid arthritis
  - Mainly in hands, neck ok.
6. DVT (2018)
7. Dementia and NH resident
8. Stroke 2019

Echo 12 months ago demonstrates : Mod AR and normal LV systolic function.

Medications : clopidogrel, rabeprazole, atorvastatin, irbesarten.

Advised to stop clopidogrel one week pre-operatively.

Presented to hospital on morning of surgery via ambulance with unilateral weakness and ? TIA/CVA. CT brain did not show any acute bleed. She had dual antiplatelet drugs re-commenced.

**Discussion:-**

1. High risk patient – is surgery really necessary? It seems that the recurrent UTIs were affecting the limited amount of cognitive function the patient had remaining.
2. Should we have commenced aspirin while off clopidogrel? Much discussion around pros and cons of aspirin continuation and the evidence with regard bleeding in the POISE trial. However, that evidence was in major surgery in patient with coronary and not cerebro-vascular disease.
3. On follow up, the patient made a full recovery with antiplatelets, IV rehydration and antibiotics.

**ADDITIONAL ATTACHMENT**

- See attached the latest release from ANZCA and the Australian Diabetes Society on Periprocedural Diabetic Ketoacidosis (DKA) with SGLT2 Inhibitor Use.

[http://www.anzca.edu.au/documents/ads\\_alert-update-\(002\).pdf](http://www.anzca.edu.au/documents/ads_alert-update-(002).pdf)