"From the Trough"

Perioperative Interest Group Notes

Pig Notes 8/4/21

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.

TOPIC 1: Colon cancer and angina

Referral letter from a general surgeon requesting an urgent perioperative consult for a 63-year-old man with ascending colon cancer.
Daily angina and history of PCI sometime in the last 10 years

Background

- PCI for coronary artery disease in last 10 years
- No regular cardiology follow-up
- No anti-platelet therapy and never been on DAPT
- Daily exertional angina after walking 20-30 metres and after meals
- IDDM
- Morbid obesity

Issues

- Urgent surgery
- Consult letter is concerning that patient is high risk and not optimally managed
- More information is required in order quantify perioperative risk

Discussion

- Patient should be referred for stress imaging
- Discussion around different modalities of stress imaging. Little evidence to suggest superiority, both nuclear imaging and stress echo have high NPV for post op cardiac events.
- Stress echo investigation of choice by cardiologists but not easy to obtain in our district, especially in an urgent setting
- CTCA discussed, non-invasive test, better predictive value in younger people with decreased calcium load
- CTA vision study showed that CTCA over-estimated risk of MACE compared with RCRI. (paper attached)

- Discussion around benefits vs risks of PCI in the setting of urgent surgery.
- May not be possible to delay surgery for 3- 6 months if coronary intervention required
- Newer DES require shorter duration of DAPT
- Need to consider that PCI may not confer a clinical benefit unless a LAD lesion with large areas of myocardium affected

Plan

- Urgent perioperative consult
- Sestamibi and resting echocardiogram
- Referral to rapid access cardiology clinic already underway from surgical team
- Can also be discussed at weekly cardiology meeting

TOPIC 2: Cardiac Anaesthetist for Ganglion Removal

29-year-old lady for elective ganglion excision from her wrist.

Background

- Netherton syndrome – rare autosomal recessive disorder. Characteristic triad of congenital ichthyosiform erythroderma, a specific hair shaft abnormality termed trichorrhexis invaginata ("bamboo hair"), and an atopic diathesis.
- 2 syncopal episodes a few years ago thought to be due to acquired long QT
- Regular cardiology review with recent normal echo and holter.
- No current evidence of long QT, normal ECG at clinic

Issues

- Patient's mother is requesting cardiac anaesthetist for procedure as per previous cardiologist
- Anaesthetist called new Cardiologist with mother in room, advised she does NOT need to have a cardiac anaesthetist
- Patient's mother became distressed and left the consultation after extensive discussion that a cardiac anaesthetist wasn't required for this procedure. She stated that she no longer wanted to proceed with surgery.

Discussion

- Difficult situation to navigate
- Anaesthetic consultant and the patient's current cardiologist were both involved in the discussions
- The benefits of regional anaesthesia in peripheral surgery were discussed. This was unfortunately declined due to anxiety.
- Techniques to manage the expectations of the patient while still working within acceptable limits of time and clinical resources
- Examples of strategies from pain clinics outlined
- Elective procedure, option to delay surgery and allow family time to consider options
- Complex social and medical needs of family were recognised as significant stressors

Plan

- Follow-up nursing phone call with family revealed that patient has decided to proceed with surgery as planned
- Procedural anaesthetist informed of events

TOPIC 3: CREST Syndrome for Colonoscopy

67-year-old lady, consult from gastroenterologist for a colonoscopy

Background

Positive Faecal-occult blood test
PET scan shows potential Right-sided lesion

Issues

- CREST syndrome with Moderate pulmonary hypertension (on right-heart catheter)
- NYHA class 4 dyspnoea
- Attends Pulmonary hypertension clinic
- Currently on a phosphodiesterase inhibitor, tried numerous other therapies without success
- Significant co-morbidities including SLE and autoimmune hepatitis with liver cirrhosis (Childs-Pugh B)
- Currently being assessed for home oxygen

Discussion

- Consult letter states that the lesion appears low risk from the PET scan and there is the option to wait and repeat the scan
- Discussion around suitability for surgery in the event of a cancer diagnosis from colonoscopy
- Likely not a surgical candidate but many non-invasive options for cancer symptom-management
- Consensus was that the option for a colonoscopy was available to this patient. Some opinions differed on any further optimisation for this surgery.

