

Perioperative care in gynaecology

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Abstract

Good perioperative care in gynaecology aims towards optimising the patient's condition prior to surgery, ensuring the provision of patient-tailored treatment, minimising postoperative morbidity and length of stay in hospital, and overall improving the patient's experience.

Patients undergoing elective surgery are placed on an enhanced recovery pathway, which is an evidence-based patient-centred approach to care. It is designed to optimise patients prior to surgery, enhance perioperative nutrition, analgesia, and mobility, and post-operatively achieve faster recovery with fewer complications.

The process can start within the primary care setting at the point of referral, with a thorough preoperative assessment focussing on identification of patient-specific risk factors, their optimisation and appropriate preparation for surgery. This allows for early planning of both inpatient and outpatient postoperative care.

Keywords antibiotic prophylaxis; consent; day surgery; enhanced recovery; gynaecology; perioperative care; postoperative complications; preoperative assessment; preoperative tests; thromboprophylaxis

Introduction

Implementing an enhanced recovery pathway in gynaecology aims towards:

- Optimising the patient's condition prior to surgery by identifying and addressing specific needs and comorbidities such as anaemia, hypertension, and diabetes.
- Delivering the best possible care in the intraoperative and postoperative period by ensuring the appropriate use of anaesthesia, employing minimally invasive operative techniques where possible, achieving optimal fluid balance, and improving analgesia.
- Improving post-operative rehabilitation by optimising analgesia, ensuring the availability of appropriate rehabilitation services, encouraging early mobilisation after surgery, and ultimately aiming towards a timely recovery and discharge from hospital.
- Improving overall patient satisfaction.

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Preoperative care

Referral from primary care

Optimising patient health prior to surgery should commence with the general practitioner in primary care.

By using 'fit for list' health screening, GPs can identify and address patient-specific risk factors including anaemia, hypertension, hypercholesterolaemia, sub-optimal diabetic control, impaired renal function, obesity, and smoking, and highlight any specific needs which could affect postoperative discharge.

Detection and early treatment of such risk factors minimises unnecessary delays of surgery. Furthermore optimising these conditions prior to referral reduces the length of hospital stay, morbidity, mortality, High Dependency Unit (HDU) or Intensive Therapy Unit (ITU) admissions and re-admissions.

Through encouraging self-management of the patient's own condition and employing programmes to target smoking cessation and weight reduction, the patient's experience and overall health benefits through direct involvement in their own care.

Preoperative assessment

Preoperative assessment is performed in a specialist setting once surgery has been chosen as the preferred management option. Leaflets and contact telephone numbers should be provided because only 10% of information given in clinic is retained by the patient.

The preoperative assessment allows the patient the opportunity to establish a relationship of trust and confidence with the healthcare provider, to become fully informed about the proposed treatment, and establishes a forum to raise any initial questions or concerns.

Clinical history and examination: the assessment of the patient should include a review of the medical, surgical, anaesthetic and drug history by conducting a thorough medical review and accessing available medical records.

The physical examination should include airway, pulmonary and cardiovascular examinations to assess the risk of anaesthetic complications.

Consent: common practice is to obtain consent at the same appointment that the decision for surgery was made. However a more appropriate time for this would be at the pre-assessment appointment, once the patient has had time to weigh all treatment options, collate the provided information including written materials and DVDs, and discuss with family, friends and GP. This process of informed and shared decision-making allows for adequate time to address any questions or uncertainties which may arise and ensures that the patient has been fully informed and understands the potential risks, benefits, alternative treatments and recovery paths.

Hence if consent is taken at the same appointment that the decision for surgery was made then it should be re-confirmed on the day of surgery.

The Royal College of Obstetricians and Gynaecologists and the General Medical Council have issued guidance on the process of consent. The risks and likelihood of complications with the proposed procedure should be outlined in a way that is easily understood. Risk should be ideally quantified as a frequency with

the use of numerical aids rather than percentages or in subjective terms such as “rare” or “slight” (Table 1).

The consent should include any further procedure that might be necessary in event of complications, such as laparotomy for visceral or vascular damage that occurs during laparoscopy.

Any procedure that the patient would object to needs to be specifically and clearly documented.

