"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting 27/09/2018.
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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.

TOPIC 1: Full dental CL for recurrent abscesses

A 62 year old female for full dental CL for recurrent abscesses.
Factor V Leiden / unprovoked DVT – not anticoagulated.

-T2 DM – Hb AIC 7.7, newly diagnosed.
-Mod severe OSA
-IHD negative myocardial perfusion study.

Told by surgeon that Aspirin would cover DVT risk.

Discussed with Endocrinologist
- Happy Hb A1C 7.7
- Says unlikely to get her below 7.5

Discussed with Haematologist
- Happy for clexane but post-op.

Question: - Would you anaesthetize her with high Hb A1C?

Discussion: - Yes - endocrinologist consulted already. Recurrent abscess will interfere with glycaemic control as well so likely to be able to get better control post op.

TOPIC 2: Carotid Endarterectomy

A 52 year old female
CABG aged 39

- Recent NSTEMI 2017 - patient CABG
- Failed stent of native vessels
- Denies angina

-T2 DM – Hb A1C 7.3
- PVD – limits ex tolerance, claudication
Carotid disease incidental finding when Ix PVD.
90% occlusion ICA, 99% occlusion vertebral art.
1 no symptomatic stroke but radiologically basal ganglia stroke).
Sent back to original cardiac surgeon in Sydney.

“Low risk for surgery”
Offered no intervention
Sestamibi – reversible LV defects EF 29%
Echo: EF 54% inferoposterior hyokinesia
Revised Cardiac index: 11% risk of MACE

Question: - Is risk acceptable? (Given patient is fixed on cardiac surgeon telling her she is low risk).

Discussion: - HDU bed booked – definite requirement for admission

- Tight Haemodynamic control
- Awake surgery
- Risk is reasonable and about average for this group of patients.