



# Preoperative Anesthetic Assessment

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## Objectives:

- Learn pre-anesthetic patient evaluation and risk stratification.
- Obtain a full history and physical examination including allergies, current medications, past anesthetic history, family anesthetic history.
- Understand how patient comorbidities can affect the anesthetic plan.
- Be able to understand potential anesthetic options for a given surgical procedure.
- Be able to plan an anesthetic for a basic surgical procedure.
- Understand risk stratification of a patient undergoing anesthesia.
- The perioperative patient journey.

### Color index:

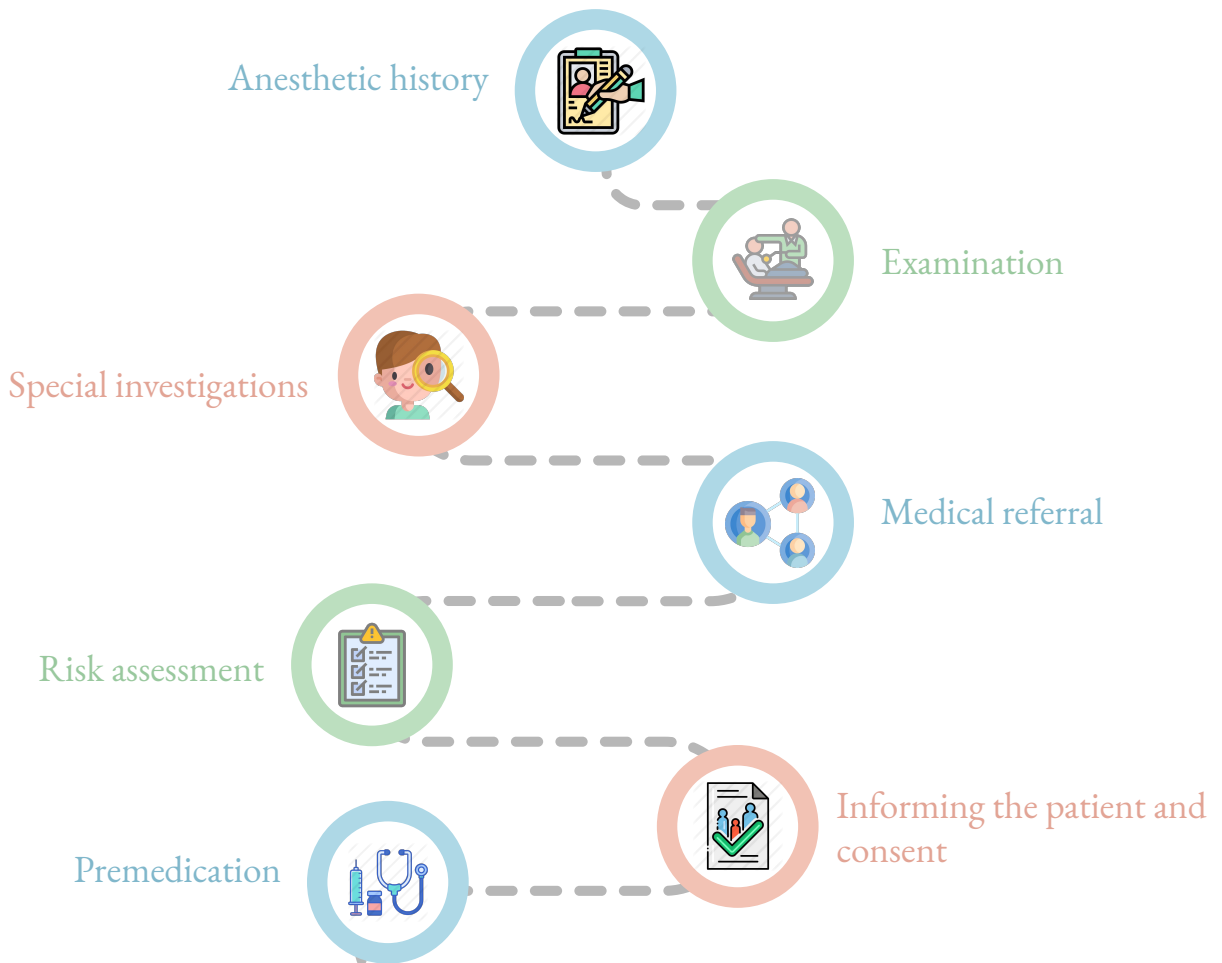
- Red: important /
- Black: content slides
- Gray: extra
- Green: dr. Notes



# NCEPOD: Classification of intervention (National Confidential Enquiry into Patient Outcome and Death)

|           | Description  | Example   |
|-----------|--|---|
| Immediate | Life/Limb/Organ saving<br><ul style="list-style-type: none"> <li>- Resuscitation occurs simultaneously with surgery</li> <li>- Surgery within minutes</li> </ul> | - Rapid bleeding: trauma, ruptured aneurysm, blunt injury |
| Urgent    | Life/Limb/Organ threatening<br><ul style="list-style-type: none"> <li>- Surgery within hours</li> </ul>  | Perforated bowel or less urgent bleeding                  |
| Expedited | Early surgery<br><ul style="list-style-type: none"> <li>- within a day or two</li> </ul>   | Large bowel obstruction, closed long bone fracture        |
| Elective  | Timing to suit patient and hospital  | Joint replacement, unobstructed hernia repair, cataract   |

## Overview: The preoperative visit



# The Goal of Preoperative visit

The preoperative visit of all patients by an anesthetist is an essential requirement for the safe and successful conduct of anaesthesia

Main aim is to assess the patient's fitness for anesthesia. The best to be performed by an anesthetist, preferably the one who is going to administer the anesthetic.

