PREOPERATIVE AND PERIOPERATIVE ISSUES IN CEREBROVASCULAR DISEASE, AN ISSUE OF NEUROLOGIC CLINICS pdf

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Review article Full text access Prevention of Ischemic Neurologic Injury With Intraoperative Monitoring of Selected Cardiovascular and Cerebrovascular Procedures: Roles of Electroencephalography, Somatosensory Evoked Potentials, Transcranial Doppler, and Near-Infrared Spectroscopy.

Therefore, rheumatologists, internists, and primary care physicians are often asked to evaluate patients in the perioperative setting. This chapter reviews the basic concepts that underlie perioperative medical care and management, emphasizing problems that are relatively specific to the patient with rheumatic disease. The purpose of the preoperative medical and subsequent perioperative management are as follows: Identification of comorbid conditions that may affect perioperative clinical decision-making. Assessment of risk both in magnitude and type. Anticipation of potential postoperative complications. Although not always possible e. The preoperative evaluation should serve as a focal point of an up-to-date medical assessment and communication among all members of the medical team who will be caring for the patient. The nature and extent of the preoperative evaluation of the patient depends on such factors as age, functional capacity, existing comorbidity, the type of anesthesia, and the type of surgery to be performed. However, some general guidelines as given here can provide a useful framework for such evaluations. History and physical examination. Except for young patients and those undergoing only minor surgical procedures, most other patients should undergo a complete medical history and physical examination immediately prior to the surgical procedure. Although it has never been demonstrated that preoperative laboratory testing improves surgical outcome, a number of investigations may be considered appropriate and are commonly performed on patients prior to major surgical procedures. Depending on the nature of the problem and the magnitude of surgery required to correct it, as well as the nature and severity of coexisting diseases, such testing might include the following: Urinalysis and culture for those patients undergoing total joint arthroplasty. Prothrombin [international normalized ratio INR] and partial thromboplastin time while these are not demonstrated to be of value as preoperative investigations, they are of reasonable value in patients requiring anticoagulants after surgery, i. A lead electrocardiogram ECG. Chest radiograph particularly in the elderly patients and those undergoing major joint or spine surgery. This type of approach can often prevent significant cardiac, pulmonary, and neurologic problems, as well as problems with clotting postoperatively. Although the standard history and physical examination remain the principal screening method for the detection of conditions likely to affect the outcome of surgery, there are two rating systems that are useful in identifying patients who are most likely to develop postoperative complications. The ASA consists of five levels of risk, which are based on the presence of a systemic disturbance; absent I , mild II , moderate III , severe IV , and virtually certain to cause death V ; the subdesignation E denotes emergency surgery. A second system, focused on the risk of cardiac complications after surgery, is the Goldman Cardiac Risk Index or subsequent modifications of the index. This system is somewhat more complex, emphasizes recent myocardial infarction and decompensated congestive heart failure as risk factors, and is the foundation upon which much of the current perioperative cardiac risk assessment is based. In patients with cervical spine instability or a rigid airway, fiberoptic intubation may be required. At the discretion of the anesthesiologist, central venous pressure, arterial pressure, and Swan-Ganz catheter monitoring may be helpful in select patients. Such monitoring is often employed in patients undergoing bilateral joint replacement surgery and in those with a history of prior cardiac disease. Patient-controlled analgesia via an epidural route of administration is a very effective method of pain control postoperatively and often facilitates postoperative physical therapy, which is important in the restoration of range of motion in patients undergoing orthopedic surgery. This technique also reduces the systemic absorption of analgesics, thereby minimizing the problem of narcotic-induced respiratory depression, sedation, or cognitive problems in the elderly patients, or bowel problems such as ileus. Parenterally administered nonsteroidal anti-inflammatory drugs NSAIDs , such as ketorolac Toradol , are a

useful alternative to traditional analgesia after surgery and can be used to reduce the requirement of narcotics after major surgery. These drugs should not be given to patients with the usual contraindications to NSAIDs such as peptic ulcer disease, renal disease, and the concomitant use of anticoagulants. Table summarizes medication concerns and reminders related to comorbid conditions. The presence and extent of cardiovascular disease in assessing the risk of noncardiac surgery cannot be overstated and is, fortunately, the most investigated and well-documented arena of perioperative medicine. A large subset of patients who undergo orthopedic procedures such as joint replacements and hip fracture repair are older individuals, or have a systemic joint disease such as rheumatoid arthritis. Both the older individuals and patients with rheumatoid arthritis have an increased incidence of coronary artery disease, the former because of age-related phenomena and the latter because of the inflammatory state itself. Practical guidelines for the physicians involved in the assessment and care of patients with cardiac disease are widely recognized. The predictive value of the routine clinical assessment, including medical history, physical examination, ECG, and chest x-ray is well established, at least with respect to the identification of the presence of pre-existing cardiac disease. However, it is also important to define disease severity and stability, as well as prior treatment received. The factors that work in concert with other clinical characteristics and ultimately define postoperative risk include the following: Functional capacity as determined by simple activity questionnaires. Comorbidity particularly diabetes mellitus, peripheral vascular disease, and chronic pulmonary disease. Type of surgery to be performed major orthopedic procedures tend to be of intermediate risk. A series of factors may predict postoperative myocardial infarction, congestive heart failure, and death after orthopedic surgery. Major predictors of increased perioperative cardiac risk are as follows: Unstable or severe angina. Poorly compensated congestive heart failure. Intermediate predictors of increased perioperative cardiac risk are as follows: Prior myocardial infarction determined from history or by pathologic Q waves. Compensated or prior congestive heart failure. Table Perioperative Evaluation and Care Category.

