International Summit
Common Issues Around the Globe

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Topics for Discussion

- Anticoagulants when needing a block
- GLP1 medications
- Elevated HTN / blood sugars on the day of surgery
- NPO / fasting for sedation cases
- Preop history and physical for cataracts

If we have time…..

- Patients who don't have a ride home or a responsible adult
- Combative patients / dementia or other cognitive issues
- Telemedicine in anesthesia
- Medicolegal implications in ophthalmic anesthesia
- When eye procedures are done with a block (s)
- Environmental impact of what we do

Anticoagulants when needing a block

- **IG:** superficial nerve blocks can be safely performed in the presence of anticoagulants
- **AK:** from 2012 guidelines, we continue warfarin and can offer STB or PFF with some exceptions. For DOACs, some colleagues have been stopping 24 hrs for STB and 48 hrs for PBB but I've evolved towards not stopping, being reviewed by national guidelines group currently & practice varies
- **LP:** blood thinning medications are not stopped for cataract surgeries and patients informed of small risks; held for other eye surgeries
- **MJ:** agree with IG, superficial nerve blocks (& surgery) can be safely performed in the presence of anticoagulants

GLP1 medications

- **IG:** No official guidelines out of Europe at this time but growing paper abstracts.
- **AK:** Not common in clinical practice yet with no national guidance; would want them starved and not deep sedation – only anxiolytic or GA
- **LP:** no comment
- **MJ:** current ASA/ASPF is stop injectables x 1 week and clears 24 hours prior to surgery, 1 day for oral; for sedation we are not doing this instead keeping sedation “light” and “avoid deep/moderate”; Canada is stopping for 3 half lives; true guidance is lacking and use growing

Elevated Blood Pressure on the day of surgery

- **IG:** greater than 180/110 unsuitable for elective procedures per AAGBI/BHS and European Cardiology guidelines
- **AK:** BP checked on first visit and sent to GP if high - if was normal and high on DOS we'd treat with anxiolytics &/or low dose anti-hypertensive as to not acutely lower BP; for GA cutoff is 170/110
- **LK:** Cataract cutoff is 180/110 but might be even lower for retina surgeries like membrane peel where DBP not more than 90
- **MJ:** Only cancel/delay if malignant HTN showing end organ damage – but no guidance on what that means. I cancel when they are not on medications and have a pressure >220/110

Elevated blood sugars on the day of surgery

- **IG:** difficult to establish a threshold but should likely aim for <200
- **AK:** blood sugar practice is variable, risk of endophthalmitis infection is so low it may not matter (0.03-0.3%) but is noncompliance a problem?
- **LK:** blood sugars less clear and typically proceed <250
- **MJ:** only delay if evidence of ketoacidosis (again, how to define?); we struggle with this as nurses don't like a variable practice , we picked 400 as likelihood that ketoacidosis is low but gives us a wide margin

NPO / fasting for sedation cases

Ophthalmic Anesthesia Society

- IG: healthy children to drink clears 1 hour before procedures
- AK: we don't routinely starve our patients as most are getting anxiolytics for "sedation"; starved for GA
- LK: NPO for 2 hours
- MJ: very strict but would like to see change here; same rules for GA as sedation of all kinds; 8 hrs for regular food, 6 hrs for light meal w/o fats, 2 hours for clears

Preop history and physical for cataracts

- **IG:** high risk patients with uncontrolled issues should be seen by their GP, low risk patients can be assessed in non-medically led clinics
- **AK:** abbreviated proforma for patients having anxiolytics by junior nurses; full assessment at preop clinic for GA
- **LK:** full assessment performed even for cataracts
- **MJ:** a full spectrum but can be targeted to severity of surgery– online patient questionnaires, phone call evaluations, bedside evaluations, etc; anesthesia provider does full bedside evaluation on DOS regardless of anesthesia type