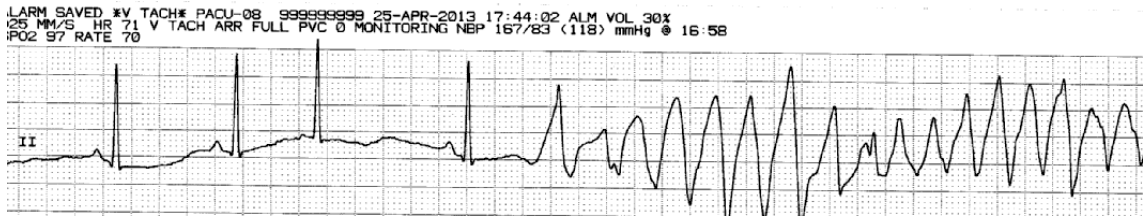


Wisconsin Society of Anesthesiologists 2013 Annual Meeting – Jonathan Kay, MD Handout

This case helps illustrate the current status of “clearance”.

A 62 y.o. lady is scheduled for C4-C7 anterior discectomy and fusion electively and requests cardiologic evaluation because her family member died “under anesthesia”. She has no risk factors except mild hypertension recently diagnosed. She insists on seeing a cardiologist because of the history. Two cardiologists opine that the patient is “cleared”. Beta blockade is recommended, instituted two weeks before surgery, but is poorly tolerated and discontinued one week before surgery. She has an absolutely uneventful geta is transferred to PACU where she is held for several hours awaiting bed placement. After visiting with her husband and eating dinner with him in PACU she becomes unresponsive and her rhythm is shown below.



After one and half hours of cpr she is pronounced dead.

The 2007 AHA/ACC guidelines for cardiac evaluation for patients having noncardiac surgery suggests abandoning the use of the word “clearance” in favor of risk stratification and optimization. The era of the surgeon requesting “clearance” from a primary care giver so that an anesthesiologist does not delay or cancel his case has ended if we follow these guidelines, which have been adopted by the ASA.

Current generations of anesthesiologists,pcps, and consultants, still labor with the tradition of “clearance” –despite the official disavowal of the concept in 2007. Shifting from this binary approach of “cleared” or “not cleared” to a thoughtful risk stratification, optimization paradigm involves more work on the part of pcps, and consultants. Instead of a one liner on a prescription pad intoning “patient is cleared”, the guidelines ask consultants and pcps to quantitate comorbidities, to assess patient’s function, and to discuss short and long term planning with the perioperative team. More importantly, surgeons and proceduralists no longer get a green light go or red light stop when asking for perioperative consultation from pcps/consultants. They may get a puzzling report instead.

Every anesthesiologist has his favorite “clearance” story of a patient who was cleared by the pcp, and/or the consultant cardiologist, only to “crash” and burn despite the magic mantra of “clearance”-like the case example shown above. Many anesthesiologists feel intimidated by the current process, situations in which the patient was not ready for a procedure by virtue of having active unaddressed problems but the patient had been already “cleared.” How does an anesthesiologist

explain to the surgeon and patient that the “clearance” was totally bogus and yet still retain the good will of the surgeon who is inconvenienced, dismayed, and puzzled? How does the anesthesiologist explain to the consultant/pcp that the new ecg changes should be investigated rather than deferring investigation to after the procedure? How does the anesthesiologist explain to the patient that the same health care system that supposedly “cleared” him is really competent to carry out the rest of his care?

This paradigm shift in approach to patients at the most basic level impacts all specialties, hospital and operating room efficiency, scheduling, and most importantly in 2013 the bottom line. The table below from Tulane estimates the lost revenue by subspecialty of cancelled cases.

