"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting on 20th June 2019.
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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.

Attendance: Monica Diczbalis, Mark Davies, Paul Healey, Pat Farrell, Rebekah Potter (Chair)

TOPIC 1: Pragmatic approach to scheduling surgery

78/F for ankle replacement
Significant pain, unstable joint, limited to wheelchair outside the house.
Issues:
1. Patient also suffers from recurrent cholecystitis and is awaiting cholecystectomy.
Orthopaedic procedure was scheduled to occur first, however it was suggested that the risk of perioperative gallbladder sepsis necessitated the cholecystectomy taking precedence. This was raised with the orthopaedic surgeon who was keen to proceed for scheduling reasons (delaying the procedure to await cholecystectomy would result in a significant delay due to surgeon availability).
Discussion:
Risk of gallbladder sepsis is probably low, but particularly in the setting of joint surgery, definitely undesirable. This may be balanced by the need to be pragmatic about scheduling.
Outcome:
Discussed with orthopaedic surgeon again who confirmed significant delay would be likely. Proceeding with ankle replacement.

2. Poorly controlled asthma with significant obstruction on spirometry. Non-compliance with medications contributing to poor control.
Discussion:
Procedure could be performed under a spinal. Some discussion around embarking on a regional technique when you are not happy to proceed to GA (ie. If regional fails). Suggested that failure will be identified before surgery commences and if the duration of the procedure can be confirmed there should be no need to convert (or if it is expected to be longer, consider an epidural).
Brief discussion around usefulness of repeating spirometry to assess the impact of (hopefully) improved compliance with medications. Felt that it would be unlikely to change management, especially if already planned for a spinal.
3. Significant dysphonia for 6-12 months. No other symptoms apart from slight SOB when lying flat.
Discussion:
Threshold for investigating voice change.
Given the patient's background of smoking and the persistent nature of the change it was felt it was reasonable to exclude a lesion that may impact airway management. Particularly given the ease of performing nasendoscopy.
Outcome:
Referred to ENT clinic. Nasendoscopy performed excluding significant pathology.

TOPIC 2: Anaphylaxis to fentanyl

27/F G1P0
Patient seen in clinic as a complex obstetric patient
Issues:
Anaphylaxis to fentanyl - history from patient of requiring adrenaline following administration of fentanyl. No formal allergy testing.
Discussion:
1. Benefit of/indication for allergy testing. Most felt that this would be worthwhile to confirm sensitivity to a ubiquitous drug.
2. Solution for epidural infusion - LA only vs LA with morphine. LA only suggested as a reasonable first line, but noted that as morphine is chemically unrelated to fentanyl it should be safe to use.

TOPIC 3: Investigating new atrial fibrillation

82/M with AF awaiting hernia repair

Patient's rate was 70 bpm without medication.

Discussed at cardiology meeting. The usual investigations for new onset AF include: ECG, echocardiogram and pathology (including thyroid function testing). In addition to usual investigations for AF it was recommended that the patient undergo Holter Monitor testing.

This was suggested that this investigation is useful in identifying particular sub-groups of patients:

- Patients who have significant tachycardia outside clinic visits
- patients who need closer follow up and potential pacemaker insertion (eg. patients with tachy-brady syndrome).
- patients whose rate decreases overnight and may benefit from a shorter acting beta blocker that does not slow rate overnight, such as Atenolol.

According to society guidelines this is generally considered an "additional" rather than "baseline" test in patients with AF (see below), but perhaps something for us to consider in addition to our usual investigations.
2014 AHA/ACC/HRS Guideline for the Management of Patients with Atrial Fibrillation
http://www.onlinejacc.org/content/64/21/e1
Recommended investigations:
- ECG, CXR (if pulmonary disease or HF is suspected), TTE for all patients
- blood tests should include serum electrolytes, thyroid, renal, and hepatic function tests, and a full blood count.
Ambulatory rhythm monitoring (e.g., telemetry, Holter monitor, and event recorders) as an additional test to judge the adequacy of rate control.

Canadian Cardiovascular Society Atrial Fibrillation Guidelines 2010: Etiology and Initial Investigations
https://www.onlinecjc.ca/article/S0828-282X(10)00016-4/pdf
Ambulatory monitoring again described as non-routine but useful in selected cases.