

Sedation in the Ambulatory Endoscopy Center



Optimizing Safety, Expectations and Throughput

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KEYWORDS

- Optimizing safety • Patient expectations • Medication • Patient monitoring
- Efficiency

KEY POINTS

- Optimizing safety is the responsibility of the endoscopist and gastrointestinal assistant of the 21st century. Each must have expertise in sedation and analgesia and patient monitoring.
- Patient expectations must be balanced with physician expectations and safety.
- The most efficient ambulatory endoscopy center will successfully navigate changes occurring in the health care system. Safety and efficiency must be viewed as 1 process.

In the United States, sedation and analgesia are the standard of practice when endoscopic procedures are performed in the ambulatory endoscopy center (AEC). Surveys indicate that physicians and patients expect that sedation and analgesia will routinely and safely be administered for endoscopic procedures.^{1,2} Over the last 30 years, there has been a dramatic shift of endoscopic procedures from the hospital outpatient department to AECs. This article will review sedation and analgesia in the AEC as it relates to optimizing safety, patient expectations, and efficiency.

OPTIMIZING SAFETY—PREPROCEDURE

The responsibilities of the endoscopist and gastrointestinal assistant of the 21st century reach beyond endoscopy. Each must have expertise in sedation and analgesia and patient monitoring, and awareness of potential complications.

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Sedation may be defined as a medication-induced depression in the level of consciousness.³ The purpose of sedation and analgesia is to relieve patient anxiety and discomfort, improve the outcome of the examination, and diminish the patient's memory of the event.³ Sedation and analgesia comprise a continuum of states ranging from minimal sedation (anxiolysis) to general anesthesia.⁴

Table 1 outlines the definitions of the levels of sedation and analgesia. Historically, in the United States, endoscopic procedures in the AEC have been performed with patients under moderate sedation using benzodiazepines and narcotics.

In the United States over the last 15 years, there has been a significant shift to deep sedation using propofol when performing endoscopic procedures in the AEC. In 2009, more than 30% of endoscopic procedures were performed under deep sedation utilizing anesthesia services.⁵ In 2015, most endoscopic procedures in AECs were performed under deep sedation utilizing anesthesia services.

Preprocedure preparation and assessment include appropriate discussion of the procedure and obtaining consent. This discussion should include indications, benefits, risks, and alternatives to the procedure. There are several other important preprocedure variables to assess and implement. According to the American Society of Anesthesiologists' (ASA) practice guidelines for sedation and analgesia by nonanesthesiologists, patients should fast a minimum of 2 hours for clear liquids and 6 hours for a light meal.⁴

A history and physical examination should be performed prior to endoscopy. The examination should focus on sedation and analgesia-related issues. The following data should be collected: (1) abnormalities of major organ systems; (2) snoring, stridor, or sleep apnea; (3) drug allergies, current medications, and potential for drug interactions; (4) prior adverse reaction(s) to sedatives or anesthetics; (5) time, and type, of last oral intake; and (6) tobacco, alcohol or substance abuse.⁴ The physical examination should include the following: measurement of vital signs, determination of baseline level of consciousness, and examination of the heart, lungs, and airway anatomy.⁴

Table 2 defines the ASA physical classification system.

	Minimal Sedation (Anxiolysis)	Moderate Sedation (Conscious Sedation)	Deep Sedation	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful response to verbal or tactile stimulation	Purposeful response after repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Modified from Gross JB, Bailey PL, Connis RT, et al. Practice guidelines for sedation and analgesia by nonanesthesiologists. *Anesthesiology* 2002;96:1004–17.

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