Dissecting the new SAMBA Guidelines

Richard Rivers, MD, PhD, MBA, Johns Hopkins University

Vinodkumar Singh, MD, Veterans Affairs Hospital Birmingham

George Dumas, MD, University of Alabama at Birmingham

Moderated by Maggie Jeffries, MD, Avanti Anesthesia, Houston

Table of Contents

67-year-old male taking lisinopril has a blood pressure of 220/108. Proceed?

Yes

0%

No

0%

Maybe

0%

67-year-old male taking lisinopril has a blood pressure of 220/108. We are proceeding. Do we treat?

Yes

0%

No

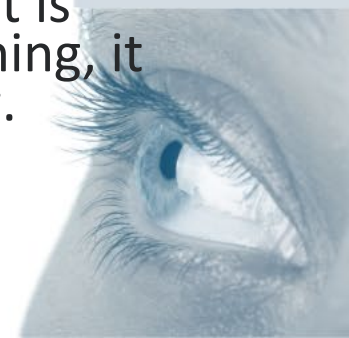
0%

Maybe

0%

Does hypertension warrant cancellation? Should they be given antihypertensives? Does it make a difference if they are on HTN meds at home?

- **Ric Rivers:** Depends… if short cataract case, nothing much matters except hypertensive crisis. If it is a long case or GA then cancellation is warranted only if symptoms of hypertensive crisis, new onset acute hypertension. Although BP reliably drops once in the OR, preop therapy is an option when BP is very high (s>220). Home medication indicates the disease is not new and if the BP is very high while medicated the patient needs to be counseled to visit their PCP.
- **George Dumas**: No cancellations unless symptomatic. Concern of bleeding in some cases or even choroidal hemorrhage. I give all antihypertensives except avoid ACE-I for GA unless patient has high baseline. Also, they may have white coat syndrome and midazolam will help.
- **Vindokumar Singh**: Hypertension causing any symptoms of end organ damage definitely needs further investigation and cancellation of surgery-these symptoms may be chest pain/discomfort, palpitations, dizziness etc. IV antihypertensives are not suggested as this may lead to precipitous fall in BP and further alter autoregulation as the patient is used to a particular BP. If the patient hasn't taken his/her routine meds in the morning, it may be worthwhile giving all those meds and recheck to make sure BP is improving.



76-year-old female has a remote history of LAD stent presents on the DOS in new onset atrial fibrillation. BP 176/92 HR 91. Asymptomatic. Proceed?

Yes

0%

No

0%

Maybe

0%

Does new onset afib warrant cancellation? What if it's rapid? What if it's slow and controlled?

Ophthalmic Anesthesia Society

- **RR:** It is warranted to cancel if it is rapid and symptomatic and especially if patient detected something new. We would cancel can send to ED. Slow and controlled proceed as planned.
- **GD:** If cataract only and rate is already controlled proceed.
- **VS:** New onset Afib is a significant finding in the preop area. If the patient is symptomatic and the HR is below 110, it may be okay to proceed with cataract surgery with the advice to visit PCP as soon as possible. If the HR is >110, it may have associated cardiac dysfunction (rate-related) and needs further cardiac workup and treatment

56-year-old female with diabetes on metformin presents with fasting blood sugar of 467. Asymptomatic. Proceed?

Yes

0%

No

0%

Maybe

0%

56-year-old female with diabetes on injectable insulin presents with fasting blood sugar of 467. Asymptomatic. Proceed?

Yes

0%

No

0%

Maybe

0%

Does hyperglycemia warrant cancellation? Do you have a hardline cutoff?