## The goal of preoperative visit:

01

To educate about anesthesia, perioperative care and pain management, to reduce anxiety.

02

To obtain the patient's medical history and physical examination.

03

To determine which lab test or further medical consultation are needed .

04

To choose care plan guided by patient's choice and risk factors.

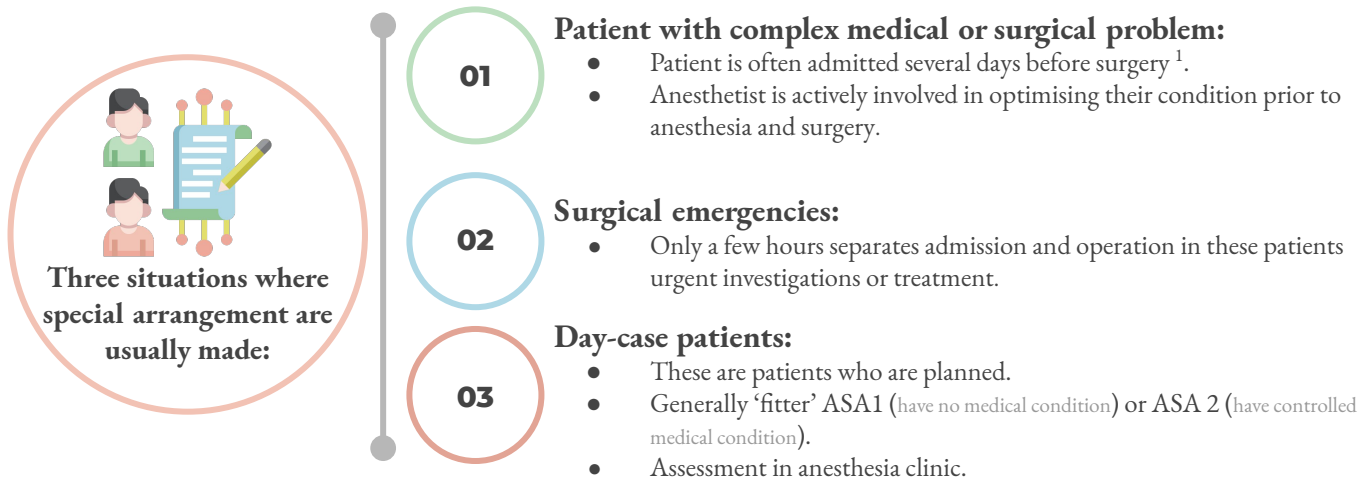
### Visit allows

- Best anaesthetic technique
- Any potential interactions between concurrent diseases
- Anaesthesia anticipated
- Provides an explanation
- Reassurance for the patient

### Coexisting illness

- Improve the patient's condition prior to surgery
- Seeking advice from other specialties
- Optimise treatment
- Final decision

# Preoperative visit:

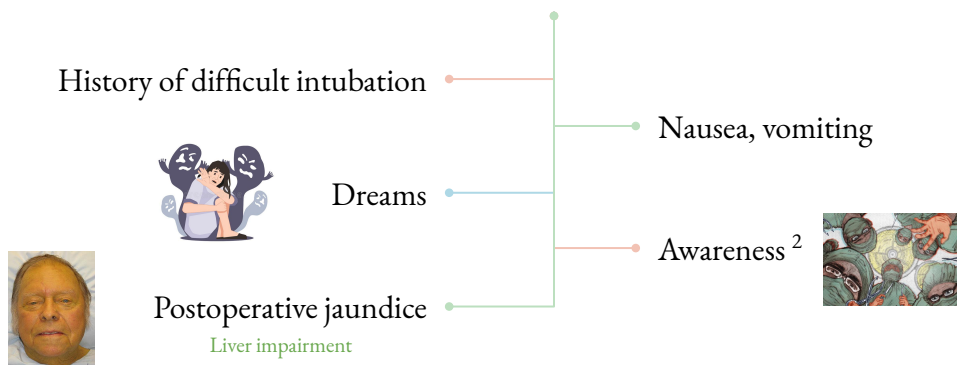


## Anesthetic history And Examination:

Previous anesthetics and operations:

- Hospitals.
- Enquire about inherited or 'family' diseases: sickle-cell disease, porphyria.
- Difficulties with previous anesthetics

## Difficulties with previous anesthetics



## Present and past medical history:

- All the aspects of the patient's medical history.
- Relating to the cardiovascular and respiratory systems and its severity.

1- For necessary investigations to be done like cardiography, X-ray or echo before surgery.

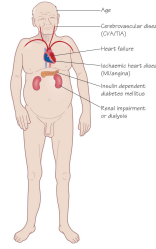
2- Patient can recall what he heard during surgery (intraoperatively).

