



# Spring 09 Newsletter



May 2009

## Welcome,

Dear Colleagues,

Welcome to the spring edition of the newsletter. We are once again preparing for this year's conference and we have further information for you in this edition.

There is a huge amount of excellent work going on in and around pre-op assessment and on a weekly basis the Preoperative Association is being contacted for information about "How to". Why not share your developments at this year's conference. You could choose to submit a freepaper or a poster. Abstracts are welcome from all healthcare professionals.

If you would like to contribute an article / interest piece / news item for the newsletter please send to the editors via the pre-operative association website. ([www.pre-op.org](http://www.pre-op.org))

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## Message from the Chair

The field of preoperative assessment is still a relatively new concept in many institutions, although great progress has been made. Yet there is no "one size fits all" model, and even those with well established services are having to constantly evolve to the ever changing health-care environment.

The focus for many of us over the last twelve months has been the introduction of the 18 week pathway. This focussed our minds on streamlining services, minimising delays and increasing throughput. Now we must aim to ensure that we are able to maintain this productivity without compromising quality. Lord Darzi's recent NHS review has highlighted the need to improve quality across the whole healthcare arena, and it is very important that in the drive to treat more patients we do not do so at the cost of quality.

But there is a potential cloud on the horizon. In the current global financial situation, it is likely that healthcare funding will be very tight in the next few years.

We will have to justify any expenditure/expansion, and be able to present strong evidence to justify the service we provide. In many ways, we are at an advantage – as a new "specialty", we have developed in a time when market forces and strong business cases have become the norm. Our challenge now is to continue to collect evidence of both the effectiveness and efficiency of our services.

Without this data, there will always be external pressures put upon us, particularly on those who are just beginning to create centralised preoperative assessment services.

As many of you will have seen on the website, we are pleased to announce that this year's annual conference will be held on Thursday 12<sup>th</sup> November at the East Midlands Conference Centre, Nottingham, the venue of our first ever conference back in 2004. We are already putting together the programme, and as the venue is larger than in recent years, we hope to have more "break-out" rooms to cater for all interests. Thanks to all of you who attended last year's event, and in particular for the feedback we received. We always look very closely at your comments, and hope this year's event will be even more enjoyable than last year.



Dr David Earl  
Chair, Pre-op Association

**Date for your diary**  
**Confirmation of CONFERENCE 2009**

**Thursday 12<sup>th</sup> November 2009 – East Midlands  
Conference Centre Nottingham**

**Register now! Reduced rates for fully paid up  
members of the Preoperative Association.**



**REGISTRATION FEES**

**Pre-op Member Rate\*\*£170.00**

**Non- Member Rate £225.00**

*(\*\*In order to qualify for this rate delegates must be a paid-up member of the Preoperative Association )*

**Please visit [www.pre-op.org](http://www.pre-op.org) for more information and to access the online  
registration form.**



# FAQ'

Replies are the individual views and opinions of members of the Preoperative Association steering group and whenever possible supported by the best available evidence, however if you have an alternative view or comment to enhance the debate please contact us at [www.pre-op.org](http://www.pre-op.org) If you have a question you would like to ask via the newsletter and website then please contact us at the same address that's [www.pre-op.org](http://www.pre-op.org)

## FAQS Spring Newsletter

### 1)How long is a Pre operative Assessment valid for?

It is difficult to offer definitive guidance. It can depend on many things. For many day case procedures in basically fit patients 3 months is probably fine, this combined with a follow-up call near to the admission date. For the average unfit hip replacement for example this is too long and things like blood tests and MSUs would need to be more current i.e. 1 month.

There is so many variables ; ASA grade/comorbidities of the patient, age, grade of surgery, medication, level of primary care in terms of chronic disease management etc and expertise of the Pre-operative Assessment team.

Having an early look at patients i.e. if sent to Pre-operative Assessment from out-patients is never a bad idea and this may help to ascertain the level of intervention required at the time and to plan their further Pre-operative care.

**Answer posted by Lee Wadsworth & Nick Lavies.**

### 2)How do I manage patients that have been treated for hypothyroidism at Pre-operative Assessment?

This disease affects 10% of women and has a ratio of 8:1 with men. Tends to have an insidious onset and sufferers can go undiagnosed for years. Symptoms include weight gain, hair loss, lethargy, depression, dry skin, non-pitting oedema and bradycardia.

Given the incidence of this disease the Pre-op Assessor will come across many patients on Thyroxine supplementation, One of the questions will be, when do I take blood for Thyroid Function Tests (TFTs)?

This disease forms part of the GP contract and the GP services are required to check TFTs minimum of every 12 months. If the GP/NP changes the dose of thyroxine then they generally wait 12 weeks before repeating the test, this illustrates the insidious nature of this condition (Simon, Everitt & Kendrick, 2005).

There is however variations in Pre-operative assessment services with regard to when they would check TFTs. It really depends on whether the patient has been stabilised on a dose of thyroxine and whether the TSH is within the normal range. Some centre's have a 6 month rule and some 3. From the authors experience some services also check the TFTs regardless of the timeframe of the

previous test, as it can be quicker than chasing up previous results.

There is evidence to support not repeating a TFT if it has been done in the previous 3 months by the primary care team; that is providing these results can be easily accessed – this can sometimes be a stumbling block.

It is also important for the Pre-op Assessor to ask people who have had hyperthyroidism treatment in the form of radioactive iodine, carbimazole or surgery when they last had their TFTS checked. In particular with regard to thyroid surgery, which is a common cause of hypothyroidism. This presents with the tell-tale scar at the front of the neck.

With all the FAQs we welcome debate and discussion in order to inform the members of the Pre-operative Association of best practice.

