"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 21st March 2019. Publication date 28th March 2019.
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.

CASE 1:

There was a broad discussion around the use of the emergency button in the operating theatre. There was agreement that it is useful to harness resources in the setting of an emergency.

1. Are there policies or guidelines around its use? Should there be?
2. Does everyone in the operating theatre feel empowered to use it in the setting of an emergency?
3. What if the button is not pressed?

Various situations and permeations of situations were discussed. Further discussion with the Operating theatre committee advised that there is no policy on its use at JHH.

CASE 2:

67 year old male presented to the perioperative clinic for assessment for cystoscopy and SPC insertion. The indication for surgery is due to pain from the permanent IDC. His background medical history includes

- IHD – AMI 1998, with 2 stents. No recent cardiology follow up.
- Atrial fibrillation
- COPD – Home O2
- Obesity – 130kg
- Type II Diabetes Mellitus. Oral hypoglycaemic agents. Last HbA1c : 6.4 %
- Permanent IDC
- Chronic kidney disease – eGFR 31mL/kg/min

His last general anaesthetic was in November 2018 for a cystoscopy, with no reported complications. His current exercise tolerance is 5m on the flat and he normally mobilises with a wheelchair. His examination demonstrated reduced AE bibasally and pitting oedema to mid shin. His ECG showed SR.

Discussion:-

- Indication for surgery – not life threatening, however the pain from the IDC was significant for the patient. He accepted he was a high risk for anaesthesia.
- Consideration of LA only for this procedure. This case was discussed with the urology team. Their preference was for GA. It was noted that SPC insertion can be done on the ward. However an obese patient makes this difficult.

- His predicted mortality for this procedure was calculated with the SORT tool (available as app). The predicted mortality was 1.5%. Advanced care directives were discussed with this patient in the clinic with his family present.
- Any potential for optimisation of this patient? There was some signs of heart failure on examination. His last echocardiogram was done in 2015. It was felt that an updated echocardiogram would help quantify heart failure signs and symptoms.

CASE 3:

23 year old female P2G1 (30/40), admitted to hospital with non-labour uterine pain. She was previously on opioids, but discontinued due to side effects. Was prescribed a PCA, but refused to use it.

Her background medical history:

1. Asthma
- poorly controlled on symbicort, salbutamol and steroids
- is an inpatient in ICU on hi-flow oxygen due to type 1 respiratory failure
2. Klippel Trevanauy Weber
- Skeletal abnormalities, cutaneous haemangiomas, neuro-vascular malformations, coagulation disorders (DVT, DIC, PE)
- She has a very vascular thickened uterus – myometrial haemangiomas and varicosities.
3. Iron deficiency anaemia – currently on iron infusions
4. Anxiety/Depression

She has had a previous NVD with epidural. The obstetric plan is to manage patient and aim for vaginal delivery at 37-38 weeks.

Discussion:-

- Use of gadolinium for MRI in pregnancy to assess for abnormal vascular malformations around the spine. Unsure of current practice and safety. This was followed up with Dr Chris Abel (Radiologist) – current practice at JHH is to avoid gadolinium in pregnancy due to unquantified risk to foetus. Gadolinium is renally excreted and some studies have shown that it can accumulate in the CNS of young children with multiple exposures. The risks of this accumulation is unknown. In pregnant patients the gadolinium crosses the placenta and is exposed to the foetus. There is likely repeat recycling in amniotic fluid. If there is an overwhelming need for a contrast MRI for the safety of the pregnant mother, they will aim to delay the MRI to as late as possible to reduce the duration of exposure of the gadolinium to the foetus (assuming the neonate will then be able to clear the gadolinium).
- Use of pain holiday with epidural. Long discussion of pros and cons, including lively discussion from Dr Davies. The consensus was that while her pain may be relieved in the short term by an epidural, it is only a temporary measure, and the pain will likely be worse when the epidural is ceased due to reduced pain modulation.
- Risks associated with malformations of the uterus. High risk for torrential bleeding, aim for vaginal delivery. It was noted that communication should be made to the department about this patient, given that delivery may need to be expedited due to her current viral respiratory illness.