# Anesthesia Inquiries in history

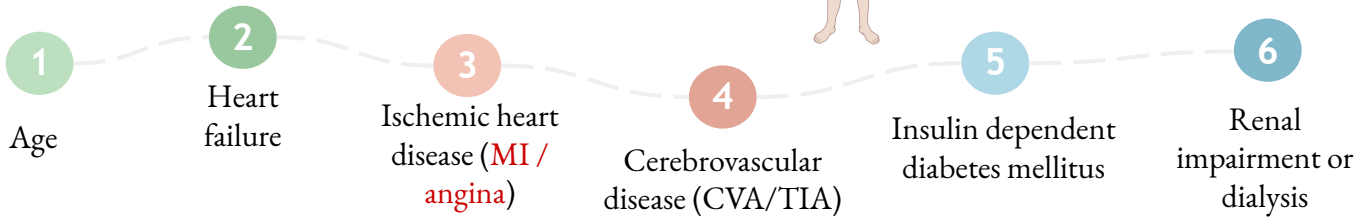
Anesthetic history



## Cardiovascular system



Patient factors associated with cardiac risk:



Specific inquiries must be made about:

1. Angina: Incidence, Precipitating factors, Duration, Use of antianginal medications, e.g. glyceryl trinitrate (GTN) oral or sublingual.
2. Previous myocardial infarction and subsequent symptoms.
3. Symptoms indicating heart failure: Heart failure will be worsened by the depressant effects impairing the perfusion of vital organs <sup>1</sup>
4. Myocardial infarction are at a greater risk of perioperative reinfarction
5. **Elective surgery postponed until at least 6 months after the event**
6. Untreated or poorly controlled hypertension (diastolic consistently > 110 mmHg) may lead to exaggerated cardiovascular responses.
7. Both hypertension and hypotension can be precipitated → which increase the risk of myocardial ischemia.
8. Valvular heart disease: prosthetic valves may be on anticoagulants, need to be stopped or changed prior to surgery and give Antibiotic prophylaxis <sup>2</sup>

| Active cardiac condition   | Minor cardiac condition  |
|--|--|
| Unstable coronary syndromes (severe or unstable angina, recent MI)   | Advanced age >70   |
| Decompensated CHF  | Abnormal ECG:<br>- LV hypertrophy<br>- LBBB<br>- ST-T abnormalities<br>- Rhythm other than sinus |
| Significant arrhythmia or heart block. Affect hemodynamic of the pt, induce severe chest pain/mental status.       |  |
| Severe aortic or mitral valvular disease (AS<1.0 cm ; mean gradient 40 mmHg; symptomatic mitral or aortic disease) | Uncontrolled systemic hypertension   |

1- Patient should be assessed properly. Doctor should request echocardiography and check ejection fraction (EF), valvular status and pulmonary artery (PA) pressure.  
2- Abx prophylaxis is given for every VHD patients.



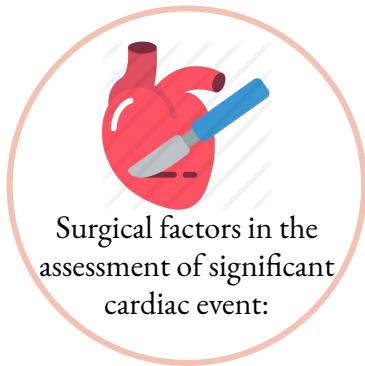
# Anesthesia Inquiries in history



## Cardiovascular system cont..

### Cardiovascular MET Estimation:

| METs         | Exercise                                      | Recreation   | Work/Household Activities   |
|--------------|---|--|---|
| 1.5-2.0 METs | Slow walk 40-60 min mile                      | Watching TV<br>Playing Cards                         | - Desk work<br>- Light house work<br>- Making bed<br>- Brushing hair/teeth                      |
| 2.0-3.0 METs | Walking 24-30 min mile<br>Cycling level 5 mph | Golf with power cart<br>Play musical instrument      | - Driving car<br>- Cooking / washing dishes<br>- Ironing / sweeping<br>- Showering              |
| 3.0-4.0 METs | Walking 20 min mile<br>Cycling 5.5 mph        | Bowling Billiards<br>Golf with pull cart<br>Shopping | - Janitorial work<br>- Vacuuming / Kneeling<br>- Climbing stairs slowly<br>- Sexual intercourse |
| 4.0-5.0 METs | Walking 15-17 min mile<br>Cycling 8 mph       | Dancing<br>Gardening<br>Golf carrying clubs          | - Painting house<br>- Carrying 20-40 lbs<br>- Raking leaves<br>- Shoveling snow                 |
| 5.0-6.0 METs | Walking 13-15 min mile<br>Cycling 10 mph      | Canoeing<br>Stream Fishing<br>Baseball               | - Carpentry<br>- Shoveling heavier snow   |



- Low risk <1%
  - Minor orthopedic and urology
  - Gynaecology
  - Breast
  - Dental
- Intermediate 1-5%
  - Major orthopedic and urology
  - Abdominal
  - Head and neck
- High risk >5%
  - Aortic, major vascular
  - Peripheral vascular
  - Intraperitoneal / intrathoracic



## Respiratory system <sup>1</sup>

### Patients with pre-existing lung disease:

- Prone to postoperative chest **infections** if they are obese or undergoing upper abdominal or thoracic surgery
- Chronic obstructive lung disease: **sputum production** (volume and color), **Dyspnea**.
- Bronchial Asthma, including precipitating factor and last attack, previous hospital admission.
- Upper respiratory tract infection (anaesthesia and surgery should be postponed **at least 2 weeks**, unless it is for a life-threatening condition).
- **COVID swab** for all suspected **patient <sup>2</sup>**.



## GI system <sup>3</sup>

- Indigestion and GERD reflux.
- Heartburn (may indicate the possibility of a hiatus hernia)

1- Any Pt with COPD, severe asthma, bronchiectasis should be referred to a pulmonologist to optimize their condition before going to surgery  
 2- Done for all patients NOT only suspected.  
 3- Those conditions (GERD, hiatal hernia) will aspirate gastric content so we do modified rapid induction to shorten the time of anesthesia induction thus secure airway and prevent aspiration



# Anesthesia Inquiries in history cont..



## Rheumatoid diseases

What is the symptoms of rheumatoid diseases that are very important for preoperative assessment?