- **RR:** This is only relevant if it approaches 400, or life-long insulin dependent diabetic tells you it is out of control. May also treat with insulin before induction if glucose is over 330 and patient takes insulin.
- **GD:** Cancel if concern for DKA. Can check urine ketones. No number, depends on baseline and if type 1.
- **VS:** Only major complications of DM with fluid/electrolyte shifts should lead to cancellation of surgery. This includes DKA, Non-ketotic hyperosmolar states. The recent introduction of anti DM meds has complicated the issue even further, but for cataract surgery, there is no hard serum glucose cutoff. We have used regular insulin to correct blood glucose levels to < 350-400, but evidence is lacking regarding the benefits. Rapid correction may in fact hasten the proliferative retinopathy process and also cause osmolality shifts especially in insulin naive patients.

25-year-old otherwise healthy patient weighs 425lbs (193kgs) and a BMI of 68.6. Proceed?

Yes

0%

No

0%

Maybe

0%

Should there be a weight limit? BMI limit? Does sedation versus GA make a difference?

Ophthalmic Anesthesia Society

- **RR:** A free-standing surgery center may have limits. Outpatient facility near hospital can allow pretty much anyone assuming they have the appropriate beds.
- **GD:** Stretcher limit is weight limit. BMI is concerning, particularly if >50. BMI is indicative of a phenotype which includes OSA, pulmonary HTN, etc. Airway exam is important as is site of surgery
- **VS:** Most of the time, the weight limit is based on the bed weight bearing capacity. It has to be taken in account that many of these morbidly obese patients can't lie flat making it hard to do the ocular surgeries under MAC. The risk of conversion to general should be always considered on a case-to- case basis.

General anesthesia vs MAC - is there a difference in how you approach the case?

Ophthalmic Anesthesia Society

- **RR:** Yes. Short MAC case with little chance of GA requires less workup than a long GA.
- **GD:** MAC better when worried about hypotension. GA best for special needs and some extremely anxious patients.
- **VS:** Prefer MAC for cataract patients. General involves use of multiple medications with the increase in risk of side effects including anaphylaxis and potential airway issues.

What is the optimal pre-op medication management? Take all meds? Stop some?

Ophthalmic Anesthesia Society

- **RR:** It depends on if you prefer to treat hypertension, or hypotension, in the OR. Only need to worry about anti-coagulants for plastics cases.
- **GD:** Take most. GLP1 drugs should optimally be held 7 days for IV and 1 day for orals. If unable, consider alternatives including longer NPO times. Hold stimulants. Hold PO diabetic drugs. Give long-acting insulin. Always give meds for pulmonary issues , pulmonary HTN, and severe heart failure. Give all pain and psychiatric meds am of surgery. Consider holding ACEi for 24 hours if GA planned
- **VS:** For cataract, no need to stop any medications except DM meds (short acting that can lead to hypoglycemia). If there is a risk of conversion to general anesthesia based on patient characteristics, the guidelines should be followed.

Patient on stable hemodialysis is scheduled for cataract surgery. Proceed?

Yes

0%

No

0%

Maybe

0%

Patient on home oxygen is scheduled for cataract surgery. Proceed?

Yes

0%

No

0%

Maybe

0%

Can we do ASA IV patients in an outpatient setting? What if they are on Hemodialysis? What about pacemaker dependent or AICD? Home O2?

- **RR:** We can do pretty much anyone as an outpatient unless they are at high risk of needing post-op ventilation, have severe pulmonary HTN, or severe cardiac dysfunction requiring special monitoring or using an LVAD.
- **GD:** Depends on resources, type of anesthesia, and case being considered. Dialysis might be OK depending on timing and the above factors. Would suggest ability to check K. Pacemaker dependent and AICD depend on site of surgery and if monopolar cautery is used. Has the devices been checked recently? Has the device fired recently? Ability to check 12 lead ekg may be useful.
- **VS:** For cataract surgery, its fine to do it in outpatient settings. The risk of complications for cataract surgery under MAC is very very low. The biggest issue is the process and familiarity of equipment and staff in cataract surgery. Most errors in cataract surgery are wrong side surgery and wrong lens placement, which is more likely in a unfamiliar environment.