"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 7th November 2019. Publication date 20th November 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: Bilateral parathyroid exploration on a 95 year old

A 95 year old Female for a bilateral parathyroid exploration with hyperparathyroidism. Apparently no focal hyperactive nidus (i.e. definite adenoma) identified. No reported osteoporosis or renal stones. Only (potential) hyper-PTH symptom is generalised aches & pains - the proposed indication for the surgery.

- PTH 96
- Calcium 2.84
- Respiratory – clear chest, 100m before SOB with AWW
- Social, lives alone, gets assistance with cooking and cleaning
- Patient is NESB & needs a person to translate.

Discussion: - If this was your Grandmother, would you want her to have the operation? Consensus was "No!" Suggestions were:

- Discuss our concerns as to balance of risk versus gain with surgeon (Dr Bendinelli).
- Patient thinks this will take away the pain.
- Would we be upsetting her general health if we went ahead?

CASE 2: Bronchoscopy, Right Mini Thoracotomy, Apical Resection/Nodes

A 73 year old Female for a Right Apical Lung Lesion

- Weight 70kgs, has lost 25kgs over the last 6 months
- BMI 25. Loss of appetite
- FEV1/ FVC 49%. FEV1 0.94 L (46% Pred)
- Significant SOB in clinic. Seemingly out of proportion to spirometry.
- Ex-smoker, quit 25 years ago
- Unprovoked PE 20 years ago – used to be on warfarin, stopped post episode of haematuria in 2014.
- Cardiac Sinus Arrhythmia
- Echo : Normal LV Function (2014)
- BSL – poorly controlled T2DM, HbA1c 10.3, BSL 19.1 at time of visit
- Had hypoglycaemic episode 4 days previously
- Diabetes maintained by GP

Discussion:-

- Concern expressed that weight loss out of proportion to that expected from small tumour without secondary spread. If metastases have been excluded is weight loss due to her poorly controlled diabetes?
- Also concerns about difficulty of ensuring euglycaemia perioperatively if patient presents on day of surgery with BSL/HbA1c similar to above. Suggestion to involve endocrine service's Rapid Access Team to optimise diabetic management, may require insulin infusion perioperatively.
- Also concerns about cause of SOB. Is it due to poor cardiac function & agreed a minimum she needs a TTE.
- Suggestion also made to re-evaluate in clinic next week including getting an ABG.
- Surgeon should be advised of concerns

CASE 3: **Laparoscopic Hysterectomy**

- A 68 year old for lap hysterectomy.
- Previous history of 2 Basilar aneurysms in 2014, with treatment via endovascular coiling.
- Follows up Neurosurgeon in Sydney
- Has known small MCA aneurysm, stable in size for 5 years. Now being monitored with 2nd yearly MRI/MRA
- Interestingly Neurosurgeon had recommended family screening every 5 years given patient's history and also 1st degree relative with cerebral aneurysm

Discussion: - Should we change our anaesthetic/surgical technique?

- Aim obviously is to avoid hypertension and keep BP stable through entire perioperative period.
- Laparoscopic hysterectomy more challenging in this regard than TAH intraoperatively because of positioning & pneumoperitoneum but more comfortable & therefore presumably less hypertension afterwards.
- Consensus was that it would be reasonable to attempt Laparoscopic procedure but to try & minimise head down tilt & warm surgeons of possible need to convert to TAH.

CASE 4: **L4 Laminectomy (re-do)**

- Known ischaemic heart disease : Triple vessel CABG in May 2019.
- Spirometry : FEV1: 2.05 L. FEV1/FVC 69%
- Asbestos exposure
- Follow up with respiratory specialist
- Rheumatoid, Psoriatic and osteoarthritis
- Social – lives with wife, needs help with ADLS, Truck driver – Air conditioning Duct Work (Asbestos), Social drinker.
- Patient has chronic back pain/ no weakness.
- Cardiologist seen in June wasn't initially aware this surgery was coming up.

Discussion: - What's the Risk?

- Reasonable to discuss with cardiologist/cardiac surgeon to seek "clearance" for elective surgery.
- Would a longer wait would be better for patient?
- Anti-platelet drugs - Aspirin will need cessation for this procedure
- Bypass surgery successful if viewed in light of now having reduced perioperative risk for cardiac events
- Note : discussed with Cardiac surgeon – Ok to proceed

CASE 5: Gastroscopy +/- Banding

A 72 year old Male for a Gastroscopy +/- Banding

- In AF - 2.9% yearly risk of stroke (CHAD Score).
- Possible oesophageal varices given chronic alcoholic
- Cardiologists want clearance to start anticoagulation
- Background
    - 20 beers per day now down to 10 per day
    - Crohn's disease
    - 1 episode of PR Bleeding in past.
- Liver no cirrhosis, impaired. 26 Bilir, GGT 230, ALP 122.
- Renal normal, coagulation normal, AST normal, Platelets normal.

Discussion: - Concerns were not about risk or appropriateness of procedure itself, but whether this patient is an appropriate candidate for anticoagulation (even if no varices).

- Have the cardiologists considered this patient's risk of bleeding?
- This risk can also be calculated using the "HAS-BLED" score. https://www.mdcalc.com/has-bled-score-major-bleeding-risk Using this tool, his annual risk of major bleeding approaches 10% (& the algorithm suggests alternatives to anticoagulation should be explored).
- Other concerns included: This is someone who may he unlikely to even take his medication. Also, patient still drinking a lot every day and do you want him to be anticoagulated every day?