- (1) Chronically anaemic<sup>1</sup>.
- (2) Severely limited movement of their joints → (3) makes positioning for surgery and airway maintenance difficult.
- (4) Tendency for dislocation of atlanto-occipital joint<sup>2</sup>.



## Diabetes

- Patients have an increased incidence of:
  - 1- Ischaemic heart disease. 2- Renal dysfunction. 3- Autonomic and peripheral neuropathy
- Intra- and postoperative complications.



## Neuromuscular disorders

- Care with muscle relaxants<sup>3</sup>.
- Coexisting heart disease.
- Restrictive pulmonary disease



## Chronic renal failure

- Anaemia
- Electrolyte abnormalities<sup>4</sup>
- Altered drug excretion<sup>5</sup>
- Restricts the choice of anaesthetic agents



## Liver disease<sup>6</sup>

- Infectious or obstructive liver disease
- Altered drug metabolism
- Altered coagulation function.



## Epilepsy

- Well controlled or not, compliance to medication.
- Avoid anaesthetic agents potentially epileptogenic (e.g. enflurane, ketamine).
- Predict convulsions which induced by withdrawal effects of anesthesia drugs<sup>7</sup>



## Drug history and allergies

- Identify all medications: 1- Prescribed. 2- Self-administered.
- Allergies to drugs: Topical preparations (e.g. iodine), Adhesive dressings, Foodstuffs.

1- Can mask cardiac disease

2- During intubation do not flex the patient's head

3- We give small small doses of muscle relaxant succinylcholine if indicated because it may induce malignant hyperthermia

4- Hyperkalemia, hyponatremia and acidosis

5- e.g. rocuronium is a muscle relaxant, if it's secretion is prolonged the Pt will be paralyzed for longer time

6- FFP prescription, they have tendency for bleeding

7- We have to be prepared in the recovery room for convulsions, if it happened give diazepam

# Anesthesia Inquiries in history cont..



## Social history

- Smoking: (Number of cigarettes, amount of tobacco). Nicotine stimulates the sympathetic nervous system causing: tachycardia, hypertension and coronary artery narrowing.
- Alcohol: (Induction of liver enzymes, tolerance)
- Addiction: Difficulty with venous access, Thrombosis of veins and Withdrawal syndromes)
- Look for tattooing.<sup>1</sup>



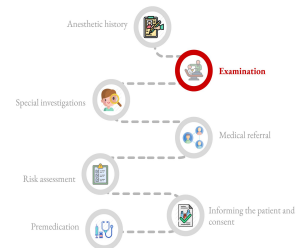
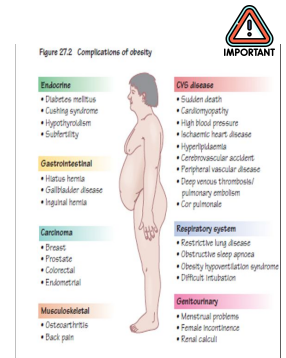
## Pregnancy

- Increased risk of regurgitation and aspiration.
- Elective surgery is best postponed until after delivery.



## Obesity

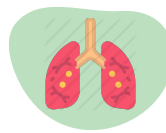
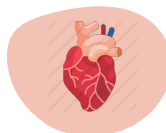
- Cardiovascular, Respiratory, Sleep apnea and snoring, Diabetics, Fatty liver.
- Technical problem: Airway, aspiration, intravenous access and positioning.



## The examination

### Cardiovascular system:

- Dysrhythmias: Atrial fibrillation.
- Heart failure<sup>2</sup>.
- Valvular heart disease: heart murmur.
- Blood pressure is best measured at the end of the examination.



### Respiratory system:

- Cyanosis<sup>3</sup>
- Pattern of ventilation
- Respiratory rate
- Dyspnoea<sup>4</sup>
- Wheeziness<sup>4</sup>
- Signs of collapse
- Consolidation and effusion

### Nervous system:

- Chronic disease of the peripheral and central nervous system.
- Evidence of motor or sensory impairment should be documented.



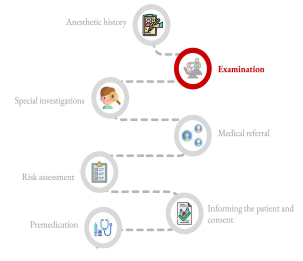
### Musculoskeletal system:

- Restriction of movement and deformities
- Reduced muscle mass
- Peripheral neuropathy
- Pulmonary involvement
- Particular attention to the patient's cervical spine<sup>5</sup> and temporomandibular joints

1- Sometimes it accompanied with hepatitis C or HIV  
 2- You have to auscultate looking for tachycardia, S3, S4 and basal crepitation.  
 3- Indicate very low oxygen saturation "emergency"  
 4- Should be treated before surgery  
 5- Especially with rheumatoid arthritis patients will have subluxation.

