Perioperative Interest Group
PIG Weekly Meeting Minutes
Thursdays Weekly 12.30pm – 1.30pm

Date: 31 October 2013

Chair: Ross Kerridge Registrar:

Record of Attendance: Julie-Anne Avard, Michelle Davies, Tracey Taylor, Leanne Saillard, Mich Poppinghaus, Ross Kerridge, Todd Eggleton, Jo Walsh.

CASE 1: ***Patient with a lupus anticoagulant found on a previous blood test 12 months ago and confirmed on testing at the preoperative clinic. How should this affect management?***

"Lupus anticoagulant" is a confusing term as the various proteins that are included under the term 'lupus anticoagulants' cause 'anticoagulation' or prolonged APTT in vitro but are pro-coagulant invivo, Population prevalence in a normal population is about 1%. In the absence of any history of thrombophilia, it is accepted that it is inappropriate to give any intervention or therapy, and the finding of the lupus anticoagulant alone does not indicate an increased risk of DVT. Appropriate management perioperatively is to be scrupulous to ensure that the patient gets "normal" DVT prophylaxis, but otherwise the patient should be managed normally.

CASE 2: ***33 year old woman with an umbilical hernia and history of hereditary angioedema manifesting in facial swelling and abdominal pain.***

There are case reports of these patients developing fatal airway obstruction due to angioedema after only minor trauma (even clipping of finger nails!) This patient had been seen by Michael Boyle. On his recommendation, she was admitted the day before surgery. She was on long term Danazol. She was given an infusion of C1 preoperatively, repeated on the morning after surgery. The anaesthetist avoided airway manipulation for this case and there were no adverse outcomes.

CASE 3: ***A Jehovah's Witness patient with multiple comorbidities presenting for a hip replacement.***

Apart from her medical problems, she is also a Jehovah's Witness. This was noted in the clinic however no further action was taken. The orthopaedic surgeons subsequently enquired about whether she should be loaded with EPO preoperatively. Her blood count was normal (Hb 134) but iron studies showed a ferritin of 35 (NR 30-300). The NBA guidelines suggest that a ferritin of 30 to 100 may imply mild iron deficiency and on this basis it was decided that she should have intravenous iron therapy preoperatively, but not EPO. EPO could be seen as having possible adverse effects of causing a hyper-viscosity syndrome, and is probably not indicated in the absence of significant anaemia. Intravenous iron takes up to 2 days to become available for haemopoiesis, as it must be processed by macrophages and redistributed to the erythrocyte-producing cells. Hence it is better to give it preoperatively rather than at the time of blood loss.

Todd Eggleton related a recent case of a Jehovah's Witness involved in a trauma who bled down to a haemoglobin of 36. He was given iron and EPO in intensive care at this time and his haemoglobin was 98 two weeks later.

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CASE 4: ***What is the appropriate management of a patient on Prasugel (trade name Effient)?***

Prasugel is a strong anti-platelet inhibitor acting by blocking the ADP3 receptor. It has recently gone on PBS, and has become more commonly used. It is a stronger antiplatelet agent than clopidogrel, but otherwise broadly analogous. In acute cardiology interventions, use of prasugel results in less post-stenting infarcts, but an increased risk of adverse bleeding events. Similarly to clopidogrel, it does not "wear off", but new platelets are not affected. Therefore in a patient with normal haemopoiesis, stopping the drug about 5-7 days preoperatively should give adequate platelet activity at the time of surgery. Ticagrelor is a similar drug, with similar effect, which may become more commonly used when listed on PBS.

CASE 4: ***38 year old lady with multiple sclerosis and 34 weeks pregnant transferred her care to Newcastle from Southern Queensland because of the intransigence of the anaesthetic team at another hospital to consider the possibility of regional anaesthesia intrapartum.***

She was admitted the day before induction for careful neurological assessment and documentation neurologically. An epidural was then performed once she went into established labour and she had an uneventful vaginal delivery without complications.

