Preoperative Preparation and Planning of the Oral and Maxillofacial Surgery Patient

Jeffrey D. Bennett, DMD

KEYWORDS

• Patient preparation • Medical history • Medication reconciliation • Airway assessment
• Postoperative analgesia • Postoperative nausea and vomiting • Perioperative antibiotics
• Transference of care

KEY POINTS

- Understanding who the patient is requires obtaining a complete and accurate medical history.
- Not all patients are the same – caring for the pediatric, geriatric, and medically compromised patient present different concerns.
- Systems should be implemented to alert the office and practitioner to critical aspects of patient care, which can minimize errors.
- One size fits all is inappropriate in regard to postoperative analgesia.
- Routine postoperative antibiotics are usually not indicated.
- Optimizing patient outcome requires a plan for transference of care when the primary surgeon is not available.

INTRODUCTION

Ensuring patient safety depends on many variables. Each, when not fully addressed, increases the potential for patient harm. This article focuses on patient preparation. The goal of patient preparation is to ensure that the patient is in optimal condition to proceed with the planned procedure. This requires that the surgeon know who the patient is by obtaining a complete and accurate medical history, including medication reconciliation and tracking the results of all laboratory, diagnostic, and imaging studies. Patient optimization ensures that the surgeon strives for the best results; recognizes perioperative risks, which can contribute to an adverse event are identified and managed; minimizes and controls perioperative pain; is judicious in case selection; and arranges continuance of care throughout the perioperative period.

MEDICAL HISTORY

The first step in patient preparation is to obtain a complete medical history. Without such, the practitioner does not truly know their patient. Accreditation standards for predoctoral dental education dictate that a student is competent in obtaining a medical history. Many before me have written about the application of this standard, and the difference in opinion of many educators as to its satisfactory achievement with some feeling that there is a significant disregard for patient medical assessment in dental education, minimizing the

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1481 West 10th Street, Indianapolis, IN 46202, USA
E-mail address: jb2omfs@gmail.com

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accreditation standard.[1–3] Understanding the importance of the medical history and physical examination, oral and maxillofacial surgery accreditation standards require a distinct course in medical history taking and physical examination for all residents.

The medical history provides information about the patient's past and present history and consists of past medical history, past surgical history, social history, medications, allergies, and a review of systems. Each component is critical. Any incomplete or contradictory information between sections must be explained, investigated, and/or clarified. Filling the informational gaps may be as straightforward as identifying a justification as to why the patient is taking a specific medication (eg, clarifying why a patient is taking an antihypertensive medication when the patient does not list a history of hypertension) or inquiring as to whether the patient is, has stopped, or should be on a medication for a specific condition identified in the medical history (eg, clarifying why a patient with a history of atrial fibrillation is not taking an anticoagulant).

Medical intake forms are usually good for providing a checklist of medical conditions (eg, hypertension) for the practitioner and/or patient to check off. A prepared checklist provides a foundation from which a medical intake can begin. For the individual with low health literacy, however, the form may be confusing and the individual may incorrectly respond "no" to many of the questions. Many patients may not have seen a physician for several years and the medical history responses reflecting a negative health history may not reveal the patient's actual health. A prepared checklist is also usually insufficient in allowing full documentation of a review of systems. The review of systems would detail the severity of a known disease or identify potentially undiagnosed disorders, clarifying potential inconsistencies in a checklist medical history form.

Fortunately, for most practitioners a significant percentage of their patients are young and healthy, and a review of systems is noncontributory and can be completed quickly. However, for the geriatric patient, the medically compromised patient, or the patient with an unrecognized condition, the review of systems may entail a detailed discussion and provide significant information that may alter the planned treatment.

Accepting a patient-completed unremarkable health form, using an abbreviated medical history without obtaining a review of system despite understanding the inadequacy and potential for missed information is the act of neglecting or doing something wrong, which is an "act of commission." Failing to understand the necessity or lack of knowledge to obtain a complete review of systems is a failure to do the correct thing, which is an "act of omission."[4] This failure does not necessarily result in an undesirable outcome. At times, a significant adverse event may occur that is successfully managed by the primary team without any long-term sequelae. The lack of an adverse event, the lack of recognizing an adverse event, or the management of a "close call" may actually contribute to the sense by the practitioner that their abbreviated history taking methodology is sufficient, regardless of whether they appreciate the deficiency in the history and the missing information.

MEDICATION RECONCILIATION

Many patients who present to the oral and maxillofacial surgeon are taking multiple prescribed and over-the-counter medications. This is most prevalent in the geriatric population, where approximately 36% of the patients are taking 5 or more medications weekly.[5] Herbal or dietary supplements may not routinely be inquired about when taking a medical history, yet up to approximately 20% of the population may be taking such a supplement with an even higher percentage of use among the elderly population, with 1 study reporting approximately two-thirds of the elderly population using one such supplement.[5–7]

Medication reconciliation is a critical safety matter. It is the process by which the practitioner establishes a complete and accurate a list of medications that the patient is taking. The process in which to gather this information may be challenging and time consuming, because many patients may neither accurately maintain a record of what they are prescribed nor what they are taking. Asking the patient to bring their medication bottles with them to the appointment, inquiring from family, requesting the information from the patient's primary care doctor, or contacting the pharmacy are potential sources of information. When a patient receives care from multiple physicians, each of these doctors may be prescribing medications. The oral and maxillofacial surgeon cannot assume that each of these doctors has been in contact with the patient's other doctors and thus they have a complete and accurate list of medications. With more than 1 doctor prescribing medications, if communication between doctors is lacking there may be a higher likelihood of a potential drug–drug interaction, which may be unrecognized and not manifest itself until surgery or medications prescribed by the oral and maxillofacial surgeon. With advancements in information technology