Outpatient Surgery Magazine

Print Article

October, 2015

Would You Operate on This Patient?

Let safety be your guide when deciding whether to take on borderline cases.

Dan O'Connor, Editor-in-Chief

PATIENT SAFETY An increasing number of patients with significant medical histories and multiple co-morbidities are presenting for outpatient surgery. Anesthesiologist Benjamin Jacobs, MD, never forgot what a surgeon told him many years ago: "You never regret the case you canceled." Those wise words ring especially true today, when everything in surgery is on the rise: the weight of the patients, the complexity of the cases, the competition for volume and the pressure to operate on patients you might never have considered for same-day surgery a few years ago. It's almost enough to blur the lines and make you accept a borderline case you might not otherwise.

"The questionable case that you don't cancel — the entire time you're worried," says Dr. Jacobs, the co-director of anesthesia services at Paoli Surgery Center in suburban Philadelphia. "During the case, you're looking at the monitors

and at the patient and praying that all goes well. You actually are worried until the patient physically leaves the facility. You check with the nurse who made the post-op phone calls to confirm that the patient is doing well."

Do what's best for the patient

Nobody wants to cancel or postpone a case. It's bad for business, and it's inconvenient for the surgeon and the patient, who's been NPO since midnight, took time off from work and arranged for a ride. Yet even when there's pressure from all sides to do the case, "you just have to stand your ground and do what's best for the patient," says Dr. Jacobs. "One bad case can ruin your center."

Just recently, Dr. Jacobs turned a patient away and referred him to the hospital 100 yards up the driveway from the ASC. "We turfed him up to the hospital," is how Dr. Jacobs puts it. The reason? Dr. Jacobs foresaw a difficult intubation. The 59-year-old male was scheduled for right shoulder arthroscopic surgery to be performed in the sitting position. His medical history was unremarkable: no significant cardiopulmonary history, a surgery to remove a renal mass in 2001 and severe osteoarthritis. His past surgical history included several lumbar disc surgeries and a cervical fusion performed within the past few years. At 5-foot-9 and 150 pounds, he certainly wasn't overweight.

But the airway evaluation a week before his procedure date set off the alarms. The surgery center does all of its shoulder cases under an interscalene block, but Dr. Jacobs was concerned about a difficult intubation should the need arise. "He had minimal-to-no neck extension," says Dr. Jacobs, "so we opted to have his procedure done at the hospital."

At first, the patient was annoyed to have his case postponed, but Dr. Jacobs says the man shook his hand and thanked him once he explained his reasoning. "It's an airway issue — this is for your safety. Could we handle it here? Absolutely. But if something were to go wrong, I'd much rather have you in the hospital, where 4 other anesthesiologists and a respiratory therapist are available to assist."

It's easier to turf the case up to the hospital when your surgery center literally sits at the doorstep of a 231-bed hospital. "If we were 50 miles from the nearest hospital, I'd think harder about it," admits Dr. Jacobs.

Dr. Jacobs recalls another borderline patient, this one a 63-year-old male, 6-foot-1 and 180 pounds., scheduled for microdirect laryngoscopy with excision of a vocal cord mass. His history included hypertension, sleep apnea and CPAP, and severe aortic stenosis status post valve replacement in 2011. A stress test the month of surgery showed no ischemia, normal wall motion and a well-functioning prosthetic valve. Dr. Jacobs deemed this patient suitable for surgery. First, a clearance note from the cardiologist said his cardiac status was stable. And while sleep apnea is a major concern with an airway procedure, Dr. Jacobs says this patient's was mild to moderate at most, after discussing the patient with the surgeon. Plus, the surgical procedure is usually rather quick and the surgeon said the mass was small. One concern: On the day of admission, the patient admitted to a 50-year smoking history (he quit in 2013). The case went well. The patient was an easy mask ventilation, but was a slightly difficult intubation. "The

anesthetic was otherwise uneventful, as was his recovery-room stay," says Dr. Jacobs.

HANGING TOUGH "Stand your ground and do what's best for the patient," says Dr. Jacobs.

Changing times

Outpatient surgery used to be cataracts and carpal tunnels: short, simple, safe surgeries. Advances in regional anesthesia, surgical technique and long-lasting post-op pain control have opened the floodgates to more patients undergoing more painful, invasive surgeries, like total joints and lap choles, in the morning and still getting home in time for dinner.

