

*A guide for the referring physician:*

*What do the surgeon and anaesthetist need to know?*

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Andrew Severn did a spot of geriatric medicine in 1982 with Brian Payne in Norwich, at which stage he was noticed trying to set up an ad hoc intensive care unit on the ward. Subsequently, and to Brian's relief, becoming an anaesthetist he made the mistake of telling an interview committee that he enjoyed anaesthesia for hip fractures. Further ventures into the interface between geriatric medicine and anaesthesia have seen him writing on anaesthesia for parkinsonism, and a regular faculty member of the Stanmore Fragility Fracture course. He also contributed to the Blue Book and is editor for the curriculum of geriatric anaesthesia for the Royal College of Anaesthetists.

Andrew was involved in the Age Anaesthesia Association from the beginning, running it as secretary for 10 years before becoming its President last year. He has an anaesthetic and chronic pain practice in Lancaster.

I recently attended a meeting about the introduction of an enhanced recovery programme for the fast tracking of patients with colorectal cancer through surgery. All the 'stakeholders', with one obvious exception were there. Anaesthetists, surgeons, specialist nurses, stoma therapists, occupational therapists, managers, they were all there and contributing to the discussion. The idea of putting an 85 year old patient through a right hemicolectomy in three days is clearly attractive to my Trust and there is a momentum gathering.

I regret to say that our Department of Medicine for the Elderly was not represented at the meeting. On my asking what plans there were to engage this department in the matter there were three highly significant replies from the meeting[a1]. Firstly that the business of assessing suitability for surgery in this population was a surgical responsibility and was done by 'eyeballing' the patient in the surgical outpatients. Secondly, that it was proposed that any patients who didn't do as well as hoped would simply be able to 'go to rehab' after a predetermined short stay on the surgical ward. Thirdly, of course, there was the matter of target setting. The driving force for this venture is the desire to have the condition treated within a fixed time frame, so any condition, such as malnutrition or cardiac dysfunction, that might in an ideal world require sorting out preoperatively would have to be ignored in the interests of expediency, hence the less that these areas were explored, the more efficient the service would be.

I trust that this meeting shares my anxiety that the patients whose interests are looked after by this audience risk being sidelined and that the real issues to do with quality of survival have already been ignored. It is clear from the brief discussion in my hospital noted above that surgeons and anaesthetists don't actually *know* what they need to know[a2]: if geriatrics could be reliably spot on with prediction of mortality they might be interested. So rather than telling you what we need to know I intend to ask you what you think we need to know.

So the first thing the surgeon and anaesthetist needs to know is :

*'Is the opinion of the elderly care physician relevant to the proposed operation?'*

And here I am going to leave the uncharted water of fast track colorectal surgery and talk about something closer to my own experience[a3].

The Belfast group has had unparalleled opportunity to examine in detail the cardiovascular status of patients with hip fracture. We have data on the incidence of aortic valve stenosis and the correlation between clinical and echocardiographic findings[a4] . We have some fairly difficult to understand data on anaesthetic technique and mortality in groups with or without cardiac valve lesions. What we don't get , however, either from the data or from speaking to the Belfast group, is the sense that the information obtained was able to change outcome.

Rather, the information provided to the anaesthetic team has concentrated on one measured variable, the gradient across the aortic valve[a5]. We have no evidence from modern anaesthetic practice that the gradient across the aortic valve is relevant: such data as we have about anaesthetic hazard comes from 50 year old observations on rheumatic heart disease in pregnancy. Despite this, aortic stenosis has become a surrogate for poor 'anaesthetic risk' simply because it can be measured. If there is a conflict in your hospital over the need to measure the aortic gradient before an anaesthetic, think ' Do I, as a physician, need this measurement ?' If you don't , then the chances are that the anaesthetist doesn't really have to have it either. If , on the other hand, you think that the clinical presentation is compatible with severe aortic valve disease , with all the dangerous complications of syncope, left ventricular strain and so on then say so. The careful data assembled by the Belfast group in urgent surgical cases becomes not so much a tool for predicting mortality according to aortic gradient but a demonstration that patients who wait an average of 8.4 days between injury and surgery have higher mortality than those who wait 5 days[a6].

The lesson to be learnt from this exercise is that there is a gulf between our respective professions that is currently very difficult to bridge. Recently an interesting email exchange occurred within the group of 'Blue Book' authors about the way in which the requirement for preoperative echocardiography

has become a source of conflict. It had to be stopped before someone got hurt.. But it should not be a conflict. As anaesthetists we should be able to approach the physician and say : What do you make of this patient's circulation[a7]? Are there any aspects of it that fall outside the normal for this age group? And we should be able to use your description that the problem is aortic stenosis , aortic sclerosis , diastolic dysfunction or isolated systolic hypertension, based on whatever clinical or laboratory findings are relevant to the case.

If we leave aside the unresolved issue of delays for fixation of hip fracture and the question of definition of 'medically fit' for urgent surgery, the issue we should be discussing today is frailty and the way this may impact upon , for example the 88 year old for joint replacement or cancer surgery. I appreciate there are many ways of defining the frailty syndrome, but a loss of reserve is the fundamental problem. Loss[a8] of reserve of skeletal muscle , leading to immobility, predisposition to postoperative respiratory and thromboembolic complications. Loss of cardiovascular reserve, leading to an inability to cope with the stress response to surgery. The surgeons call it 'eyeballing' in that they, like all of us, can[a9] recognise the far end of the spectrum, but we need to be far more ambitious. We wish to identify the patient who may not be as good as our 'eyeballing' might imply. I put it to you that this is a geriatric professional skill. And we need that information.

There will be some units where this information is conveyed to the surgical team but it is clear that this isn't the standard that was being put forward by my hospital. Realistically also, it may be difficult to cover all potential patients with the staff available. But there is a new opportunity that I think can work for both our professions and ensure that the appropriate issues are highlighted in vulnerable patients.

The new opportunity is the development of nurse led preoperative assessment clinics. Run by senior nurses answering to surgeons it has been set up to prevent cancellations of surgery. At its worst it's a surrogate house surgeon[a10] for the days of EWTD and MMC : simply a way of ordering every conceivable investigation in advance so there is no excuse for a last minute cancellation. The nurses obviously haven't been trained to the standard of the preregistration house officer of my day but they have learnt that if they hear something in the chest other than 'lub – dup' then getting an echocardiogram will pass the buck.

At its best it's a valuable alternative to the surgical eyeballing. The surgeon has astigmatism[a11], a defective vision caused by the conflicts of targets, the technical challenge of the case, the expected impact on the waiting list and the risk to reputation in the event of a postoperative death. The preoperative nurse is freed from all of this, and I would suggest ,as an experienced clinician with a working knowledge of surgical or medical wards, will have tacit understanding of what frailty is. The nurse also has , at the

moment at least, a luxurious amount of time to undertake the task of preop assessment.

So here is the opportunity. Get onto your preop assessment nurses and persuade them that reports of weight loss and fatigue[a12] , that evidence of muscle wasting or nutritional status and whatever other parameter you want to use are just as important to the outcome as the murmur or[a13] the serum rhubarb. Get them to spend that 10 minutes on the MMSE, give them easy contact details with your team so they can report anomalies. Give them a list of medicines like amantidine and pergolide that[a14] must not be stopped. Use that information to plan your own involvement with selected patients or to make sure that patients with specific needs have their needs met on admission. Do it now while the new nurse specialty is in its infancy , and you will have anaesthetic and surgical friends for[a15] life.