Guidelines for the Preoperative Process

Preparation of Patients for
Procedural Sedation and Anesthesia.

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PREOPERATIVE ASSESSMENTS

The Departments of Anesthesiology and Internal Medicine are committed to facilitating the best possible care for patients by providing all surgeons and other providers, who require anesthesia services for their procedures, a clear process for pre-anesthesia evaluations, preoperative testing, and perioperative management algorithms.

Please follow the attached guidelines to help ensure that your patient’s anesthesia care is not cancelled or delayed on the day of the procedure.

For all cases scheduled for surgery, interventional, and endoscopic procedures, please follow the process outlined below:

1. **TRIAGE.**
   
   a. Please have your patients fill out the “Patient History Questionnaire” attached to this letter and return by mail or by fax to the Pre-Admission Testing Center (PATC) at Hartford Hospital.

   The Patient History Questionnaire and all Preoperative Guidelines are also available online at: [http://xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx](http://xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx).

   b. Refer to our Preoperative Guidelines to determine the appropriate triage for preoperative assessment. Please determine if your patients should be scheduled for a Pre-Admission Testing Center visit. This will be either an Anesthesia Consult or a routine visit. It may be possible that your patient may completely bypass this step if deemed appropriate, and simply show up the day of their procedure.

   c. To schedule an appointment or to speak with a staff member for preoperative evaluation guidance please call (860) xxx-xxxx.

2. **TESTING AND INSTRUCTIONS.** Follow the Preoperative Guidelines to determine what laboratory studies and additional tests are required; as well as what medications to hold on the day of surgery, and NPO guidelines. When sending patients to the PATC for their preoperative assessment, please fill out and sign an order sheet stating what lab studies you would like performed on your patient prior to surgery. Please only order lab studies that you want, and not ones that you think Anesthesia will want. The PATC practitioners will order appropriate labs for Anesthesia. This order sheet can be scanned and emailed or faxed to PATC in order to allow quick access by practitioners in the PATC. This will help eliminate unnecessary lab studies and minimize confusion regarding required lab work.
3. **OUTSIDE STUDIES.** If outside facilities are utilized to generate lab studies, other diagnostic tests, or consultation reports, please obtain these results, and scan / email or fax to PATC directly so they are available. Additionally, the patient should be instructed to bring copies of these results with them to the PATC the OR on the day of the procedure. For every patient requiring an ECG, please inform them to obtain a copy (whenever possible) of a previous ECG for comparisons.

4. **PATC REVIEW OF OUTSIDE EVALUATION.** Patients that do not require a PATC visit may still have reports or diagnostic tests, as well as H&Ps that should be made available 72 hours prior to surgery. This will allow a review of their findings preoperatively, and determinations made regarding fitness for procedures. For these patients, their reports should be scanned and emailed to PATC by your office staff, or may be faxed directly to our Clinical Documentation Center at (860) xxx-xxxx along with a cover sheet detailing the patient's name, full eight digit Hartford Hospital medical record number if available, birth date, date of surgery, and surgeon's name. This information is then converted to our document management system (???) allowing electronic access to these documents.

Please instruct your patients that they will be contacted the day prior to their surgery (Friday for Monday surgery) by a nurse from the Preoperative area. Make certain your patients have valid phone numbers where they may be contacted during the day. If the patient has not received a phone call by 8:00pm, please have them call one of the numbers listed below, depending on where they are scheduled for surgery:

- Hartford Hospital (PATC)- (860) xxx-xxxx.
- West Hartford Surgery Center – (860) xxx-xxxx

**HISTORY AND PHYSICAL EXAMINATION**

History and physical examination, per JCAHO standards, must be **within 30 days** in stable patients (from the date of planned surgery), and updated on the day of surgery by the surgeon.

If a patient routinely receives care from a specialist, i.e. cardiologist or pulmonologist, a recent note from that physician about the patient’s current status is invaluable for our evaluation. Additional information such as a recent stress test, pulmonary function tests, echocardiograms, etc., is always helpful.
PREOPERATIVE TESTING

There is good evidence in the literature that routine pre-operative testing does not improve perioperative outcomes, may do harm, and is very expensive. In an effort to reduce unnecessary testing, we are recommending utilizing the following approach.

Pre-operative testing should be individualized based on the results of a careful medical history and physical exam, which must be done no later than 30 days prior to the procedure. The invasiveness of the surgery should also be considered.

Enclosed for your review, is the ASA Physical Status Classification System and the Classification of Surgical Procedures ranked by invasiveness. Categories 1-3 are relatively non-invasive and any lab work should be guided by the patients’ condition. Category 4-5 are quite invasive and may require some lab and x-ray and EKG work-up even in relatively healthy patients.

ASA Physical Status Classification System

Classification system adopted by the American Society of Anesthesiologists for assessing preoperative physical status.

I. A normal healthy patient
II. A patient with mild systemic disease
III. A patient with severe systemic disease
IV. A patient with severe systemic disease that is a constant threat to life
V. A moribund patient who is not expected to survive without the operation
VI. A declared brain-dead patient whose organs are being removed for donor purposes

The addition of an 'E' indicates emergency surgery.