"It's not uncommon for ASA 3 patients to undergo procedures lasting more than an hour," says anesthesiologist Sean Daley, MD, of Sarasota (Fla.) Anesthesiologists. "As more and more surgeons want to do these patients in an outpatient setting, conflicts arise for sure."

Dr. Daley says it's wise to evaluate borderline patients on a case-by-case basis, examining the patient, the comorbidities and the procedure. A patient may have hypertension and diabetes and be moderately obese, but if his blood pressure is under control and he's had no recent hospital admissions, it's probably safe for him to undergo a 90-minute shoulder arthroscopy. "If you can check off those boxes and if this guy is in a good state of health," says Dr. Daley, "he's probably fine for the procedure."

This same patient, however, would probably not be a good candidate for an outpatient spine case, says Dr. Daley. Sleep apnea, which Dr. Daley calls "one of the biggest risk factors you see," changes everything. "Those are the ones you're more hesitant about. You have to know how you're going to control post-op pain and if the patient is using his positive airway pressure device."

Another factor pushing cases to outpatient settings is the increasing number of private-pay patients. If patients have a say in where their surgery is to be held, they'll no doubt weigh the impact their choice has on their wallets: a $200 co-pay at the surgery center is easier to swallow than a $2,000 co-pay at the hospital. What's clear in talking to caregivers is that you can't lose sight of the patient's safety when deciding whether — and where — to operate on a borderline patient.

"The convenience of the surgeon does not take priority over the safety of the patient," says anesthesiologist Vince Kasper, MD, the director of regional anesthesia at United Anesthesia Services in the Philadelphia area. "Safety should always win over convenience and cost."

Still, there are pressures to fill the surgical schedule, which can put the surgeon, anesthesia provider and administrator in the uneasy situation of having to accept or reject a borderline patient for surgery. As Marc Chudow, RN, charge nurse at the University of South Florida Morsani ASC in Tampa, Fla., says, "We are always trying to build volume. You don't get paid if you don't work."

Certain factors could instantly disqualify a patient from same-day surgery. An *Outpatient Surgery Magazine* survey of 100 surgical facility leaders listed difficult airway, obesity, history of heart trouble, sleep apnea and diabetes among them. But these are not hard-and-fast rules. "We do all of the above patients if they have cardiac clearance or are otherwise controlled and managed appropriately by their primary care doctor," says Carol Wenzel, RN, the director of nursing at the Kenwood Surgery Center in Cincinnati, Ohio. "It depends on the procedure and if anesthesia feels like they can be managed at our facility."

Who's suitable for an ambulatory procedure? It helps to follow American Society of Anesthesia (ASA) admission guidelines (osmag.net/SKh8fU), which say that "patients with a high burden of comorbidities, particularly those with poorly stabilized medical conditions, are not suitable for ambulatory surgery." You should also have your own guidelines for BMI limits, cardiac history (including myocardial infarction, heart failure or a history of hypertension) and chronic respiratory history (especially chronic obstructive pulmonary diseases and asthma).

"If there is a question," says one administrator, "the anesthesia provider or medical director usually have the final say." But sometimes, laments another, "anesthesia challenges and overrules our BMI policy."

As older and sicker patients undergo more complex surgical procedures in an ambulatory setting, the ASA says patient selection has become the cornerstone of safe and efficient perioperative care. "Who's a good candidate? Who's not? It should be less of an argument and more of a discussion," says Dr. Daley. "To do that, you need criteria — some evidence to back up what you're talking about. There's a line. You can say, 'This guy's probably going to be okay, this guy's not.'"

Take a 2-hour shoulder arthroscopy with complex rotator cuff repair. The patient has an unusual EKG finding that could be indicative of an ischemic event and a vague heart history. The surgeon wants to do the case. "There's

nothing wrong with him. No chest pain," he says. But Dr. Daley sees things differently. "You're in a situation where you feel that something is probably not right. If you contacted the patient's cardiologist, you probably wouldn't hear back until the end of the day."

These are the gray areas, says Dr. Daley, the uncontrolled, unidentified clinical issue. What he'd say to the surgeon: "You're right. Maybe there's nothing wrong with this guy. But based on his history, we're probably better off postponing the case until after we have a cardiology consult."

YOU MAKE THE CALL
Would You Do This Case?

You're an anesthesiologist at a fast-paced, high-volume orthopedic surgery center. A nurse from pre-admission testing brings a patient chart for you to review. She tells you that a patient was just added onto the surgery schedule for tomorrow and that Dr. Smith, the orthopedic surgeon, needs to do this case before he flies out of town tomorrow afternoon for a conference.

