"From the Trough"

Perioperative Interest Group Notes

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 10/6/21

TOPIC 1: **Recurrence nasopharygeal cancer**

61 year old male for EUA and nasopharyngeal biopsy - ? recurrence of nasopharyngeal B cell lymphoma.

Background

1. Nasopharyngeal B cell lymphoma 2020
   - Diagnosed in China in 2020 where patient was working
   - Treatment with chemotherapy (R-CHOP x 5)
   - Prolonged hospital admission and repatriation back to Australia
   - Complicated by recurrent aspiration pneumonia despite PEG tube, upper limb DVT requiring anticoagulation, MSSA bacteraemia due to CVC infection.
   - Severe depression post discharge – currently on Mirtazepine.
2. Ex-smoker (40 pack years)
3. SCC neck 3 years ago. Surgical resection of superficial SCC and lymph nodes.

Issues

- Phone consultation – however patient only able to answer yes/no to questions. Further information via D/C summary Concord hospital and niece.
- Limited airway assessment on phone!
- Aspiration risk. Ensure PEG feeds ceased at normal fasting times.

Discussion

- Difficulty of airway assessment for phone consultation was discussed. In particular the head and neck and ENT surgical patient population. Note that most ENT patients have FNE documented at their outpatient appointment on DMR. There is no photos, however detailed descriptions are made. Therefore do we need further airway assessment! The pros and cons of further assessment for airway planning was discussed. This patient had multiple featues of difficult airway and aspiration risk.

- Airway management for procedure. Pros and cons of ETT vs THRIVE were discussed. Note recurrent aspiration despite PEG. Question raised : does THRIVE increase aspiration risk? Limited evidence noted.

- Short notice patient seen 1 day prior to surgery. Phone call to treating anaesthetist to 'pre-warn' them of patient on list.

TOPIC 2: Elderly female with ? endometrial cancer

89 year old female with PMB and bilateral pelvic masses.
Distant patient (Armidale), with proposed procedure – laparoscopy, BSO, D + C, cone biopsy or LLETZ +/- mirena insertion.

Background

1. AF on warfarin
2. CCF – managed medically, PRN frusemide. Low normal systolic function on most recent Echo.
3. CVA – 2012 with only remaining effect of impaired balance requiring walking stick.
4. HTN
5. Severe OSA – on CPAP with good compliance
6. Severe pulmonary hypertension on Echo cardiogram (2/21) Estimated PASP – 65mmHg.

Issues

- Phone consultation – patient requesting due to difficulty of transport and travel. Long conversation, including trends in weather and climate!
- Patient very involved in decision making around health care. At this stage uncertain about optimal management and location. Considering less invasive options at hospital in Armidale (i.e D and C/Mirena) vs travel to Newcastle for larger laparoscopy. Has even consulted her old GP for advice, who she felt had similar values to her own! All her local friends also have opinions to consider!
- Higher risk patient – NSQUIP risk score – mortality 1.8%, serious morbidity 13%, discharge to location other than home 22%. Although DASI by phone was 4.6 METS.

Discussion

- Difficulty of phone consultation for 'tricky' patients. The triage criteria for phone vs face-to-face appointments was discussed. At this stage major surgery (LOS> 1day) was the baseline consideration for face to face. However the Preoperative clinic is taking feedback on other groups of patients who it is felt were better suited to face to face appointments. Note that there is currently Medicare funding for telehealth consultations until Dec 2021. Although it seems unlikely that a post-pandemic world will return to all face to face appointments!
- Invasive vs non-invasive treatment options for surgery. Patient was having ongoing consideration of treatment. At this stage she is planned for D and C on day of surgery in Newcastle.

TOPIC 3: Morbid obesity, OSA and diabetes

50 year old female for Laparoscopic salpingo-oopherectomy +/- laparotomy +/- mirena exchange. Multi-loculated ovarian mass on US.

Phone consultation.

Background

1. Morbid obesity – BMI 48
2. OSA – tested 6 years ago, not requiring CPAP, however now 25 kg heavier
3. Diabetes – poor control HbA1c 14%
4. Smoker – 20 per day.
5. Asthma – uses Ventolin once per month. No hospital admissions.

