SOCIETY FOR AMBULATORY ANESTHESIA
Outpatient • Office Based • Non-Operating Room
@samba_hq

SAMBA 2024 Annual Meeting
May 2-4, 2024

Patient Selection; 6 P"s of OBA

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Disclosures

- I receive funding from the International Anesthesia Research Society
- I am an author of UpToDate “Preoperative Evaluation” and receive compensation
- I am the Executive editor of A&A Practice
- On editorial staff of Anesthesiology and Anesthesia and Analgesia
- I have received funding from Medtronic

KISS (Use the ASA-PS!)

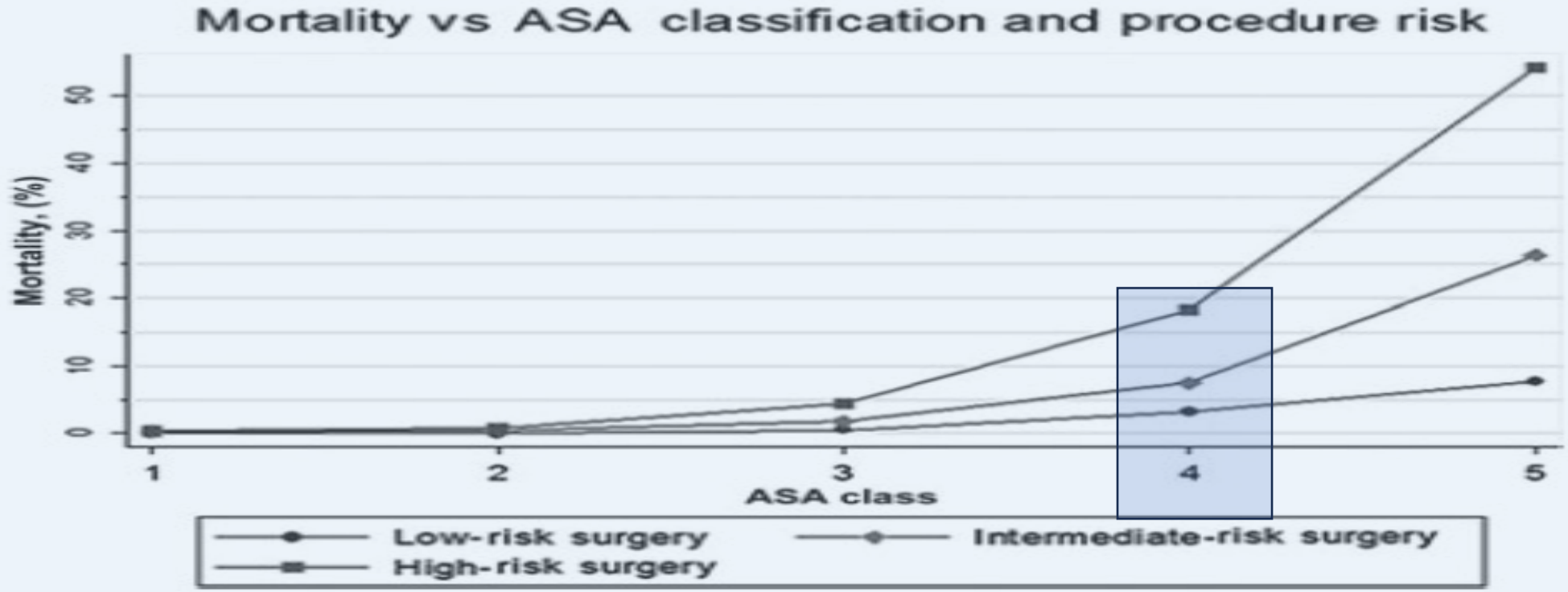


FIGURE 1. The observed mortality rate as a function of American Society of Anesthesiologists' physical status and surgery-specific risk.

Anesthesiology 2018;128:1140-; Drugs & Aging 2023;40:335–3; Hip Int 2015;25:215-

FRAILITY AND POSTOPERATIVE COMPLICATIONS

- ✓>140,000 frail patients having ambulatory surgeries (hernia, thyroid, parathyroid and breast)
  - ✓Increasing frailty ↑ Complications
  - ✓Pulmonary complications most common adverse events
  - ✓Local anesthesia and MAC ↓ Serious 30-day complications

CONCLUSIONS AND RELEVANCE Frailty is associated with increased perioperative morbidity in common ambulatory general surgery operations, independent of age, type of anesthesia, and other comorbidities. Surgeons should consider frailty rather than chronological age when counseling and selecting patients for elective ambulatory surgery.

