

# **Department of Anesthesiology Guidelines for the Preoperative Preparation of the Surgical Patient**

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Delivery of a safe anesthetic requires current, objective information prior to the surgical procedure. The patient's medical status should be stable, optimized and documented. Laboratory testing is warranted under certain circumstances, although these requirements are becoming less frequent. The following guidelines should help to avoid unnecessary testing, promote cost effectiveness, prevent unnecessary delay, and ensure a safe surgical procedure.

## **History and Physical Examination**

A legible history and physical examination is the *cornerstone of preoperative preparation*. 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.

The Anesthesiologist desires information with regards to the following:

1. What are the patient's ongoing medical problems?
2. Is the patient optimally managed?
3. What is the patient's cardiopulmonary functional reserve, and are there any objective tests available to document this?
4. What is the current medical regimen?

We ***do not*** ask the referring physician or specialist to "***clear the patient for surgery***". What we do ask is for *objective information* so we can determine anesthetic risk, discuss these with the patient, and plan optimal anesthetic management. If there is any question as to the adequacy of information requested in questions 1-4 above, the patient should be referred to the Pre-admission Evaluation Center (PEC).

History and physical examination, per JCAHO standards, must be less than 30 days old in stable patients (from the date of planned surgery), and updated on the day of surgery.

## **EKG and Laboratory Data**

There is mounting evidence that routine preoperative testing is very expensive and does not improve overall outcome. Other than a *few routine caveats*, preoperative testing should be *individualized* based on the H & P and the severity and duration of the planned procedure. A debilitated patient requiring a minor procedure (cataract surgery) may need little additional testing, whereas a healthy patient undergoing major vascular surgery (thoracotomy) may require a significant work up.

A surgical classification system is enclosed which categorizes procedures by their relative risk and invasiveness. Categories 1-2 are relatively minor procedures and lab work should be guided by the patient's medical condition. Categories 3-5 procedures are more extensive and usually require additional testing even in healthy patients.

The only required preoperative test is an EKG in all patients over 50, or in diabetics over the age of 40. All other testing is dictated by patient condition or surgical procedure. Please refer to the attached guideline sheet which you can share with your office staff.

## **NPO Requirements**

**Adults** NPO after midnight

### ***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**

## Medication on the Day of Surgery

Take most routine medication on the morning of surgery with a sip of water, especially cardiac, hypertension, GERD/ulcer, pulmonary, neuro/seizure meds. The exceptions are ACE-Inhibitors (ACE-I) and Angiotension receptor blockers (ARB) which should be held on the day of surgery.

**Diabetic** patients should be scheduled as the first case of the day if possible. Otherwise, they should plan to arrive at the facility in the early morning where a glucose can be immediately checked and intravenous fluids started. Depending on the medications taken, the following protocol should be followed:

Treatment	Evening before Surgery	Day of Surgery
Oral diabetic agents	Hold	Hold
Insulin injection	Take usual dose	Hold
Insulin pump	Continue basal rate	Continue basal rate
ACE-I, ARB	Take usual dose	Hold

Patients on **anticoagulants** such as heparin, low molecular weight heparin (Lovenox), coumadin, clopidogrel (Plavix), ticlopidine (Ticlid) and physician prescribed aspirin (Aggrenox). These patients require **specific instructions** to be determined on a case-by-case basis by the surgeon, anesthesiologist and cardiologist (or physician who prescribed the anticoagulation regimen). The risk of discontinuing anticoagulation, especially in patients with coronary stents, must be balanced against the risk of increased surgical bleeding. ACC/AHA Peri-operative Cardiovascular Evaluation Practice Guidelines have been published in *Circulation*, Sept 2007 for further reference.