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## Best Practice & Research Clinical Gastroenterology



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### Quality assurance in perioperative care

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Nowadays more and more clinical guidelines are developed. Clinical guidelines aim to assist practitioner and patient decision making about appropriate care for specific clinical conditions. Furthermore, guidelines can play a crucial role in the quality cycle form guidelines to clinical practice. However, this does not necessarily mean that these guidelines are actually implemented and the ultimately goal, improved patient outcome, is achieved. Care gaps exist between guidelines and daily clinical practice in perioperative care. Research should be focused on identification of barriers to adherence and subsequent effect implementation strategies to achieve higher standards of quality of care. A multi-factorial approach to improving use of guidelines in clinical practice may improve the treatment of patients with peripheral arterial disease.

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#### Introduction

One of the perceived advantages of therapeutic endoscopy is that it is at least potentially safer than traditional surgical approaches to conditions such as bile duct stones and bleeding ulcers. As such it is used frequently in patients who may be acutely ill, or suffering from major co-morbidities, or both. Under such circumstances, the greatest risk is for cardio-vascular complications. Careful pre-procedural assessment and anaesthesia assistance should minimise these risks, which have been reviewed in details recently [1]. Our experience in attempting to minimise the risks of vascular surgery can illustrate the difficulties in developing firm evidence-based guidelines, and ensuring that they are followed in practice.

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## Perioperative risk assessment

Atherosclerosis is a generalised disease with symptoms ranging from angina pectoris, myocardial infarction, stroke to claudication. The prognosis of patients with peripheral arterial disease (PAD) is predominantly determined by the presence and extent of the underlying ischemic heart disease (IHD). Patients with PAD undergoing vascular surgery are at high risk for postoperative cardiac complications [2,3] When considering a patient for non-cardiac vascular surgery, a careful preoperative clinical risk evaluation and subsequent risk-reduction strategies are essential to reduce postoperative complications. To assist physicians with decision making, clinical guidelines are developed. The overall theme is to start secondary prevention for atherosclerotic disease prior to surgery, to improve not only late outcome after surgery, but also reduce immediate postoperative cardiovascular events; the major cause of morbidity and mortality. The preoperative evaluation can be considered as the opportunity to identify those patients, who would normally not present them to the physicians.

## Guidelines

Using the best evidence is a fundamental aspect of quality of health care and valid guidelines for clinical practice are an important tool to inform evidence-based practices. The aim of clinical guidelines is to improve patient care by providing recommendations about appropriate health-care in specific circumstances. In 2009 the first European Society of Cardiology guidelines on perioperative care were developed [3]. This decision-making process integrates clinical markers, early coronary evaluation, functional capacity and the type of surgery involved.

Clinical practice guidelines are sets of recommendations that are developed systematically to assist practitioners and patients in making optimal healthcare decisions for specific clinical conditions [4]. The recommendations are mostly classified according to a test, procedure, treatment, or strategy is useful and effective considering the size of treatment effect (Class I, IIa, IIb, and III) and according to an estimate of certainty of the treatment effect (Level of Evidence: A, B, or C). Optimally, guideline recommendations are derived from the results of major randomised clinical trials (RCTs). On the other hand, it is important to recognise that for a large proportion of clinical questions for which definitive trials are not available, recommendations are based primarily on expert opinion (Level of Evidence: C). It should also be noticed that the highest level of evidence recommendations based on clinical trials are subject to the limitations of RCTs. The highly selective trial populations lessen generalizability to clinical practice which represents a rather heterogeneous population. A recent analysis of the distribution of levels of evidence for recommendations in American College of Cardiology/American Heart Association found that for the perioperative guidelines, Level of Evidence: A (multiple clinical trials and/or clinical trials) accounted for 26%, and Level of Evidence: B (a single randomised trial or nonrandomised studies) for 54%, and Level of Evidence: C (expert opinion and observational studies) for 20% [5].

By translating the best available scientific evidence into specific recommendations, guidelines can serve as useful tools to achieve effective and efficient patient care [5]. Additionally, successful perioperative evaluation and management of patients undergoing noncardiac surgery requires careful teamwork and communication between surgeon, internist, pulmonologist, anaesthesiologist, cardiologist and the patients' primary care physician. It is important to update guidelines on a regularly basis to reflect the most recent clinical evidence and furthermore, guidelines should be easy to use in clinical care.

## Guidelines and clinical practice

### *Exploring the gap*

Atherosclerotic risk factor control, lifestyle improvement and optimal pharmacological treatment are key elements of perioperative and long-term management of patients with PAD. In general, two strategies have been used in an attempt to reduce the incidence of perioperative myocardial infarctions and other cardiac complications: pharmacological treatment and preoperative coronary revascularization. In recent years, most attention has been given on the role of pharmacological treatment,

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