Sven Felsby, Denmark
a) Most complications occur **after** the first 24 hours. We cannot chaperone patients for a week.

b) Opioid use should be minimised.

a) Better to build a **safety net** around the patient than imposing a burden upon a relative, who may not be competent – or may be absent.
Today

Factors that incapacitate the patient

Can we modify some of these factors?

Does it really matter?
Postoperative observation

Post-anaesthetic observation

Post-surgical observation
post-anaesthetic observation

- Opioid  hypoventilation (µ)
- Relaxants  aspiration, hypoventilation
  (paralysis and O₂-chemoreceptor block)
- Gas, opioid  PONV
- All  sedation, airway obstruction, hypothermia, vasodilation
40 minutes of remifentanil

Remifentanil 100µg bolus, 2500µg/h infusion
40 minutes of propofol

Propofol 100mg bolus, 300mg/h infusion
post-anaesthetic observation

- Opioid hypoventilation (μ)
- Relaxants aspiration, hypoventilation (paralysis and O₂-chemoreceptor block)
- Gas, opioid PONV
- All sedation, airway obstruction, hypothermia, vasodilation

All factors expect PONV can and should be fully reversed before arrival to the recovery room
Five half-lifes

2-3 hours after propofol-remifentanil sedation

5-6 hours after propofol-remifentanil anaesthesia + 100µg fentanyl

15 hours if morphine is given
post-surgical observation

- Bleeding, fluid losses
- Pain
- Operation-specific complications

All factors should be attended to before leaving the recovery room
10% of patients had difficulty finding company

50% found it unnecessary

No critical episodes by systematic follow-up in 20 years
10298 patients 2012 – 2015
of whom 1319 patients were home alone:
1167 (88%) denied problems at home

152 (12%) had a problem.
Of these 152:

39 had no need for a relative
113 needed a relative

56 uneasy
21 daily activities
15 pain
5 dressing
4 PONV
15 unspecified

Problem solutions:

64 solved by themselves
21 contacted a relative
2 contacted emergency dpt.
9 contacted physician the day after operation
20 unspecified
The support may not be competent.

Safety net:

Verbal and written guidance

Emergency telephone number

Follow-up call
Information

Oral information, preferable with escort present
  Amnesia after general anaesthesia
  Carer may share discharge instructions when picking up

Leaflet in plain, clear language

What to expect:
  Pain, bleeding, sutures / wads / catheters
  Contact person at facility
  Follow up phone call and/or visit

Emergency telephone number
Time from day surgery to first hospital contact among patients with complications that were definitely or likely related to the procedure.

Practice Guidelines for Postanesthetic Care

An Updated Report by the American Society of Anesthesiologists Task Force on Postanesthetic Care

PrACTICE Guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints, and are not intended to replace local institutional policies. In addition, Practice Guidelines developed by the American Society of Anesthesiologists (ASA) are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice Guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert and practitioner opinion, open forum commentary, and clinical feasibility data.

This document updates the “Practice Guidelines for Postanesthetic Care: A Report by the American Society of Anesthesiologists Task Force on Postanesthetic Care,” adopted by the ASA in 2001 and published in 2002.*

- What other guideline statements are available on this topic?
  - These Practice Guidelines update the “Practice Guidelines for Postanesthetic Care,” adopted by the American Society of Anesthesiologists in 2001 and published in 2002*
- Why was this Guideline developed?
  - In October 2011, the Committee on Standards and Practice Parameters elected to collect new evidence to determine whether recommendations in the existing Practice Guideline were supported by current evidence
- How does this statement differ from existing Guidelines?
  - New evidence presented includes an updated evaluation of scientific literature. The new findings did not necessitate a change in recommendations
- Why does this statement differ from existing Guidelines?
  - The American Society of Anesthesiologists Guidelines differ from the existing Guidelines because it provides updated evidence obtained from recent scientific literature

Methodology

A. Definition of Postanesthetic Care

A standard definition for postanesthetic care cannot be iden-
Recommendations:
All patients should be required to have a responsible individual accompany them home.
Fashion

Rules to **disregard**:  
Have voided  
Have eaten  
Minimum recovery time  
Company at home

Rules to **keep**:  
Stable hemodynamics  
No supplementary O$_2$  
No bleeding  
Preoperative mental state  
Acceptable pain and PONV  
Well informed  
Escort from hospital to home
Complications
- what to do
Cognitive dysfunction after minor surgery in the elderly

Admission: 199
Day surgery: 173
7 days: POCD 6.8%
3 months: POCD 6.6%

Risk factors:
Age > 70 years
OR 3.8 [1.7-8.7], P = 0.01

Admission vs. day surgery
OR: 2.8 [1.2-6.3], P = 0.04
Minor sequela are common and may lead to delays in discharge, unanticipated admission and returns to the hospital.

Guidelines!
Have a plan!
Factors that incapacitate the patient
- Surgery, cytokines, pain
- PONV, opioids
- Fear, uncertainty

Can we modify these factors?
- Some of them

Does it really matter?
- Depending on patient and type of surgery
a) Most complications occur after the first 24 hours.

b) Verbal and written guidance from nurses, surgeon and anaesthetist.

c) build a safety net around the patient and allow them to go home alone