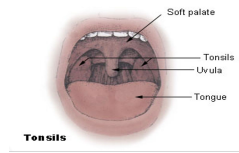


# The examination:

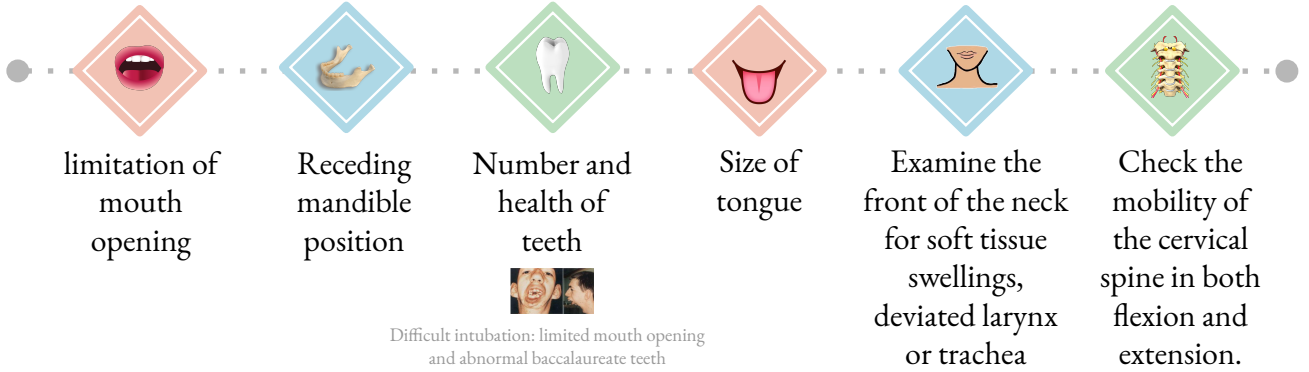


## Examining the airway:

- Try and predict difficult intubation.
- Assessment is often made in three stages



Observation of the patient's anatomy:  
Look for:



## Airway evaluation:

Take very serious history of prior difficulty.

Head and neck movement (extension).



Alignment of oral, pharyngeal, laryngeal axes

Cervical spine arthritis or trauma, burn, radiation, tumor, infection, scleroderma, short and thick neck

Jaw Movement:



Receding Mandible: Inability to sublux lower incisors beyond upper incisors

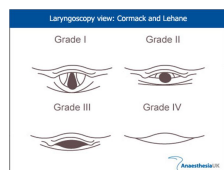
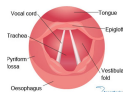
Protruding Maxillary Incisors (buck teeth)



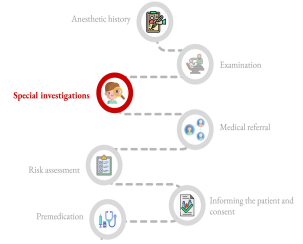
Laryngoscopy view: Cormack and Lehane:

- 1- Grade I: complete glottis visible
- 2- Grade II: anterior glottis not seen

- 3- Grade III: epiglottis seen, but not glottis
- 4- Grade IV: epiglottis not seen



# Special investigations:



## Baseline examinations

If no concurrent diseases, investigations can be limited to:

| Age   | Sex    | Investigations                   |
|-------|--------|----------------------------------|
| <40   | Male   | Nil                              |
| <40   | Female | Hb.                              |
| 41-60 | Male   | ECG, blood sugar, creatinine     |
| 41-60 | Female | Hb, ECG, blood sugar, creatinine |
| >61   | All    | Hb, ECG, blood sugar, creatinine |

## Additional investigations

### Urea and electrolyte

- In patients taking digoxin, Diuretics
- Diabetes, renal disease.
- Vomiting/ Diarrhea.

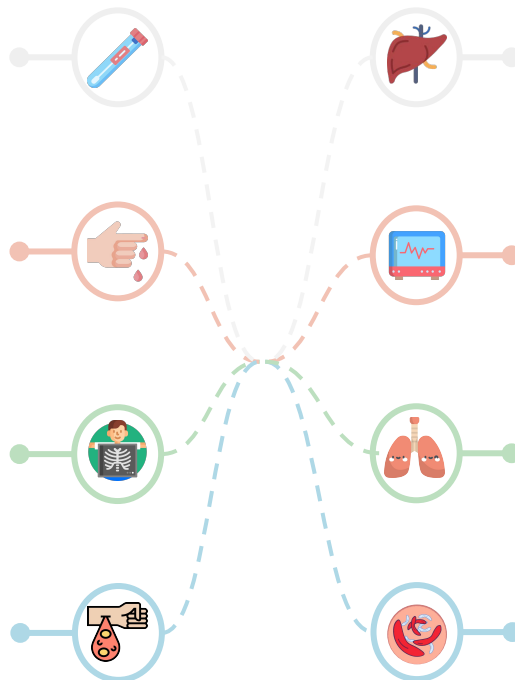
### Blood sugar

- Diabetes
- Peripheral arterial disease
- Taking long term steroids

### Chest X-ray <sup>1</sup>

### Coagulation screen <sup>2</sup>

For any pt will undergo regional anesthesia



### Liver function tests

- Hepatic disease.
- High alcohol.
- Metastatic disease.
- Evidence of malnutrition.

### Electrocardiogram (ECG)

- Hypertensive.
- With symptoms or signs of heart disease.

### Pulmonary function tests

Pt with COPD, Bronchial asthma, bronchiectasis

### Sickle-cell screen

When +ve family hx

1- For all patients with pulmonary disease, cancer patients or suspected pneumonia.  
 2- For all patients with anticoagulants, liver disease and cancer patients.



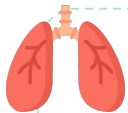
# Medical referral:

Optimization of coexisting medical (or surgical) problems may mean postponing surgery



## Cardiovascular disease:

- Untreated or poorly controlled hypertension or heart failure.
- Symptomatic ischaemic heart disease (unstable angina).
- Dysrhythmias: uncontrolled atrial fibrillation, paroxysmal supraventricular tachycardia, second and third degree heart block.
- Congenital heart disease or symptomatic valvular heart disease.