J Am Coll Surg 2016;222;930- ; J Am Coll Surg 2010;210:901-; JAMA Surg 2018;153:160-

Frail Index

Box. Variables Corresponding to Frailty Traits That Are Included in the 11-Variable National Surgical Quality Improvement Program Modified Frailty Index

- History of diabetes
- Impaired functional status
- History of chronic obstructive pulmonary disease or pneumonia
- History of congestive heart failure
- History of myocardial infarction within 6 months
- History of percutaneous coronary intervention
- Cardiac surgery or angina
- Receipt of hypertensive medications
- Peripheral vascular disease or rest pain
- Impaired sensorium
- History of transient ischemic attack or cerebrovascular accident with persistent residual deficit

JAMA Surg 2018;153:160

Heart Failure and Low-risk Surgeries

- ✓ 19353 HF patients having ambulatory surgery in VASQIP
- ✓ **Mortality risk with HF, 2%** vs 0.39% without HF
  - ✓ **Adjusted odds ratio [aOR], 1.95**; 95% CI, 1.69-2.44
- ✓ Symptomatic HF had greatest risk of **mortality**
  - ✓ **Risk, 3.57%; OR, 2.76**; 95% CI, 2.07-3.70
- ✓ Asymptomatic HF **mortality risk elevated**
  - ✓ **Risk, 1.85%; OR, 1.85**; 95% CI, 1.60-2.15
- ✓ HF patients had higher **30-day postoperative complications**
  - ✓ **5.65%** vs 2.65%; aOR, 1.10; 95% CI, 1.02-1.19
- ✓ ***"Although risk models place emphasize CAD over heart failure, HF has a significantly higher risk of periop death than CAD"***

JAMA Surg 2019:154:907-; JACC 2014;64:e77-

Association of Time Elapsed Since Ischemic Stroke With Risk of Recurrent Stroke in Older Patients Undergoing Elective Nonneurologic, Noncardiac Surgery

- ✓Stroke within 30 days before surgery: 8-fold higher risk of stroke
- ✓Risk of stroke significantly decreased at 90 days

