SWG Anesthesia Bariatric Surgery Guidelines

May 2023

On either their PAT visit or their EGD appointment, bariatric patients with a BMI ≥ 50 will have an anesthesia consult to

- Stratify risk as described below
- Discuss the anesthesia plan
- Fill out a pre-anesthesia assessment
- If the patient is considered Maximal Risk, order an airway prep: Robinul IV and a 4% lidocaine aerosol

Anesthesia will be called to PAT to see patients with a BMI 50-70, unless they have already been cared for in SW Endoscopy. Anesthesia will be called for patients with BMI > 70 regardless of prior procedures

RISK STRATIFICATION TO DETERMINE AIRWAY MANAGEMENT FOR INDUCTION AND EMERGENCE

Risk stratification to be based on the BMI and the presence of any one of the following risk factors:

- Diagnosis of OSA
- Neck circumference of ≥ 60 cm
- Abnormal airway exam

  Abnormal airway exam to be defined as the presence of dentition with either:
  - Mallampati IV
  - Micrognathia (TM distance < 5 cm)
  - Prominent incisors

	Standard Risk	**Elevated Risk**	**Maximal Risk**
Definitions	BMI < 50 Regardless of risk factors -or- BMI 50-59 Without risk factors	BMI 50-59 With risk factors -or- BMI 60-69 Without risk factors	BMI 60-69 With risk factors -or- BMI ≥ 70 Regardless of risk factors
Induction: Intubation type	*Rapid sequence induction - Standard or modified	*Rapid sequence induction – Standard or modified	Awake laryngoscopy to determine the safety of RSI vs. awake intubation (with laryngoscope or fiberoptic bronchoscope)
Induction: provide supplemental O_2 during intubation (e.g., HFNC)	No	Yes	Yes
Induction: Back-up anesthesiologist immediately available; case timing	Optional. Can be second or third case	Optional. Make it first case of the day if possible	Yes. First case of the day
Induction: Personnel performing intubation	APP	Physician	Physician. Consider 2nd physician if BMI ≥ 80
Emergence: Personnel present for extubation	APP ± anesthesiologist	APP + anesthesiologist	APP + anesthesiologist
Extubation: application of positive pressure device on arrival to PACU	Yes, if OSA, or as needed	Yes	Yes

*Before proceeding with induction, stop and ask:

- Will this patient rapidly desaturate after induction?
- Will this patient be difficult to mask

] IF BOTH YES - CONSIDER AWAKE TECHNIQUE

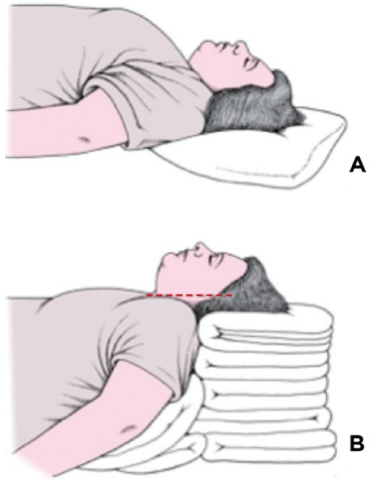
FURTHER SAFETY MEASURES

1. PAA Airway prep if awake technique planned
   - Robinul
   - 4% lidocaine aerosol

2. Pre-induction preparation
   - Positioning ramp-up for airway management – Tragus of ear should be at level of sternum (B in above)
   - If elevated risk, have difficult airway cart with non-disposable FO bronchoscope in room in addition to Glidescope

3. Intubation confirmation – Hypoxia with lack of $ETCO_2$ requires immediate visual confirmation of ETT placement

4. Two IVs; second IV placed after induction



SUMMARY OF REMAINING ANESTHESIA ERAS STEPS

1. IV acetaminophen in PAA
2. Scopolamine patch in PAA
3. Chlorhexidine oral rinse (for full bypass only; ordered by surgeon)
4. Maximal antiemetic prophylaxis (Decadron max dose 4 mg IV)
5. Analgesia – modest dosing of fentanyl; no Toradol; no block; no Precedex
6. Maintenance – Sevoflurane in air and oxygen
7. Succinylcholine for intubation; Zemuron for intra-op
8. Sugammadex reversal; extubation in OR
9. Surgeon will order PACU anti-hypertensives (SBP target < 150)
10. Order OSA protocol for all patients regardless of lack of pre-op diagnosis

PRE-HOSPITAL ERAS STEPS

1. Counseling; Wt. loss
2. Medical clearances
3. OSA screening
4. HbA1C threshold met
5. ACEIs and ARBs to be held for 24 hours