I. Chantel, Everitt & Kendrick (2005) Oxford Handbook of General Practice. 2<sup>nd</sup> Edition. Oxford University Press, Oxford.

**Answer posted by Lee Wadsworth**



# FOCUS ON: SMOKING CESSATION

## FOR HOW LONG SHOULD YOU GIVE UP SMOKING BEFORE SURGERY?

### Introduction

A recent review in the British Journal of Anaesthesia [1] presented the evidence for best practice in smoking and alcohol cessation before surgery. In this edition of the newsletter, I will summarise the evidence with regard to smoking and in the next newsletter I will do the same for alcohol.

### Pathophysiology of smoking

Smoking causes a number of pathophysiological changes. Carboxyhaemoglobin levels are increased in the blood and may be as high as 15 % in heavy smokers, thus significantly reducing the oxygen carrying capacity of the blood. High nicotine levels mimic sympathetic nervous system reflexes resulting in a raised heart rate and blood pressure. The combination produces an imbalance in oxygen supply and demand, and may render surgical wounds hypoxic. Fortunately the half-life of both COHb and nicotine is short so abstinence for only 24 hours will virtually eliminate their effects.

Smoking impairs immune function leading to an increased risk of infection but research has shown that recovery of the immune system takes place after four to six weeks abstinence. Smoking also increases mucus production and reduces ciliary function in the lungs. This combined with depressed immunity may therefore lead to pulmonary complications. Six to eight weeks of abstinence is required for these pulmonary changes to improve.

### Is there evidence of post-operative outcome benefits from stopping smoking?

There have been three randomised controlled trials in patients evaluating the effects of smoking cessation on outcome after surgery. In one study [2], two groups of 60 daily smokers having hip or knee replacement were compared. One group stopped smoking completely or reduced consumption by 50 % six to eight weeks before surgery; the other group continued smoking. The intervention group had significantly fewer wound-related complications (5% versus 31%). However, further analysis revealed that the beneficial effect on wound complications only occurred in those who stopped smoking completely. There was no difference in pulmonary compli-

A second study showed a beneficial effect of 3-4 weeks smoking cessation before general surgery, significantly reducing postoperative complications from 41% to 21%. A third study, however, did not show any beneficial effect of 1-3 weeks smoking cessation before colo-rectal surgery. [3] A further study in volunteers having a small sacral incision performed under local anaesthetic, tried to identify the optimal period of abstinence to decrease the incidence of wound infection. They found that four weeks' abstinence reduced the incidence of wound infection to the level in non-smokers [4]

### Conclusion

The evidence is therefore that there needs to be a minimum of four weeks' abstinence from smoking but preferably six to eight weeks to get the full benefit on outcome. The main benefit appears to be a reduction in wound related complications and this is not negated by nicotine patches. If smoking cannot be stopped, then just 24hrs abstinence will confer a benefit on oxygen carrying capacity of the blood.

**Nick Lavies**  
Consultant Anaesthetist, Worthing



## References

### References

- [1] Tonnesen H, Neilsen PR, Lauritzen JB, Moller AM. Smoking and alcohol intervention before surgery: evidence for best practice. **British Journal of Anaesthesia** 2009; 102:297-306
- [2] Moller AM, Villebro N, Pederson T, Tonnesen H. Effect of preoperative smoking intervention on postoperative complications: a randomised control trial.

### Lancet 2002; 359: 114-117

- [3] Sorensen LT, Jorgensen T. Short-term smoking cessation intervention does not affect postoperative complications in colorectal surgery. **Colorectal Disease** 2003; 5:347-352
- [4] Sorensen LT, Karlsmark, T, Gottrup F. Abstinence from smoking reduces incisional wound infection. **Annals of Surgery** 2003; 238:1-5

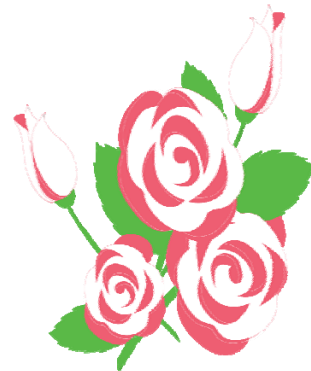
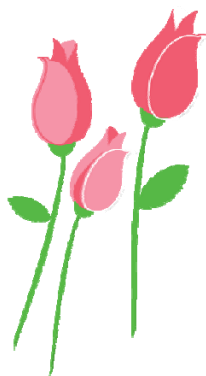
# How long the pre-operative blood tests and MRSA screening are valid?

During Christmas time, we have posted a question to you all on the Pre-operative association website asking how long the pre-operative blood tests and MRSA screening are valid. This was in response to a request from within our organization.

In our hospital (before January 2009), blood tests and MRSA screening results were valid only for 6 weeks in all patients. During Lean process exercise, it was brought to our attention that we were bringing back a large number of patients for blood testing and MRSA screening, as they were more than 6 weeks old. This was costing about £82k per annum. This includes not only the cost of the tests but also the time spent by the nurses in organizing the same. Then we went in and audited (100 patients) and compared all the blood results and MRSA screening results with the past results. To our surprise we found no difference between them. Hence, we have extended our validity for 3 months, of course with some exceptions.

Many thanks for those who have replied to our questions on the website. There is a wide variation in practice across the country ranging from 3 weeks to 6 months for blood results (n = 40) and 3 weeks to 3 months for MRSA screening (n = 30). In majority of the Trusts, blood test results are valid for 3 months (n = 22). The MRSA screening results are valid for 4 weeks (n = 8) to 3 months (n = 8). The information you have shared with us is supporting changes in practice within our organization and will improve patient care and major financial savings for the trust.

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