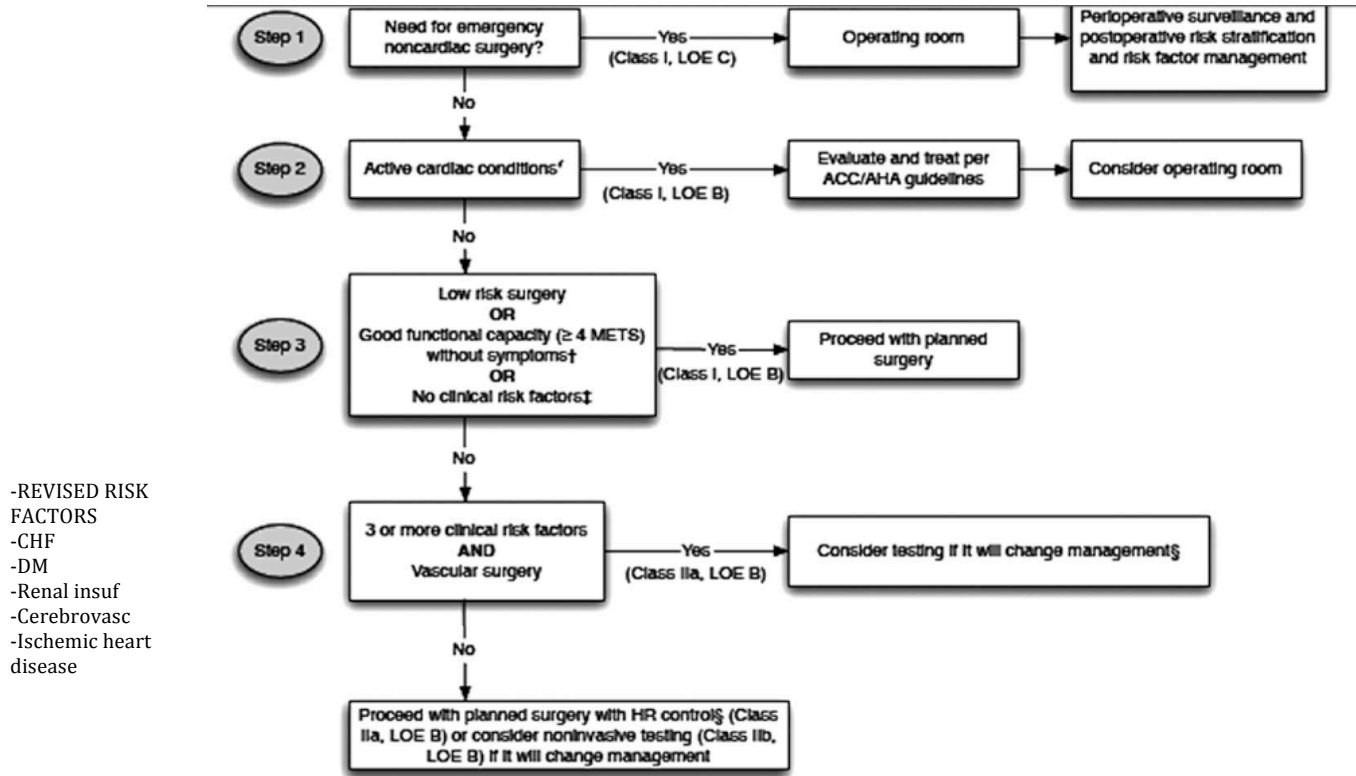
Specialty	Total, n	Total Loss Revenue, \$	Revenue Loss Per Case, \$
General Surgery	45	211,810	4,707
Neurosurgery	2	2,825	1,412
Ophthalmology	11	40,712	3,701
Orthopedics	11	78,962	7,178
Otolaryngology	9	14,913	1,657
Pediatrics	6	34,186	5,697
Plastic Surgery	3	7,628	2,542
Radiology	6	13,156	2,193
Thoracic Surgery	7	38,804	5,543
Urology	4	30,179	7,545
Total	104	473,175	4,550

Although it is difficult to put an actual money value on delays, they similarly impact the bottom line and patient satisfaction.

Our goals for this lecture:

1. Explain how the new guidelines work using case examples
2. Explore the steps needed to start the Herculean task of changing human behavior to institute the guidelines
3. Consider how and where the anesthesia consultant fits in this brave new world

Revised Guidelines



We will explore this simplified version of the new guidelines with specific cases:

1. 76 y.o. stemi with known severe CAD, DM, and prior stroke for orif of femur. BNP is severely elevated. Oliguric for the last 12 hours.
2. 50 y.o. with severe HOCM for elective robotic prostatectomy
3. 92 y.o. with severe aortic stenosis for orif of femur

References for clearance redux:

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Fazio G et al. Drugs to be avoided in patients with long QT syndrome: Focus on the Anesthesiological Management. World J Cardiol. 2013. 54(4): 87-93.

Fleischmann KE, Bechman JA, Buller CE et al 2009 ACCF, AHA Focused update on Perioperative Beta Blockade. 2009. JACC: 54(22); 2102-2128.

Fleisher LA. Cardiac risk stratification for noncardiac surgery. Update from ACC/AHA 2007 guidelines. 2009. Cleveland Clinic Journal of Medicine. 74(4)s9-s15.

Lubarsky D. Giving Anesthesiologists what they want: How to write a useful preoperative consult. Cleveland Clinin Journal of Medicine:2009. 76; S32-S36.

Please address inquiries/comments to Jonathan Kay using email: jkay11@mac.com