Classification of Surgical Procedures (For detailed list of procedures - see Appendix A)
PREOPERATIVE EVALUATION ALGORITHM

Definitions:

**Low Risk Medical Conditions** — Healthy with no medical problems (ASA I) or well controlled chronic conditions (ASA II)

**High Risk Medical Conditions** — Multiple medical comorbidities not well controlled (ASA III) or extremely compromised function secondary to comorbidities (ASA IV).

**Low Risk Surgical Procedure** — poses minimal physiological stress (ex. – minor outpatient surgery).

**Intermediate Risk Surgical Procedure** — Medium risk procedure with moderate physiological stress and minimal blood loss, fluid shifts, or postoperative changes.

**High Risk Surgical Procedure** — High risk procedure with significant fluid shifts, possible blood loss, as well as perioperative stress anticipated.

**A** — May have preanesthesia assessment done day of surgery

**B** — Recommend PATC remote screening or visit at least 24 hours preoperatively. Should have evaluation performed by PMD prior to visit.

**C** — Recommend PATC visit at least 48 hours preoperatively. Should have evaluation performed by PMD prior to visit and anesthesia consult.
General Guidelines for all patients scheduled for low or intermediate risk surgery with no significant comorbid conditions (ASA I or II):

- **Do not obtain routine laboratory tests** (CBC, Coagulation studies, Electrolytes, BUN and Creatinine) in patients undergoing minor or routine procedures who do not have a significant past medical history.
- **Do not repeat tests** in patients with normal CBC, Metabolic Panels or Coagulation values within 4 months of surgery and no change in clinical status since these labs were obtained.
- **ECG only on asymptomatic patients with significant risk factors** for atherosclerotic disease. ECG is acceptable if done within 1 year of surgery and no interval change in cardiac symptoms over this period of time. If there is any cardiac history, or the previous tracing is remarkable for abnormal findings, then a comparison tracing is required within one month of surgery.
- The following **new onset EKG abnormalities** require further cardiac evaluation:
  - Any **new onset cardiac arrhythmia**, i.e. atrial fibrillation or flutter, SVT, Type 2 second degree or 3rd degree heart block, LBBB
  - ST wave elevation or depression
  - Q wave pattern indicative of MI
  - Prolonged QT interval with hx of syncope or family hx of sudden death
  - Short PR interval with palpitations, syncope
- The following diagnoses, if noted in previous EKGs or by physician history, usually do not require further evaluation:
  - First degree or Type 1 second degree heart block
  - Known RBBB, LBBB, LAFB, PVCs
- **No CXR or PFTs** unless patient has active pulmonary disease or symptoms.
- **No coagulation testing** (PT/PTT, platelet count) unless there is a history of bleeding, easy bruising, or the patient is **on anticoagulants**. Please reference the section on “Preoperative Medication Management Guidelines” below.
- **Hb/ HCT on any suspicion of severe anemia** due to menstrual blood loss, history of anemia or leukemia, recent chemotherapy or radiation therapy.
- **Glucose testing for all diabetic patients** on day of surgery, whether on insulin or oral agent.
- **Pregnancy testing will be offered on the day of surgery** for appropriate patients if warranted by surgeon order, medical history or patient request. Exception to testing is history of tubal ligation, hysterectomy, or patient refusal. Any patient with a positive pregnancy test will be counseled regarding known effects of anesthesia and surgery, and given the option to proceed or postpone based on this discussion.
**Specific Guidelines for ASA III or IV status patients with Medical Conditions that may require focused evaluations and testing:**

For patients with underlying diseases, focused evaluations and tests are outlined in the "Algorithms for Preoperative Management" (please reference Appendix). If the patient routinely receives care from a cardiologist or pulmonologist, a note from that physician about the patient’s current status and results of any testing is very valuable for our pre-operative evaluation. We want the benefit of information the referring physician has, so we can determine anesthetic risks and plan optimal anesthetic management.

Consultants should not be asked to “clear the patient for surgery” or anesthesia but should answer three questions:

1. What is the severity of the patient’s medical disease?
2. What is the patient’s cardio-pulmonary reserve and is there additional testing needed to further clarify severity of illness?
3. Is the patient stable and medically optimized at this time?

**PREOPERATIVE FASTING GUIDELINES**

In general, all patients should be NPO after midnight for all procedures the next day.

*For late afternoon cases only:*

- Clear liquids until 4 hours prior to scheduled arrival at surgical site
- Water, black coffee or tea (*NO CREAM OR MILK*, sugar is OK)
- Clear broth or juice; no pulp - “see through”

These afternoon case exceptions will be discussed *individually with the patient by the preoperative nurse* the day before surgery and should not be discussed by the surgeons’ office with the patient.

**Children 1-10**

- NPO 6 h for food, including animal/breast milk, or formula
- NPO 2 h for clear liquids

**Children < 1**

- NPO 6 h for food, including animal milk or formula
- NPO 4 h for **breast milk**
- NPO 2 h for clear liquids

Note: all times are prior to scheduled arrival time due to uncertainties regarding gastric emptying, such as gastroparesis/ileus, obesity (BMI>35), or narcotic use.
PREOPERATIVE MEDICATION MANAGEMENT GUIDELINES

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