The patient is a 36-year-old Asian female scheduled for an open reduction and internal fixation of proximal humerus fracture. The patient is 5-foot-2 and 124 pounds, with a history significant for hypothyroid, GERD, asthma (not well controlled) and recent (8 months ago) deep vein thrombosis (DVT). The patient is taking Coumadin for her DVT.

You have some concerns about this patient so you call the surgeon's nurse practitioner, Diane. You discuss your concerns regarding potential blood loss for this case, especially since the surgery center has no blood bank. The closest hospital with a blood bank is 17 miles away. Diane reassures you that Dr. Smith has fixed 2 proximal humerus fractures in the past at this very surgery center and that the patient discontinued her Coumadin 3 days ago. Diane says she'll call the surgeon to express your concerns. She calls back and says that Dr. Smith understands your concerns and is willing to consider giving the patient tranexamic acid to prevent any bleeding. You check with the chief administrator of the surgery center to obtain a list of cases that are approved for this center. A humerus fracture is not on the list. How do you proceed?

Tranexamic acid is an antifibrinolytic. It works by preventing blood clots from breaking down too quickly. This helps to reduce excessive bleeding. You should not use tranexamic acid if you have a history of blood clots.

I would give the utmost attention to cases scheduled in a freestanding surgery center (no blood bank) that are not amenable to a tourniquet. If significant bleeding is anticipated, I would consider performing the case in another facility because a situation in which there is substantial blood loss may require an urgent transfer.

The asthma is another concern. This patient will likely require an endotracheal tube because of the potential for blood loss and the positioning (likely beach chair). Placement of the endotracheal tube could stimulate bronchospasm in an asthmatic.

The Coumadin should not be an issue if the international normalized ratio (INR) is normalized before surgery. However, if it is not normalized then it may increase the patient's risk of substantial bleeding during surgery — especially from an area where no tourniquet can be applied.

— Vince Kasper, MD

Dr. Kasper (vincent.kasper@gmail.com) is the director of regional anesthesia at United Anesthesia Services in the Philadelphia area.

Where do you draw the line?

You're not alone if you sometimes feel pressured to accept a borderline patient for surgery. "I think we all have," says Bonnie Bowman, CRNA, of South Boston, Va. "As anesthesia providers, we have an obligation to put patient safety first. Trust your gut feeling about a patient."

It's not always the type of surgery, but the type of anesthesia that's the bigger concern. "The surgery can sometimes be the easiest phase," says Ms. Bowman. "But an ASC is not prepared or equipped to deal with all of the problems that can occur in borderline patients."

Anesthesia clearly calls the shots when it comes to deciding a questionable case, according to our survey. Nearly half (48.5%) of our 100 respondents say anesthesia providers have the final say on whether you'll operate on a borderline patient. Surgeons make the call 10.1% of the time. In 41.4% of cases, it's a collaboration.

"The decision is not made unilaterally," says Ms. Bowman. "It involves the surgeon, the patient and family. Often the deciding factor is post-care and the possible need for overnight hospitalization."

Does procedure type affect your decision to accept or reject a borderline patient? "Yes, we are more likely to accept someone borderline for a minor procedure vs. a complicated case," says Amiee Mingus, RN CPAN, director of clinical operations at Regent Surgical Health in Westchester, Ill. Andrea Crigger, RN, BSN, CNOR, RNFA, of Wythe County Community Hospital in Wytheville, Va., agrees, saying you can look at different ways to administer anesthesia that may be less stressful on the patient, such as monitored anesthesia care or IV sedation.

One way to reduce the inconvenience of same-day cancellations is a pre-surgical testing program that identifies factors that can increase the risk for complications, says David Taylor, MSN, RN, CNOR, of Methodist Hospital in San Antonio, Texas. We asked our panelists when they typically disqualify a patient. Most (42.6%) do so during a telephone screening, but nearly one-third (31.7%) do so on the day of surgery and about one-fourth (25.7%) do so during pre-testing.

It's a tough balancing act, pleasing surgeons and protecting patients. "Surgeons don't want to be inconvenienced by cancelled cases," says Ms. Mingus. "We don't want to dissatisfy patients, either. Even when a patient slips through the cracks and makes it all the way to the day of surgery, we still err on the side of caution." Indeed, you never regret the case you canceled.