OBSTRUCTIVE SLEEP APNEA

Are these patients contra-indicated in the office?

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Case Scenario

You are a new graduate from an anesthesiology residency program. You have joined a private practice group in town. There has been a cancellation at the plastic surgery office that your group provides anesthesia coverage. Dr. Plastic calls your group to ask for anesthesia services for an add-on case. You are told the patient has been NPO for 8 hours. The Chief of Anesthesia sends you to the office to provide the anesthesia service. You arrive at the plastic surgery office and your patient walks in the pre-op area.

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Case Scenario

Mrs. C. Pap is a 52 year old woman scheduled for lipo-abdominoplasty. She had been on the wait list and was notified late the night before of a cancellation.

- Vitals: BP 145/90 HR 94 O2Sat 96%
- Height 5'2
- BMI 45
- Type 2 Diabetes: Metformin BID
- HTN: Lisinopril and HCTZ
- GERD: Prilosec

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EXPERTS' OPINION

Controversies in office-based anesthesia: obstructive sleep apnea considerations

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TABLE I.—*Differences in ambulatory* versus *office-based anesthesia.*

	Ambulatory anesthesia	Office based anesthesia (subset of ambulatory anesthesia)
ASA standards	Applicable	Inconsistent
Facility setup	Must comply with local, state and federal laws and regulations	Must comply with local, state and federal laws and regulations
Practice	Usually integrated with larger hospital	Usually free-standing
Complexity of cases	Minor to major Duration not applicable	Minor to major procedures Duration not specified Subject to state regulation
Facility certification	Subject to state and local licensure. TJC, CMS set standards	Not all states require licensure. Most national organizations set standards*
Criteria for accreditation	Strict	Anesthesia requirement remain nonspecific
Equipment and Monitoring standards	ASA standards applicable	Variable
Cost of the procedure	More	Less
Adverse events	Lower	Higher

TJC: The Joint Commission; AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities; CMS: Center Medicare Services; AAAHC: Accreditation Association for Ambulatory Health Care.

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Making the Argument

PROs: OSA can be cared for in OBA setting

- Studies comparing OSA patients in ASC vs. Inpatient; no clinically significant adverse outcomes
- Office based liability claims could have been prevented by better monitoring and patient selection, not specifically related to OSA patients
- Safe as long as surgeon is credentialed for same procedure I ASC and Hospital
- Multimodal pain mgmt. is essential
- Determining factor is the availability of resources, not the location

CONs: OSA is a contraindication in the OBA setting

- OSA patients have increased prevalence of comorbidities
- GA increases upper airway collapsibility in a dose dependent manner
- Anesthetic medicines impair the arousal response, protective mechanism for OSA patients
- OSA patients have increased propensity to have a difficult airway
- Most OBA lack the same resources available to an anesthesiologist in a ASC
- Variability or lack of federal oversight in OBA setting

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Things you can do

1. Measure the OSA risk using the STOP-BANG questionnaire
   - Snore?
   - Tired?
   - Observed Apnea
   - BP
   - BMI
   - Age
   - Neck circumference
   - Gender

   0-2 low risk; 3-4 moderate risk; 5-8 high risk
2. Comprehensively trained OBA anesthesiologist
   - Only 16 % of anesthesiology residency programs have an office-based rotation

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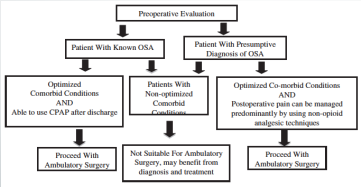
Society for Ambulatory Anesthesia Consensus Statement on Preoperative Selection of Adult Patients with Obstructive Sleep Apnea Scheduled for Ambulatory Surgery



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