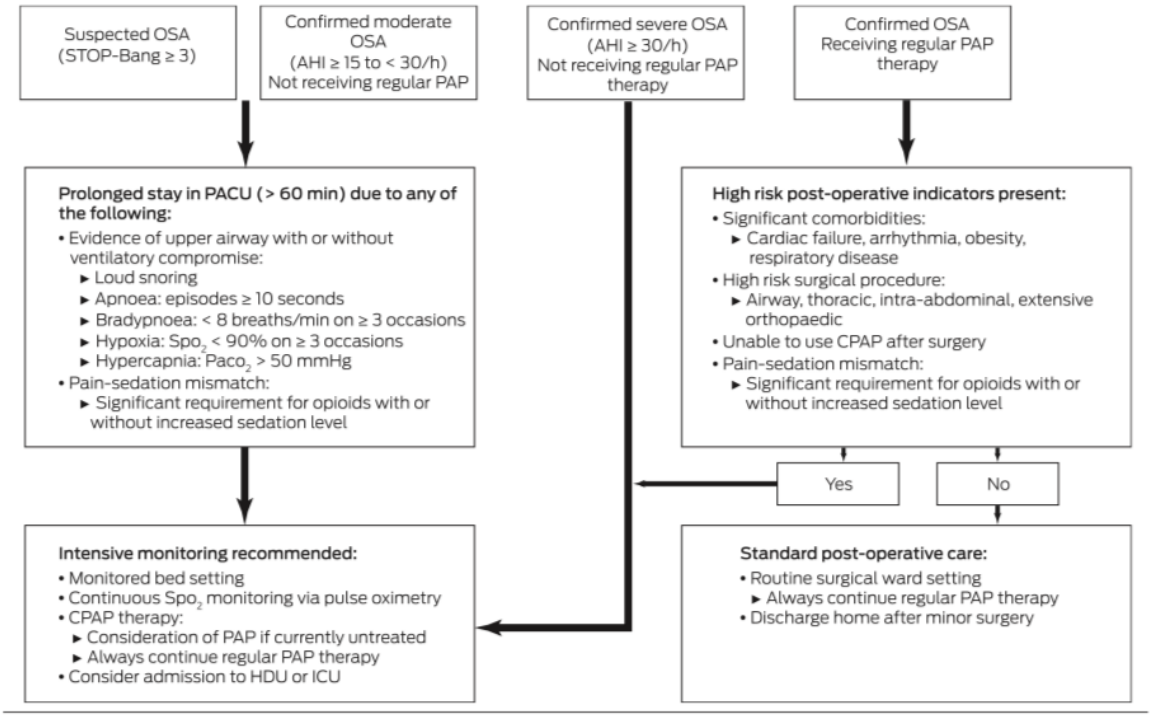
Issues

1. Diabetes optimization – was referred to rapid access
2. OSA – likely worse now. However limited time to optimize prior to surgery.
3. Smoking – advised to stop

Discussion

- How long to wait to optimize patient. This patient has many potentially modifiable preoperative risk factors. However following discussion with surgeons, they recommended a maximum delay of 1 month to optimize conditions, in order to avoid potential progression of disease.
- Attempt made to reduce smoking and optimize diabetes. Patient commenced on opti-insulin (old Lantus). Poorly compliant and limited interation with Rapid access diabetes service.
- ICU post operatively. Note previous OSA at lower weight not requiring CPAP. Uncertain invasiveness of procedure. At this stage listed as ICU3 – ie potential for ICU, however not requiring ICU bed prior to starting surgery. Note attached guide on management post operatively for those patients with known OSA. Ideal location post-operatively is with respiratory monitoring (RR and SaO2). ICU may be excess to needs, however is only option in current JHH set up.

4 Postoperative risk stratification and management of patients in post-anaesthesia care unit (PACU) with confirmed or suspected obstructive sleep apnoea (OSA)*



AHI = Apnoea–Hypopnoea Index; BMI = body mass index; CPAP = continuous positive airway pressure; HDU = high dependency unit; ICU = intensive care unit; $Paco_2$ = arterial partial pressure of carbon dioxide; Pao_2 = arterial partial pressure of oxygen; PAP = positive airway pressure; SpO_2 = peripheral oxygen saturation measured by pulse oximetry. * Adapted from Seet and Chung[51] and Hillman and Chung[52] and from the ASA[32] and SASM[33] guidelines. ◆