"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting 24th May 2018.
Publication date 31st May 2018.
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.

TOPIC 1: High-Risk surgery in nonagenarian

Background:

95 yo man, presented for anaesthetic consult for bowel cancer surgery – Presented with anaemia due to malignant polyp (since 2016)

Medical history:

- CABG + AVR done + PPM ? for AF on Rivaroxaban
- Renal impairment, Cr 140
- Anaemia, Hb 80s, regular iron replacement
- Background cognitive function not assessed, but son has noticed increasing forgetfulness

Clinically: walks less than 50m, minimal physical activities

Investigations:

- CXR; cardiomegaly, fluid overload
- Stress ECHO: EF 30%, perivalvular regurgitation, diastolic dysfunction gd III/IV

Question for discussion/suggestions

- Appropriateness for surgery? given the risk factors, high perioperative complications: cardiac, renal, exacerbation/acceleration of cognitive impairment

Surgical indication? Non-obstructive polyp, no immediate complication except occult PR bleed leading to anaemia. Non-cancer related life expectancy without treatment– 2-3 years?

- What do we do if we think that surgery is inappropriate but patient/family insists on surgery even though they understand the risks?
    1. Patient can seek second anaesthetic opinion.
    2. We should resist being pressured to do something inappropriate even if the patient/family 'wants' it.
    3. Give the patient/family time to think further and schedule a follow-up discussion
- Suggestion:
    1. Discussion with cardiologist - risk and benefit of stopping or modifying anti-coagulation as a way of reducing occult bleeding/anaemia
    2. Further explanation to patient and family – high perioperative risk >> benefit
    3. Cognitive assessment and ACAT etc– Will be appropriate for care planning regardless of surgery.

TOPIC 2: Surgery in patient with diabetic complications.

Background:

78 lady, Newly diagnosed uterine CA presenting for laparoscopic hysterectomy, BSO +/- pelvic LN dissection

Medical history:

- Poorly controlled diabetes with retinopathy, neuropathy, diabetic foot ulcers, ?nephropathy (improving and almost normalized renal function)
- Most recent endocrine review:- consult April 2017 reported improving sugar control after revised insulin ? lost to further follow-up
- Hypertension – well controlled
- CABG 2007 – cardiologist reviewed 2015: stable IHD
- Early Parkinson symptoms – mainly tremors: seen by neurologist 2.5 years ago, no treatment, ? lost to follow-up with neuro
- Mild cognitive impairment
- Mildly Overweight (BMI 30)
- Arthritis, bilateral rotator cuff tears
- Recent ophthalmic herpes zoster: on antiviral, eye drops, topical steroid
- Persistent bilateral foot ulcers: community nurse dressing, antibiotic, GP follow-up. Recently referred to Vasc Surgeon.

Clinically:

- Limited mobility, using 4WW, less than 100m (unsure what's the main reason ? arthritis ? SOB ? parkinson's symptoms? Obesity)
- PSM at tricuspid area and ESM at Aortic area, no signs of CCF

Investigations:

- BSL in clinic 19.1, HbA1C 9%(Aug 17), Cr 70, eGFR 72 (May 18)
- ECHO 2015; moderate diastolic dysfunction, mod bilatrial enlargement, mild PHT
- Repeat ECHO 2018: mild LVH, normal LV systolic function, impaired LV diastolic function, mild LA enlargement, mild AR, trivial TR, unable to calculate PASP

Question for discussion/suggestions

- Diabetic control: See Patient's endocrinologist before surgery OR JHH endocrine fast track referral for diabetic control. May need to admit one day early for BSL monitoring and insulin infusion.
- Ideally should have proper baseline neurocognitive and neurophysiology assessment, discussion with patient and family members about postoperative cognitive impairment.
- It's not just the glucose control:- Importance of 'minor' aspects of anaesthetic care:-
    - Careful positioning during surgery: shoulders, joints, foot ulcers
    - Careful eye tapes, lubricant
    - Pressure areas
    - Perioperative medication management
    - Infective complications