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2: Perioperative Care of the Patient with Rheumatic Disease | Musculoskeletal Key

Prevention of Ischemic Neurologic Injury With Intraoperative Monitoring of Selected Cardiovascular and Cerebrovascular Procedures: Roles of Electroencephalography, Somatosensory Evoked Potentials, Transcranial Doppler, and Near-Infrared Spectroscopy.

Advanced Search Perioperative stroke is a potentially devastating complication with an incidence of 0. Although rare, stroke in the perioperative setting is associated with an adjusted 8-fold increase in mortality, thus developing preventive strategies is of paramount importance. In this editorial, the preoperative approach to a patient at high risk of stroke is reviewed based on the SNACC consensus statement, with additional discussion of the crucial question of when to schedule surgery in patients with a history of stroke. Consistent independent predictors of perioperative stroke across multiple epidemiological studies include older age, history of cerebrovascular disease such as past stroke or transient ischaemic attack , kidney failure, atrial fibrillation, and valvular disease. In terms of beta blockade, the POISE-1 trial demonstrated that the administration of perioperative metoprolol to non-cardiac surgical patients with cardiovascular risk factors was associated with a significantly higher incidence of stroke and mortality; 5 a recent Cochrane database review supports this interpretation. Although the recommendations suggested a delay of at least 1 month between stroke and elective surgery, despite prior studies suggesting no increased risk of adverse events, 11 , 12 there were virtually no data to support this recommendation. Timing of surgery following stroke: An elusive question in preoperative assessment and risk modification has been when to operate on patients with recent major vascular events. For example, the timing of surgery in patients with recent acute coronary syndrome is well investigated 11 , 13 , 14 if not solved , whereas the timing of surgery in patients with a history of stroke has been inadequately addressed. This is clearly important, as prior cerebrovascular disease is an important risk factor for perioperative stroke. Since publication of the consensus statement, new data have been published on the timing of non-cardiac surgery following ischaemic stroke. Although observational, the data suggest that, if possible, elective surgery should be deferred until 6 months after a stroke. Given that contemporary data show that non-cardiac surgery is associated with higher risk for 6 monthsâ€”1 year following an acute coronary syndrome, 7 , 9 it seems unsurprising that stroke may exert a similar effect. Importantly, even minor surgeries after ischaemic stroke were associated with adverse outcomes. In a previous analysis of data from England and Wales, Sanders and colleagues 11 included patients having elective major joint arthroplasty, but only patients 0. This led the authors to speculate that clinicians avoid elective surgery shortly after a stroke because they consider this a higher-risk period. The data from Jorgensen and colleagues focusing on a diverse non-cardiac, non-neurological surgery population support the clinical decision making inferred based on data from major joint arthroplasty, clarifying the situation greatly. The unanswered questions for patients with prior stroke at risk of perioperative stroke When to conduct emergency surgery, such as hip fracture repair, following a stroke remains unclear. Here the pressure to treat an emergent or urgent condition leads to a clinical dilemma. These decisions must be a compromise between the cerebrovascular vulnerability or other medical issues and treatment of the surgical pathology. Indeed, delaying surgery in certain high-risk situations may be associated with greater harm than conducting early surgery. Regarding time-sensitive surgery such as for cancer , it may still be prudent to delay surgery since increasing time elapsed following a stroke is associated with a reduced risk of postoperative mortality and perioperative stroke. However, we should recognize that the absolute mortality and morbidity rate for some cancer operations remains low and clinical judgment remains the key determinant. A prudent approach should include discussion with the patient of the timing of surgery following a vascular event, and consideration should be given to delaying surgery if possible to reduce perioperative risk. Further details of this consent process are mentioned in the consensus statement. Although patients at risk of perioperative stroke, including those with preoperative stroke and other vascular risk factors, can have impaired cerebral autoregulation, 16

evidence is lacking for optimal management of their blood pressure in the perioperative period. Recent data show that perioperative atrial fibrillation increases the risk of long-term stroke. In conclusion, stroke remains a potentially disastrous complication of modern perioperative care; as such, the SNACC consensus statement provides important guidance and highlights the numerous gaps in our current clinical understanding. In this regard, we are optimistic that further modifiable non-cardiac surgical 2 , 11 and cardiac surgical risk 18 factors for perioperative stroke will be identified. None of the authors have declared any conflict of interests with regards to this editorial.

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Features articles regarding preoperative and perioperative treatment of Cerebrovascular disease. This work includes topics such as carotid artery stenting versus carotid endartectomy, intracranial vessel stenting, surgical intervention for intracranial aneurysms, clipping versus coiling of intracranial aneurysms, and more.

4: Perioperative stroke: a question of timing? | BJA: British Journal of Anaesthesia | Oxford Academic

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5: Books by JosÃ© Biller (Author of DeMyer's the Neurologic Examination)

This article emphasizes some key points in the preoperative evaluation of patients with neurologic disease. The amount of neurologic disease in the general population is a difficult number to assess accurately.

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