

# Anesthesia for Routine and Advanced Upper Gastrointestinal Endoscopic Procedures



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## KEYWORDS

- Anesthesia for endoscopy • Sedation for endoscopy
- Sedation for endoscopic retrograde cholangiopancreatography
- Anesthesia for per-oral endoscopic myotomy

## KEY POINTS

- Endoscopic procedures have expanded in their intensity and complexity.
- Sedation for endoscopic procedures has evolved to support that increase in intensity and complexity.
- Enhanced anesthesia services emphasize safety and permit tolerance for patients undergoing complex endoscopic procedures.

## INTRODUCTION

Diagnostic and therapeutic indications for gastrointestinal (GI) endoscopy have increased as technological advances continue to favor minimally invasive techniques. The role and level of involvement of the anesthesia team in the delivery of sedation in the endoscopy suite may vary according to need. Multiple professional associations have issued guidelines and recommendations on sedation and sedation levels to be delivered during outpatient endoscopic procedures. The American Society of Anesthesiologists (ASA) Task Force published guidelines for nonanesthesiologist-driven sedation and analgesia. The ASA House of Delegates on October 15, 2014 in fact released the following statement: “There is no circumstance when it is considered

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acceptable for a person to experience emotional or psychological duress or untreated pain amenable to safe intervention while under a physician's care."

It is important to understand that in routine practice, procedures vary greatly between GI endoscopic facilities, and familiarity with one's institutional guidelines is necessary to ensure the safe and efficient care for patients and practitioners. However, it is safe to say that therapeutic endoscopic procedures (eg, polyp resections, endoscopic retrograde cholangiopancreatography [ERCP], dilation, and biopsies) are more likely to require anesthesia compared with routine screening procedures.

Requests for anesthesiology in the endoscopy suite often depend on the gastroenterologist's preference, patient population, and expected time of the procedure. The choice of anesthetic depends on patient comorbidities, duration, procedure, and the abilities of the gastroenterologist. Most routine procedures are performed on an outpatient basis with an expectation for a quick recovery. Routine screening in outpatient GI care may vary on a regional basis, but most patients are screened the day of procedure. Although most procedures are performed under sedation, the ability to control the airway and intubate a patient in an emergency is crucial. The presence of an endoscope impairs ready access to the airway, so careful planning and preparation before the procedure is important if intervention may be required.

There has been an increase in anesthesia involvement in endoscopic procedures since 2000, with 98% to 99% of endoscopies being done with sedation/general anesthesia.<sup>1</sup> Reasons for this increase include:

1. An increase in endoscopists who do not want to divide their attention between performing the procedure and maintaining the sedation
2. Endoscopy procedures are becoming more common in children, whose cooperation may be gained only with the administration of general anesthesia
3. Propofol offers faster and more complete patient recovery leading to greater endoscopist and patient satisfaction<sup>2</sup>

## **OPERATING ROOM COMMUNICATION**

One of the crucial factors of the operating room environment that leads to overall safety of anesthesia is communication between all parties involved in the case. There is also a standardization of processes that have been well established that lead to a reliability built into the operating room environment. A common problem with anesthesia being delivered in remote (nonoperating room) locations is the absence of the standardization of communication and the process. This lack of communication and standardization potentially leads to:

- Decrease in efficiency in scheduling, resulting in inefficient patient preparation
- Equipment that is not maintained properly
- Greater variation in the physical set-up of the room, resulting in the decreased familiarity with the environment and equipment
- Delays in receiving needed patient information
- Inadequate monitoring for the case
- Nursing and support personnel who do not have the proper knowledge base in order to efficiently and safely take care of the patient
- Working with staff whom the anesthesiologist has not met or being unfamiliar with the staffs skill sets

The potential problems from the mentioned deficiencies are all magnified do to the distance that NORA locations are from the core operating room areas and subsequent help from colleagues.<sup>3</sup> Most of these can be addressed by allowing for an environment

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