Plan

- Multidisciplinary discussion required
- Unclear if the proceduralist feels the colonoscopy is currently indicated or would prefer to wait
- More information required before proceeding

TOPIC 4: Right Frontal Insertion of Rickman Reservoir

63-year-old lady normal pressure hydrocephalus.
History of headaches and dizzy spells.

Background

- IDDM with suboptimal glycaemic control, HbA1C = 12%
- On 110 units of Ultra-long and rapid-acting insulin per day
- Previous endocrine reviews reveal poor glycaemic control over many years
- Compliant with medications but doesn't have a glucometer
- No known diabetic complications but history difficult due to neurological symptoms
- COPD – NYHA 3 dyspnoea, current smoker
- DASI 4 METS

Issues

- Very keen for the procedure to proceed as symptoms limiting quality of life
- Difficult to ascertain reasons for poor glycaemic control
- Patient unaware of potential implications to health, particularly in the perioperative period
- Distance patient, postponement on the day of surgery would be a major inconvenience to the patient
- Unable to contact proceduralist, junior team members contacted and happy to continue

Discussion

- Endocrine and GP review organised but limited time
- Should we try and admit the patient the night before and commence an insulin infusion?
- Risk of no bed being available then procedure could be postponed
- Consensus that procedure is high risk for postoperative infection and should be postponed

Plan

- Operating Surgeon eventually contacted – happy to defer until glycaemic control improved.
- Expediate endocrine and GP reviews

TOPIC 5: Thoracoabdominal aneurysm repair and CSF drain

58-year-old lady for repair of a thoraco-abdominal aortic aneurysm

Background

- Significant vascular disease; 4.8cm aortic aneurysm, renal artery stenosis of single functioning kidney
- Mesenteric ischaemia requiring inferior mesenteric artery stent in 2020. On life-long Dual antiplatelet therapy (DAPT)
- Ex-smoker, 40+pack year history
- Active, no limiting symptoms. Works in aged care.

Issues

- Surgeon requesting CSF drain insertion for spinal cord protection but would like patient to remain on DAPT. (See attached paper on CSF Drain for SC Protection)
- Phone call to surgeon explaining that DAPT would need to be ceased in order to facilitate a neuraxial procedure
- Significant surgical concerns for IMA stent patency if DAPT were to be ceased

Discussion

- Discussed with haematologist, platelet transfusion would not be a solution
- Multiple possible options presented including brief cessation of clopidogrel and insertion of drain day before. Issue of what to do when epidural catheter in and for removal discussed.
- Tirofiban discussed due to its reversibility – limited experience
- Can the procedure be postponed allowing a longer time period between insertion of the IMA stent and cessation of DAPT?
- Consensus that insertion of the CSF drain prophylactically while on DAPT would not be accepted safe practice

Plan

- Issues discussed with surgeon. Agrees for clopidogrel to be ceased pre-operatively to facilitate CSF drain.

TOPIC 6: Toe Amputation Vs Hiatus Hernia Repair

78-year-old lady for amputation of 4 toes due to valgus deformity

Background

- Long-standing valgus deformity of toes, limiting ability to wear shoes
- Wheelchair-bound following complex ankle surgery on other foot
- Hiatus hernia with significant symptoms including daily nausea and vomiting, waterbrash and a hoarse voice

Issues

- Hiatus hernia repair scheduled for 4 weeks after foot surgery
- Patient very keen to proceed with both procedures as scheduled

Discussion

- Likely safer to defer foot surgery until after hernia repair
- Patient is aware of risks and if wants to proceed then that is reasonable

- Neuraxial anaesthesia is an option

Plan

- Discuss with general surgeon as they may not feel that timing of the foot surgery gives adequate recovery time before hernia repair