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Date: 7 November 2013 Chair: Libby Freihaut Registrar: Adrian Boyn,

Record of Attendance: James Atkins, Penny Taylor, Ross Kerridge, Peter Flynn, Julie-Anne Avard, Michelle Davies, Maree Toth, Kara Stuart, Deanne Smith.

TIMING OF MEETING

The timing of the meeting was discussed. There is no "perfect time". It was agreed that it would be better to meet from 12pm to 1pm rather than 12.30pm to 1.30pm. Meeting to continue on Thursday lunchtimes for the time being. The possibility of rotating the day during the week was considered but not this year.

CASE 1: ***A 42 year old patient with an extensive cardiovascular history (STEMI and CABG in June 2013). Has very bad dental pathology. For multiple dental removals. Patient has difficult intubation. What notification should be given to procedural anaesthetist?***

DISCUSSED: It was agreed that a 'warning note' to the procedural anaesthetist was appropriate, but it was inappropriate to expect the clinic staff to spend time trying to ring the procedural anaesthetist or take steps over and above this unless there was a particularly complicated problem. We should expect that our colleagues will check the patient records on the night prior to surgery.

CASE 2: ***Documentation of assessment of difficult intubation generally***

It had been noted that some anaesthetists are using a glide scope (or other video scope) as their first choice when managing a patient who has signs of being a possible difficult intubation. This means that there is no assessment and documentation of the view that would be obtained using a Macintosh blade. It was suggested that it would be preferable as a routine practice to assess the patient using a Mac blade and document the view obtained, and then use an alternative laryngoscope, unless there was good clinical reason to avoid the Mac blade step. Alternatively consider assessing the "Mac view" after intubation etc

CASE 3: ***82 year old for EVAR for a 6.4cm aortic aneurysm with renal artery involvement. Patient has an extensive ischaemic heart disease history. Last seen by cardiology 3 years ago, and has been stable and asymptomatic since then, on maximal medical therapy.***

A new sestamibi shows an ejection fraction of 47% and reversible ischemia in a smallish apical/inferior area. Should the patient be postponed and referred to cardiology for review? There was some suggestion that the sestamibi was probably pointless in the first place. It was agreed that it would be appropriate to discuss the case at the Thursday cardiology meeting, however it would be very surprising if the cardiologists suggested any intervention.

(OTHER CASES WERE ALSO DISCUSSED BRIEFLY)

Proposing or submission of cases for PIG Meeting

It was suggested that a template for submission of cases to the PIG meeting should be developed, loosely based on forms used in multidisciplinary oncology meetings. The idea is that anaesthetists with cases that they wish to discuss could summarise the case, and the questions to be raised, and then even if they could not attend the meeting a record of the discussion could be sent back to them, as well as form the basis for an ongoing record. This could also be an educational resource and practice viva questions etc.

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Date: 14 November 2013 Chair: Leanne Kitto Registrar: Vinay Rao

Record of Attendance: Ross Kerridge, Kim Rackemann, Vinay Rao, Ben Piper, Julie-Anne Avard, Michelle Davies, Leanne Sailyard, Ellie Malone, Nicole Grainger, others

CASE 1: Unexplained 'Faints' – how much of a concern?

A 62 female for laparoscopic TAH/BSO etc for endometrial cancer with history of treated hypertension, diabetes treated with metformin, BMI 32, otherwise reasonably well. Recently had two episodes of reasonably conventional faints, including one in a hot McDonalds whilst waiting for a meal. Recovered quickly. Patient had not been particularly concerned but mentioned it during consultation. Normal ECG, reasonable exercise tolerance. No Murmur. Should she be investigated further?

DISCUSSED: Possible causes 1.Vasovagal, 2.Autonomic dysfunction (diabetes) 3. Transient arrhythmia, 4. Aortic stenosis, 5.Carotid Stenosis 6.Other. Patient has risk factors of hypertension and a risk factor of diabetes, but no symptoms of vascular disease. The history was of reasonably classical vasovagal faint. Surgery needs to be done. Given the moderate surgery, it was felt not appropriate to delay or to investigate further. Even for more extensive surgery if the history and examination was clear it was felt reasonable just to accept the presentation as a vasovagal and only do investigations that would be otherwise indicated.