## Respiratory disease:

- Chronic obstructive airways disease, if dyspnoeic at rest.
- Bronchiectasis.
- Asthmatics: **1.** Unstable **2.** Taking oral steroids **3.** have a FEV1 < 60% predicted.



## Renal disease:

- Chronic renal failure.
- Patients undergoing chronic dialysis



## Endocrine disorders:

- Insulin and non-insulin dependent diabetics.
- Ketonuria.
- Random blood sugar > 12 mmol/L
- Hypo- or hyperthyroidism.
- Cushing's.
- Addison's disease
- Hypopituitarism



## Hematological disorders:

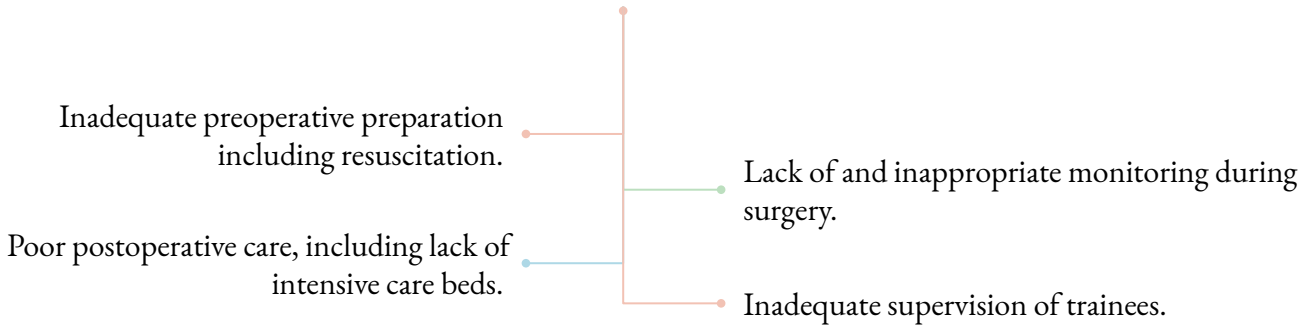
- Bleeding diathesis: haemophilia, thrombocytopenia.
- Therapeutic anticoagulation
- Haemoglobinopathies.
- Polycythaemia.
- Haemolytic anaemias.
- Leukaemias.



# Risk assessment:

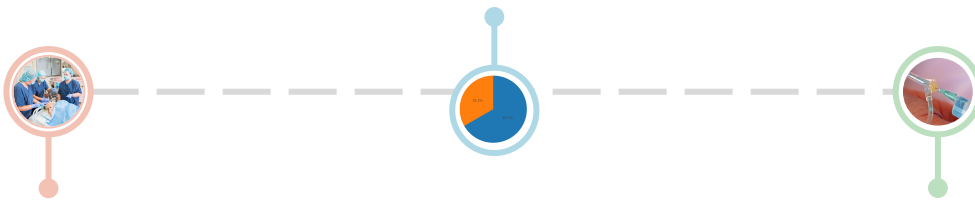


## Factors that increase risk of mortality:



## Mortality related to anesthesia:

One third of deaths are preventable.



Approx 1:26,000 anaesthetics.

Causes in order of frequency:

- 1- Inadequate patient preparation.
- 2- Inadequate postoperative management.
- 3- Wrong choice of anaesthetic technique.
- 4- Inadequate crisis management.

## Anaesthetic associated death:

- Increasing age: >60 years.
- Sex: male > female. 🧑
- Worsening physical status.
- Increasing number of concurrent medical conditions, in particular: myocardial infarction and diabetes mellitus.
- Renal disease
- Increasing complexity of surgery: intracranial, major vascular and intrathoracic.
- Increasing length of surgery.
- Emergency operations.

# Risk assessment:

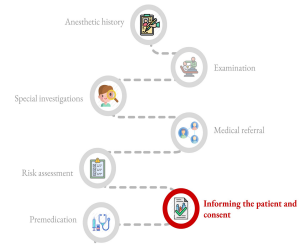


## ASA (American Society of Anesthesiologists) Grading:

| ASA PS classification | Definition   | Example, including, but not limited to  |
|-----------------------|--|---|
| <b>ASA I</b>          | A normal healthy patient   | Healthy, non-smoking, minimal alcohol use   |
| <b>ASA II</b>         | A patient with mild systemic disease   | Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease   |
| <b>ASA III</b>        | A patient with severe systemic disease   | Substantive functional limitation; one or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM/HTN, COPD, morbid obesity (BMI =>40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA<60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents. |
| <b>ASA IV</b>         | A patient with severe systemic disease that is a constant threat to life       | Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemic or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESD not undergoing regularly scheduled dialysis   |
| <b>ASA V</b>          | A moribund patient who is not expected to survive without the operation        | Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in face of significant cardiac pathology or multiple organ/system dysfunction  |
| <b>ASA VI</b>         | A declared brain-dead patient whose organs are being removed for donor purpose |   |

The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

# Informing the patient and consent:



## Informing the patient

- The choice of anaesthetic technique rests with the anaesthetist, but most patients appreciate some details of what to expect.

### The perioperative patient journey:



- Patients will ask about their immediate recovery.
- Finally:
  1. Reassure patients about postoperative pain control.
  2. Informed of the technique.
- Consent for anaesthesia.

