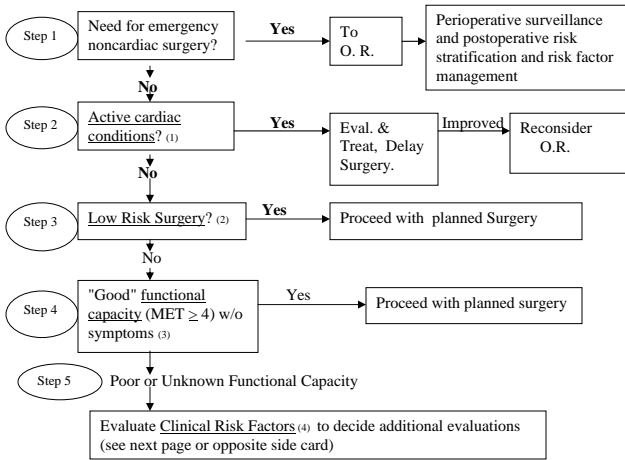


PREOPERATIVE ASSESSMENT & PERIOPERATIVE CARE



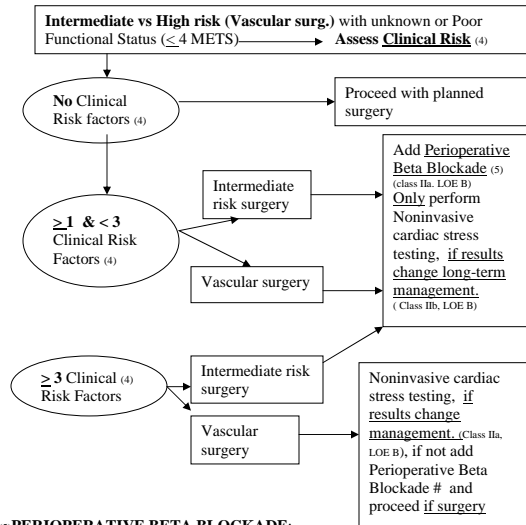
ACTIVE CARDIAC CONDITIONS	CLINICAL RISK FACTORS
Unstable coronary syndromes (ACS, recent MI (i.e. < 30 days since event))	History of Heart Disease
Significant arrhythmias	CHF (hx of)----compensated
Severe valvular disease; (AS with 40 mm Hg or 1.2 cm ² or symptomatic, MS with symptoms (DOE, pre-syncope or HF).	MI (hx of) or EKG-abnormal Q waves
CHF (decompensated (NYHA IV) or new onset	DM
	Renal Insufficiency (Cr > 2.0)
	CVA

(3) FUNCTIONAL CAPACITY

< 4 mets: walking < 2 blocks on level without stopping or unable climb flight stairs
 > 4 mets: climbing a flight of stairs or walk up (slight incline) hill 1-2 blks w/o stopping or walk level ground ~ 4 mph or heavy housework (scrub floors, move furniture)

(2) PROCEDURE RISK:

High	Intermediate	Low
Valvular and vascular	carotid endarterectomy	endoscopy
	head and neck	cataracts
	intraoperative/intrathoracic	breast surgery
	orthopedic	ECT
	prostate	superficial procedures



(5) PERIOPERATIVE BETA BLOCKADE:

Examples; -atenolol 5 -10 mg IV 30 min. pre-op, →50 -100 mg q d for > 7day
 -labetolol 100 mg q d pre-op and continue post op.
 -esmolol IV 1 hr preop, →then metoprolol q am on 1st postop day,

- Do not discontinue immediately post-op.
- Continue for at least 7 days postop, preferably 30 days postop.
- Titrate dose of drug to heart rate 50 -65 bpm.
- long-acting beta-blocker superior to short acting

The majority of geriatric patients undergoing surgery will benefit from perioperative B-blockers

(4) CLINICAL RISK FACTORS

Hx of heart disease, EKG with abnormal Q waves, CHF-compensated, CVA, DM, CKD III.

Source: Guidelines for Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery: executive summary. Am. Coll. of Cardiology/Am. Heart Assoc. 2007. Circulation October 10, 2007 For more explanation see; Web site: geriatrics.ummc.edu visit GERI Pearls evv 11-15-07

PULMONARY----Testing

Test	Predictive value	Indications
ABG	Predicts poor outcome if PCo ₂ > 45	Severe COPD
PFT's (pre-op)	-predicts post-op course in lung resection -evaluate for optimal bronchodilatation definition of optimal bronchodilatation: free of wheezing and peak flow ≥ 80% of predicted or personal best.	Anticipate Lung Resection COPD or Asthma

PULMONARY----Pre-op management:

Goal: Maximize lung function:(this applies mostly to abd/thrx procedures)Management

-Broncodilators, steroids ?	-weight loss
-D/C smoking eight weeks pre-op. in abdominal or thoracic procedures	-warn patient to call in if developing URI in immediate pre-op period
-Chest physiotherapy in thoracic and abdominal surgery (i.e. Deep breathing, mobilization. Positive pressure for pt's unable to do lung expansion exercises	-urge avoidance of NG'S as much as possible

DVT Prophylaxis

Surgery Type	Risk ^④	ES ^⑥	IPC ^⑤	LDUH ^①	LMWH ^②	COUMADIN ^③
General Surgery	none	+	+	+		
General Surgery	any	+	or	+	+	
General Surgery	multiple	+	+	+	+	+
Total Hip Replacement			+		+	+
Total Knee Replacement			+		+	+
Hip Fx Repair			+		+	+

①LDUH: low dose unfractionated heparin (5000 u sc q 12 hours)

②LMWH: low molecular weight heparin

③ Coumadin: INR goal of 2-3.

④ Risk for thrombosis

⑤ Intermittent Pneumatic Compression device

⑥ Fitted graduated stockings that extends above the knee

DELIRIUM PREVENTION To prevent delirium the clinician must address:

- 1) Risk factor assessment and modification
- 2) Medication evaluation and reduction
- 3) Environmental modification
- 4) Sensory enhancement
- 5) Tight management of all co morbid health factors