CASE 2: ***Patient for bariatric surgery with OSA & poor compliance, poorly selected & prepared.***

For open gastric bypass due to previous abdominal surgery (included failed bariatric surgery some 10 years ago). BMI 54. OSA with an AHI of 48. Has refused to use CPAP. Type II diabetes on diabex and diamicron but poor compliance. Limited exercise tolerance due to knee pain but otherwise health seems okay. BSL in the clinic of 17. Seen on a Thursday, surgery scheduled for Monday with 'waitlist reduction' imperative, and other pressures. Was it appropriate to postpone to improve diabetes control?

DISCUSSION: There was concern that the patient may not be psychologically appropriate for this surgery, and that the screening and preparation process that was appropriate for bariatric surgery had not happened. There are external considerations driving this case to be done. Echocardiogram to check for pulmonary hypertension and right ventricular changes. Outpatient optimisation will be difficult given the patient compliance. Check HBA1C and discuss with surgeon. (Post script) after discussion with the surgeon, and noting that the HBA1C was 9.8, it was decided to admit the patient on Friday for urgent endocrine review and stabilisation of blood sugars over the weekend and review on Monday prior to surgery. This case to be discussed further with the surgical executive to clarify what arrangements would be in place for future bariatric surgery.

CASE 3: ***Urgent Surgery with a Drug Eluting Stent 7 Months ago.***

Patient with a urethral mass (cancer) and a DES inserted in March 2013. Had been on coplavix. Surgeon had ceased this two weeks preoperatively. Substituted aspirin with a plan to stop three days preoperatively. Cardiologist who inserted the DES was unhappy, felt that aspirin should be continued. Surgeon was not happy with this. Discussed with procedural anaesthetist. He was happy to go ahead on this basis.

DISCUSSION: In this case there had been no communication between cardiology and surgeon – (and there was never going to be!) Cardiology input is of value to advise on size and placement of stent, and thus consider the likely consequences of perioperative stent thrombosis. Should this sort of case be "bridged" with tirofiban? This has been discussed a few times at perioperative cardiology meeting. A draft protocol has been developed but has never been used in three years since. Bridging has its own problems. Pragmatically, it seems that most centres manage these cases without using tirofiban bridging. A well-documented plan for post-operative management should be developed.

CASE 4: ***Question – should ACE inhibitors be continued or ceased prior to surgery?***

It was noted that at Gosford ACE inhibitors are continued on all cases preoperatively. The most recent 'Up to Date' review indicates that there is equivocal evidence either way.

DISCUSSED: There is a choice between risk of low BP intraop vs high BP pre and post-op. Suggested that in patients having major regional anaesthesia, and in those with well controlled hypertension, or on ACE inhibitors for other reasons, where the blood pressure is normal or low normal in the clinic, it is probably appropriate to withhold ACE inhibitors on Day of Surgery. Conversely, if a patient has a blood pressure that is high or high-normal in the clinic, then ACE inhibitors should be continued on day of surgery. There is room for individualisation in this situation.

CASE 5: ***A patient is having low risk surgery with no pathology results on our system. Should they have "background blood tests"?***

Discussed for some time. There are some guidelines on this, broadly based on what would be the appropriate tests for a patient presenting to a GP for the first time. The costs of simple blood tests is not high – probably less than the costs of chasing up the past results done on other systems……

CASE 6: ***Appropriateness of Surgery***

There was discussion (again!) of the appropriateness of some patients being presented for back surgery, particularly where they have not had appropriate non-surgical management. It was noted that some of these patients had been knocked back for surgery by some surgeons, but accepted by others. It was suggested that the issue should be raised with surgical executive and with clinical governance.