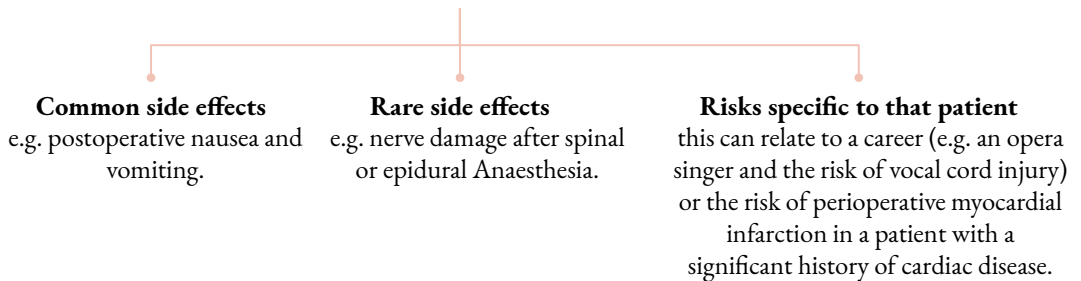


Consent form

## Consent form

- Anaesthetic consent is an important aspect of operative consent.
- All patients should have received written information in advance as well as an explanation of side effects

### explanation of side effects:



- Consent must be obtained before any sedating , premedication is given

### Consent form requirements



- Capacity necessitates**
1. Ability to understand and retain information about the treatment.
  2. Ability to weigh up the information.
  3. Ability to make a free choice.

**Enough relevant information**

1- anesthesia consent, surgical consent and blood transfusion consent.

# Premedication

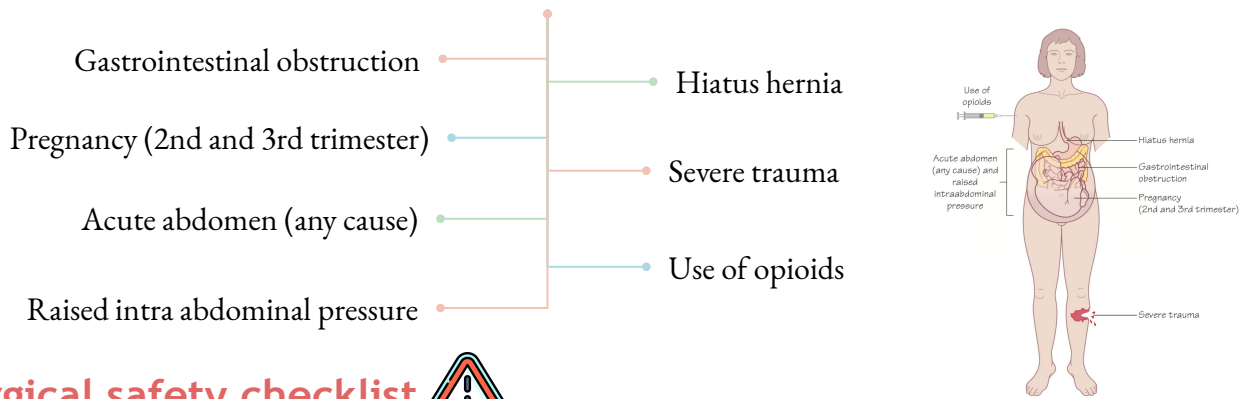


## NPO Guidelines for elective sedation:

| Ingested  | Time    |
|---|---------|
| Clear liquids (water, fruit juices w/o pulp, carbonated beverages, clear tea, black coffee) | 2 hours |
| Breast milk   | 4 hours |
| Infant formula  | 6 hours |
| Nonhuman milk (similar to solids)   | 6 hours |
| Solids (light meal; if includes fatty/fried food, consider longer faster period)            | 6 hours |

\* In emergency situation, carefully weigh the need for immediacy with increased risk of pulmonary aspiration. Use lightest effective sedation possible.

## Patients at risk of gastric aspiration even after fasting:



## Surgical safety checklist

Figure 8.2 Surgical safety checklist

**Sign in** occurs before anaesthesia starts. The patient's details are checked, as well as the operation, consent, appropriate marking of site, allergies, potential airway issues and the anticipated blood loss.

**Time out** occurs in the operating theatre before the start of the operation. The team all introduce themselves, formally identify the patient and the planned operation and site (including anticipated blood loss), as well as any medical concerns about the patient. A check of availability of all equipment and imaging for the proposed operation is also established.

**Sign out** at the end of the operation. There is a summary of the procedure, including a check of swabs and instruments, and there is a log of any unexpected events during the operation.

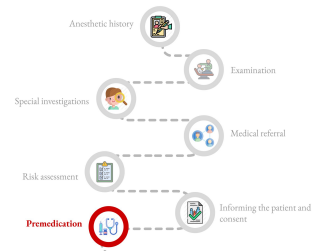
**Surgical Safety Checklist (First edition)**

