"From the Trough"
Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting
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.

Date : 29/6/23

TOPIC 1: Stoma revision, high perioperative risks

81yo male for revision of ileostomy for massive herniation of stoma

Background

- Previous ultra-low resection of rectal cancer in 2020
- Bowel obstruction from parastomal hernia (2021) complicated by toxic megacolon (requiring multiple operative interventions) and T1RF requiring ICU admission
- Urothelial cancer: was awaiting open radical nephron-uretectomy → deemed inappropriate due to peak poor functional capacity with CPET: peakVO2 10.5mL/kg/min, AT 6.2mL/kg/min. Having palliative radiotherapy and expected survival >12months.
    - Has functionally improved since this period
- COPD. FEV1 1.39L
- HTN, hypercholesterolaemia
- IDDM
- CKD: eGFR ~40 (not expected to deteriorate with radiotherapy)
- Ex-smoker: 30PYH.
- 4WW for longer distances; walking stick at home
- Needs assistance around household

Issues

- **Elevated perioperative risks**
    - Frail (CFS 5)
    - Two previous episodes of postop T1RF
    - Very high risk prediction from CPET results, for any major surgery

- **Lack of advanced care planning** – patient + family member not engaged in discussion about ceilings of care
- **Complex surgery due to hostile abdomen -** Possibility of limited extra-peritoneal surgery however not guaranteed
- **Quality of Life** – currently reduced significantly by challenges and discomfort managing herniated stoma

Discussion

- Very high risk of perioperative morbidity and mortality – does the patient accept these risk in attempt to reduce discomfort/challenges from hernia?
- Would the patient engage in prehabilitation?

Plan

- GP to provide ACD paperwork

- Prehabilitation arrangements
- MDT input regarding limitations of care and goals of care following prehabilitation
- Anaemia screen +/- iron
- GP to encourage ACD discussions

TOPIC 2: CDM - ? for open AAA

60yo male. ? fitness for AAA repair for infrarenal AAA

Background

- IHD – RCA disease: stented 2020. Subsequent dobutamine stress ECHO normal. Awaiting sestamibi.
- OSA – on CPAP
- Obesity – 114kg
- IDDM: HbA1c < 8.5%
- Rheuamtoid arthritis – hands and feet only
- DASI 5.5METs
- Respiratory:
    - PFTs: FEV1 2.52L, FEV1/FVC ratio 0.84. Minor restrictive pattern
    - Current smoker
    - OSA on CPAP

Issues

- **Elevated perioperative risk**
    - CPET:
        - Submaximal test. HR to 68% maximal (on beta-blocker). Limited by leg weakness
        - AT 4.78mL/kg/min, peakVO2 8.9mL/kg/min, V/VCO2 49.7 (all in high risk stratum)
        - No ischaemic ECG changes
        - Likely secondary to deconditioning and chronotropic limitation

Discussion

- Group understanding was that open procedure preferred in this setting due to patient age
- Chronologic age and physiologic age not equivalent
- May benefit from prehabilitation – SBP remained < 180mmHg during CPET which means exercise is possible (in context of AAA).
- Consideration for EVAR given high risk for open procedure

Plan

- Prehabilitation
- Smoking cessation
- Await results of sestamibi
- Discussion with surgeons regarding EVAR as option

TOPIC 3: Massive goitre, frail and comorbid

89yo female total thyroidectomy for large goitre. Symptoms of SOB, dysphagia and orthopnoea.

Background

- HTN
- AF – no embolic events
- T2DM – HbA1c 7.8%. Occasional hypoglycaemia
- CFS – 5

- RA – no neck involvement
- CKD – eGFR 35
- Low ET: DASI 3.9METs
- Recent COVID infection in May

Issues

- **? Appropriateness for surgery**

Discussion

- ? Requires further investigations for SOBOE – does the history fit with goitre as the cause of the symptoms
- High risk surgery, but patient is aware of risks and feels the symptoms from goitre are affecting her QoL
- Awaiting ACD planning

Plan

- Advanced care planning
- Consideration of TTE and further investigation for SOBOE to exclude causes separate to the goitre.

TOPIC 4: TURBT for bladder amyloidosis

66yo Cystoscopy + TURBT for bladder amyloidosis. Recent admission with haematuria and clot retention.

Background

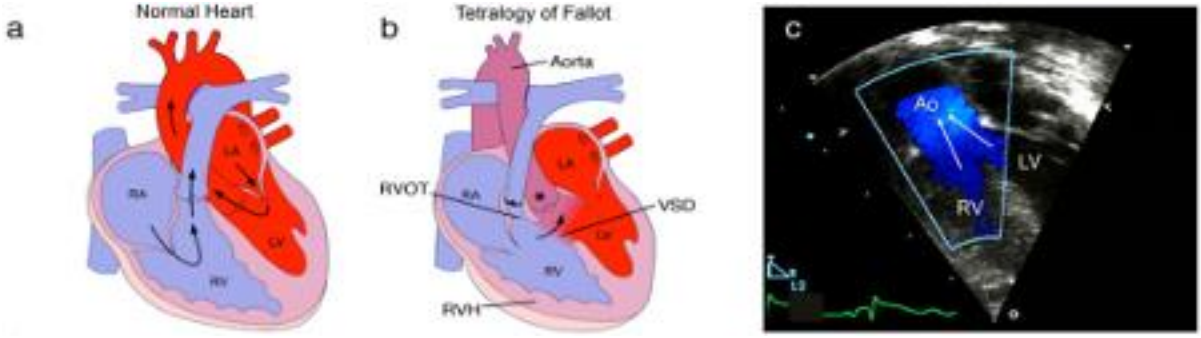
- Tetralogy of Fallot: full correction at 17yo. Tissue valve replacement (?which valve) in 2011
- AICD+PPM for CHB: 2 shocks (last in 2010). Paced 85% of time
- OSA – adherent to CPAP
- Amyloidosis – localized to bladder. No systemic manifestations

Issues

- **PTSD from procedures as child – wanting to avoid procedures where possible**
- **Surgical options**: ?flexible cystoscopy, but will require yearly TURBT
- **Increased SOBOE**: awaiting cardiology review and ECHO

Discussion

- Reasonable to await cardiology review
- Avoidance of procedure now (with conservative flexi cystoscopy) likely to lead to further hospital admissions with haematuria/retention and unlikely to avoid need for procedure
- Tetralogy of Fallot:
    - VSD with overriding aorta, RV outflow tract obstruction and RV hypertrophy
    - Presents in the neonatal period with murmur and/or cyanosis
    - In present times, patients usually undergo complete intracardiac repair during the neonatal or infant period
    - Common long term complications of repair include pulmonary regurgitation, RV failure, atrial arrhythmias, and ventricular arrhythmias.



Plan

- Await cardiology review and TTE

TOPIC 5: Osteonecrosis of the jaw secondary to radiotherapy

82yo male for mandibular reconstruction

Background

- Parotid tumour with mandibular involvement → radiotherapy and subsequent trismus
- Previous AFOI for resection, but unsuccessful surgery
- Asbestosis with pleural plaques
- T2DM

Issues

- Osteonecrosis of mandible → seen by ENT outpatient clinic → nil acute intervention required

- Poor spirometry, but inadequate study due to being unable to fit mouth of spirometer mouth-piece. Reassuringly, able to ride bike 8-10km/d.

Discussion

- Reassuring functional capacity despite poor spirometry
- Has not been on any agents associated with osteonecrosis of jaw (denosumab)
- Reassuring the patient had successful AFOI in past. Previously good experience

Plan

- No acute changes or interventions required