Delay surgery for 3 months

JAMA Surg 2022;157(8):e222236

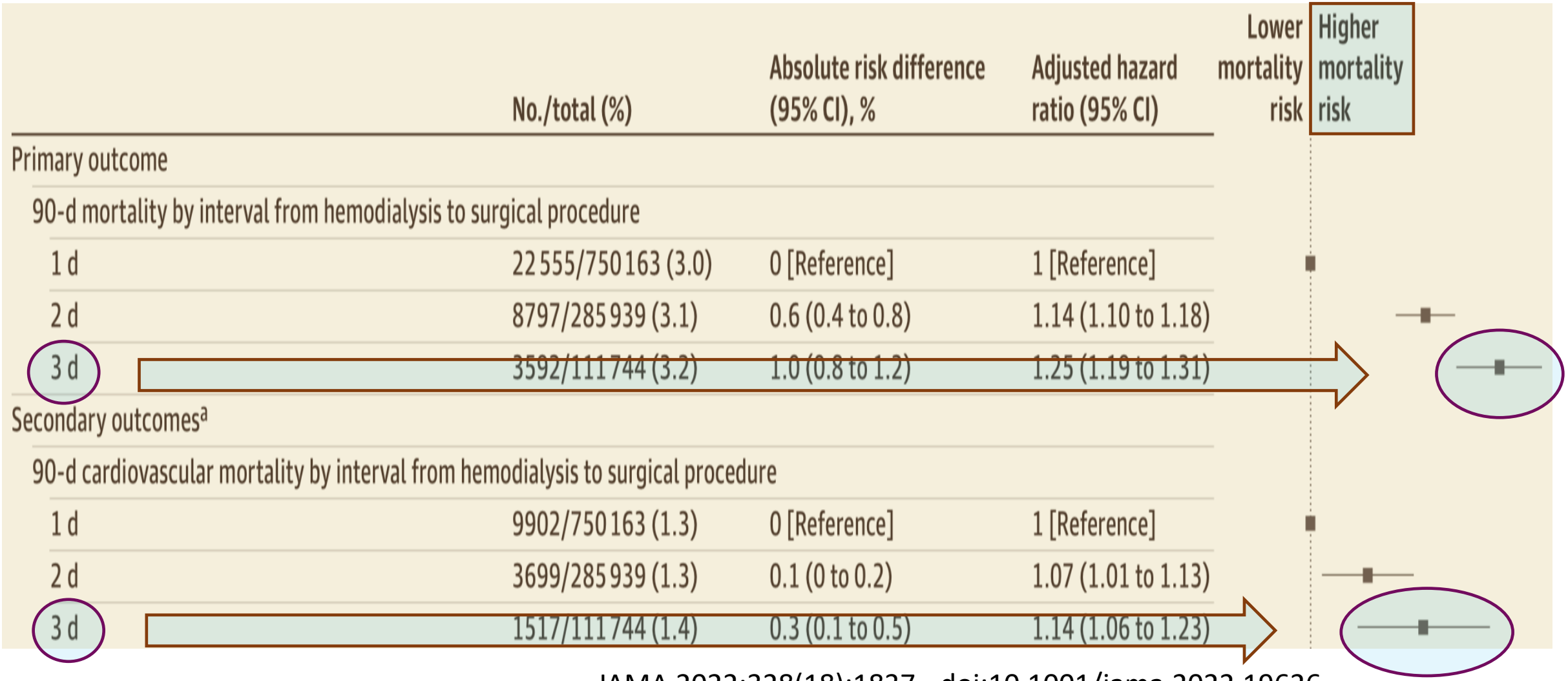
TABLE 1

Revised Cardiac Risk Index[7]

Two or more of the following risk factors make a patient "high risk."
High-risk surgery (intraperitoneal, intrathoracic, or supra-inguinal vascular procedures)
History of ischemic heart disease
History of congestive heart failure
History of cerebrovascular disease
Preoperative treatment with insulin
Preoperative serum creatinine >2.0 mg/dL

Association Between Preoperative Hemodialysis Timing and Postoperative Mortality in Patients With End-stage Kidney Disease

	No./total (%)	Absolute risk difference (95% CI), %	Adjusted hazard ratio (95% CI)
Primary outcome			
90-d mortality by interval from hemodialysis to surgical procedure			
1 d	22 555/750 163 (3.0)	0 [Reference]	1 [Reference]
2 d	8797/285 939 (3.1)	0.6 (0.4 to 0.8)	1.14 (1.10 to 1.18)
3 d	3592/111 744 (3.2)	1.0 (0.8 to 1.2)	1.25 (1.19 to 1.31)
Secondary outcomes[a]			
90-d cardiovascular mortality by interval from hemodialysis to surgical procedure			
1 d	9902/750 163 (1.3)	0 [Reference]	1 [Reference]
2 d	3699/285 939 (1.3)	0.1 (0 to 0.2)	1.07 (1.01 to 1.13)
3 d	1517/111 744 (1.4)	0.3 (0.1 to 0.5)	1.14 (1.06 to 1.23)



JAMA 2022;328(18):1837-. doi:10.1001/jama.2022.19626

Other Important Medical Conditions

- ✓Atrial fibrillation
- ✓Severe aortic stenosis
- ✓Cardiac surgery or PCI at any time
- ✓Congenital heart disease
- ✓Poorly controlled HTN
- ✓Pulmonary HTN
- ✓Severe COPD/Asthma
- ✓Obstructive sleep apnea
- ✓Cirrhosis
- ✓Recent venous thromboembolism
- ✓Extreme obesity
- ✓Diabetes
- ✓Cancer
- ✓Paraplegia/quadriplegia
- ✓Oxygen dependency
- ✓Tobacco abuse
- ✓Chronic pain
- ✓Illicit drug use

Preoperative Care for Cataract Surgery: The Society for Ambulatory Anesthesia Position Statement

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Cataract surgeries are among the most common procedures requiring anesthesia care. Cataracts are a common cause of blindness. Surgery remains the only effective treatment of cataracts. Patients are often elderly with comorbidities. Most cataracts can be treated using topical or regional anesthesia with minimum or no sedation. There is minimal risk of adverse outcomes. There is general consensus that cataract surgery is extremely low risk, and the benefits of sight restoration and preservation are enormous. We present the Society for Ambulatory Anesthesia (SAMBA) position statement for preoperative care for cataract surgery. (Anesth Analg 2021;133:1431–6)

"If a patient can lie in a position that allows the procedure there are few conditions or test results that preclude cataract surgery"

Annals of Internal Medicine EDITORIAL

Preoperative Evaluation Can Delay Ophthalmologic Surgery Without Improving Outcomes

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