Consent for treatment prior to surgery, including the benefits, potential risks and management of intraoperative complications should be taken by a medical professional who is capable of performing the procedure. GMC guidance on consent states that consent can be appropriately delegated. The operating or supervising surgeon should confirm consent on the day of operation.

Preoperative investigations: preoperative investigations should be considered only after a full assessment of the patient to avoid potentially unnecessary and expensive investigations which may not improve clinical outcomes.

National Institute for Clinical Excellence (NICE) guideline CG003 on preoperative tests provides clear pathways outlining which tests should be undertaken with the consideration of patient’s age, physical American Society of Anaesthesiologists (ASA) status (Table 2), the grade and extent of the surgery (Table 3) and the presence of co-morbidity.

Women of child-bearing age should be asked whether or not there is any chance that they may be pregnant. They must be made aware of the risks of surgery to the fetus and a pregnancy test should be carried out with the woman’s consent if there is any doubt about whether the woman may be pregnant.

MRSA screening: meticillin resistant *Staphylococcus aureus* (MRSA) is a bacterium often carried in the skin, nostrils, groin and throat, and is the cause of difficult to treat infections which are resistant to commonly used anti-staphylococcal antibiotics such as penicillins, cephalosporins, erythromycin and ciprofloxacin. Infection with MRSA can be a serious cause of sepsis, endocarditis, and pneumonia, particularly in elderly and immuno-compromised patients.

In accordance with the Department of Health (DH) and Regional Strategic Health Authority (SHA) policy all patients admitted for elective surgery, including day-case admissions, should have their MRSA status checked. Usually this is performed at the pre-assessment appointment. It is the clinician’s responsibility to follow-up this result prior to proceeding with the surgical intervention. If a patient is found to be MRSA positive, treatment should be started and the patient’s GP notified. The decision to proceed with the operation would depend on the

Presenting information on risk

Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10,000	A person in small town
Very rare	Less than 1/10,000	A person in large town

Royal College of Obstetricians and Gynaecologists.

Table 1

American society of anaesthesiologists (ASA) physical status classification

- A normal healthy patient
- A patient with mild systemic disease
- A patient with severe systemic disease
- A patient with severe systemic disease that is a constant threat to life
- A moribund patient who is not expected to survive without the operation
- A declared brain-dead patient whose organs are being removed for donor purposes

Table 2

clinical urgency, the type and extent of surgery and the potential risk of MRSA infection. If surgery is carried out in an MRSA positive patient, certain precautions may be undertaken to reduce risk to patients: theatres need to be informed, the patient should be last on the operative list and there should be a side room available for the care of the patient in the postoperative period.

Venous thromboembolism (VTE) assessment: following gynaecological surgery there is 16% incidence of deep venous thrombosis (DVT) and 1% incidence of symptomatic pulmonary embolism (PE) without the use of thromboprophylaxis. Therefore all patients are required to have a full venous thromboembolism risk assessment prior to surgery. If the calculated VTE risk is increased, NICE guidelines recommend commencing mechanical VTE prophylaxis on admission, with the use of thigh or knee length anti-embolism stockings, foot impulse devices, or intermittent pneumatic compression devices. In addition, if there is no increased risk of major bleeding, low molecular weight heparin (LMWH) is also used (or unfractionated heparin in severe renal impairment or established renal failure). The use of thromboprophylaxis is usually continued until mobility is no longer significantly reduced; this is generally 5–7 days post-operatively. However this is usually extended to 28 days in major pelvic cancer surgery where risk of VTE is deemed significantly greater.

Classification of surgical interventions in different intensity (and risk) categories

Grade 1 (minor)	Excision of lesion of skin; drainage of breast abscess; carpal tunnel release; nasal septum correction
Grade 2 (intermediate)	Primary repair of inguinal hernia; excision of varicose vein(s) of leg; tonsillectomy/adenotonsillectomy; knee arthroscopy; endoscopic bladder procedure; eye lens substitution
Grade 3 (major)	Total abdominal hysterectomy; endoscopic resection of prostate; lumbar discectomy; thyroidectomy; diaphragmatic hernia repair; operations on trachea; prosthetic femoral head replacement
Grade 4 (major+)	Total joint replacement; lung operations; radical neck dissections; organ transplantations
Neurosurgery	
Cardiovascular surgery	

Table 3

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