**Before induction of anaesthesia** → **Before skin incision** → **Before patient leaves operating room**

| Sign in   | Time out  | Sign out  |
|---|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient has confirmed                             <ul style="list-style-type: none"> <li>• Identity</li> <li>• Site</li> <li>• Procedure</li> <li>• Consent</li> </ul> </li> <li><input type="checkbox"/> Site marked/not applicable</li> <li><input type="checkbox"/> Anaesthesia safety check completed</li> <li><input type="checkbox"/> Pulse oximeter on patient and functioning</li> <li><b>Does patient have a:</b></li> <li><b>Known allergy?</b></li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes</li> <li><b>Difficult airway/aspiration risk?</b></li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes, and equipment/assistance available</li> <li><b>Risk of &gt;500mL blood loss (7mL/kg in children)?</b></li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes, and adequate intravenous access and fluids planned</li> <li><b>Intraoperative stage: from entering the theatre room to the recovery room.</b></li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Confirm all team members have introduced themselves by name and role</li> <li><input type="checkbox"/> Surgeon, Anaesthesia professional and nurse verbally confirm                             <ul style="list-style-type: none"> <li>• Patient</li> <li>• Site</li> <li>• Procedure</li> </ul> </li> <li><b>Anticipated critical events</b></li> <li><input type="checkbox"/> Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss?</li> <li><input type="checkbox"/> Anaesthesia team reviews: are there any patient-specific concerns?</li> <li><input type="checkbox"/> Nursing team reviews: has sterility (including indicator results) been confirmed? Are the equipment issues or any concerns?</li> <li><b>Has antibiotic prophylaxis been given within the last 60 minutes?</b></li> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> Not applicable</li> <li><b>Is essential imaging displayed?</b></li> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> Not applicable</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Nurse verbally confirms with the team:</li> <li><input type="checkbox"/> The name of the procedure recorded</li> <li><input type="checkbox"/> That instrument, sponge and needle counts are correct (or not applicable)</li> <li><input type="checkbox"/> How the specimen is labelled (including patient name)</li> <li><input type="checkbox"/> Whether there are any equipment problems to be addressed</li> <li><input type="checkbox"/> Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient</li> </ul> |

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# Premedication



## The 6As of Premedication:



### Anxiolysis:

- The best anxiolytic is the anesthetist who visits the patient and listens to the patient.
- Benzodiazepines | Phenothiazines.



### Amnesia:

Lorazepam | anterograde amnesia.



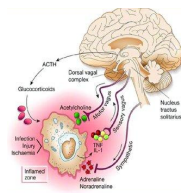
### Antiemetic:

- Dopamine antagonists | Antihistamines | Anticholinergics | Phenothiazines | 5-hydroxytryptamine antagonists |  $\alpha_2$ -agonists: clonidine, Dex.



### Antacid:

- Patients who have received opiates.
- Present as emergencies.
- If in pain
- Delayed gastric emptying.
- Hiatus hernia
- Drugs: Oral sodium citrate, Ranitidine, Proton inhibitors <sup>1</sup>, Metoclopramide, naso- or orogastric tube.



### Anti-autonomic <sup>2</sup>: given to patients have parasympathetic reflexes.

- Excessive vagal activity causing profound bradycardia.
- Halothane.
- 2nd dose of Suxamethonium.
- Surgery.
- Traction on the extraocular muscles.
- Handling of the viscera.
- During elevation of a fractured zygoma.



### Analgesic

1- e.g. omeprazole  
2- e.g. hyoscine and glycopyrronium



# Post-operative stage

**First:** At the end of the operation, the patient is either

extubated in the operating theatre  
(and an oropharyngeal airway  
inserted if needed)

transferred to the recovery room  
with an LMA still in situ .

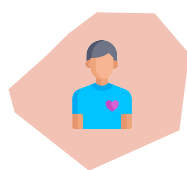
**Second:** Receive supplemental oxygen during transfer

**Third:** Many patients who do not have a general anesthesia/sedation bypass the recovery room and go straight from the operating theatre

- Examples include local anesthesia cases (e.g. minor surface surgery, cataract removal, some regional anesthesia cases).

## Once in the recovery room:

Handover occurs between the anesthetist and a recovery nurse. Important information passed on includes:



Patient's name  
and age



Blood loss



Operation  
details



Anaesthetic technique with  
emphasis on:

- analgesia given
- regional/nerve blocks
- antiemetics given
- antibiotics
- the use of local anaesthetic infiltration
- Thromboprophylaxis

# Lecture Quiz

answers: 1( C, D) 2( B, C, E) 3( A,E) 4(A) 5(A)

**Question 1: Regarding preoperative management of the high-risk patient, which of the following statements are true?**

- A. A course of antibiotics should always be given in patients with chronic sputum production.
- B. Stopping smoking prior to surgery is of little benefit.
- C. Oral medications can still be given with a little water in patients who are nil-by-mouth.
- D. A course of steroids prior to surgery may be necessary in patients with chronic obstructive airways disease.

**Question 2: Regarding consent for surgery, which of the following are true?**

- A. Children below the age of 16 years cannot give consent
- B. A social worker can give consent for a child under a care order
- C. All minor complications with an incidence above 1% should be discussed
- D. Consent is not required for life-saving surgery in a competent patient
- E. Two senior doctors need to sign the form explaining reasons for actions if an adult is deemed not competent to consent

**Question 3: Which of the following statements regarding preoperative management of specific medical problems are true?**

- A. Patients with a diastolic pressure above 95 mmHg should have their elective operations postponed.
- B. Elective surgery should be delayed until at least 1 year after a myocardial infarction (MI).
- C. There is no need to control tachyarrhythmias preoperatively.
- D. Preoperative transfusion should be considered if the Hb level <10 g/dL.
- E. In patients with malnutrition, preoperative nutrition therapy should be started 2 weeks prior to surgery

**Question 4: Regarding sedation during endoscopy, which of the following statements are false?**

- A. Sedation has no significant dangers and can be used without restrictions.
- B. All sedated patients require secure intravenous access.
- C. Co-administration of opiates and benzodiazepines has a synergistic effect.
- D. The use of supplementary oxygen is essential in all sedated patients.
- E. All sedated patients require pulse oximetry to monitor oxygen saturations

**Question 5: Preoperative assessment of patients with diabetes mellitus should include:**




- A. An assessment of functional status
- B. 24-Hour creatinine clearance
- C. Pulmonary function testing
- D. Cancellation of the surgical case if HbA1c >10%

 **Good Luck**



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Quiz



Editor



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