

THE NEW ASA OSA GUIDELINE



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*NOTE: NOT ALL SLIDES
IN LECTURE ARE
INCLUDED IN THIS
SUMMARY (~50%)*

OVERALL OUTLINE

THE NEW ASA OSA GUIDELINE

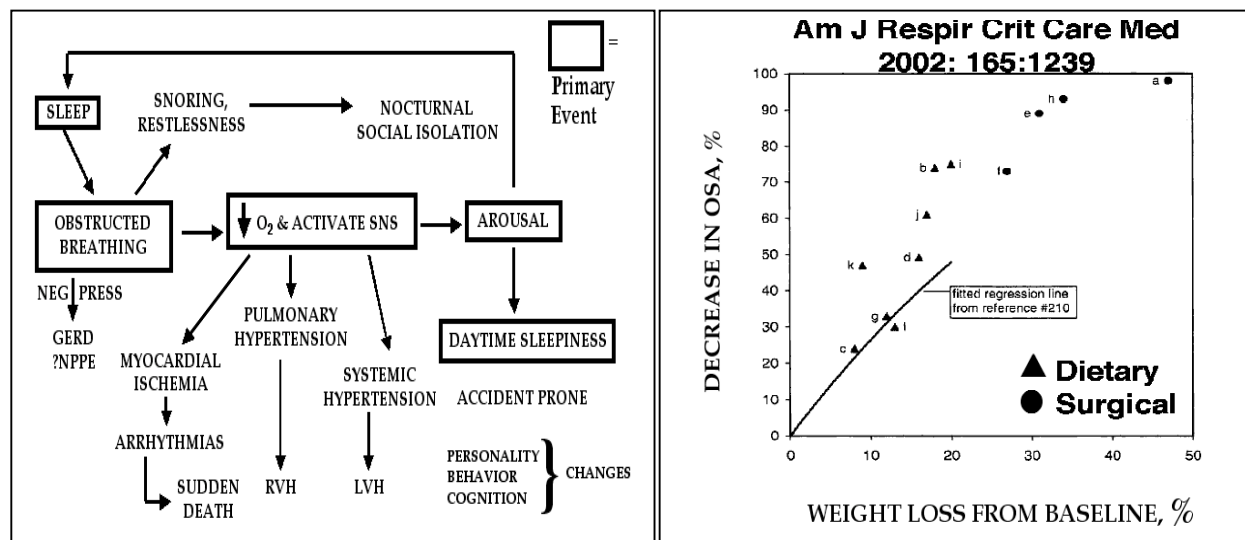
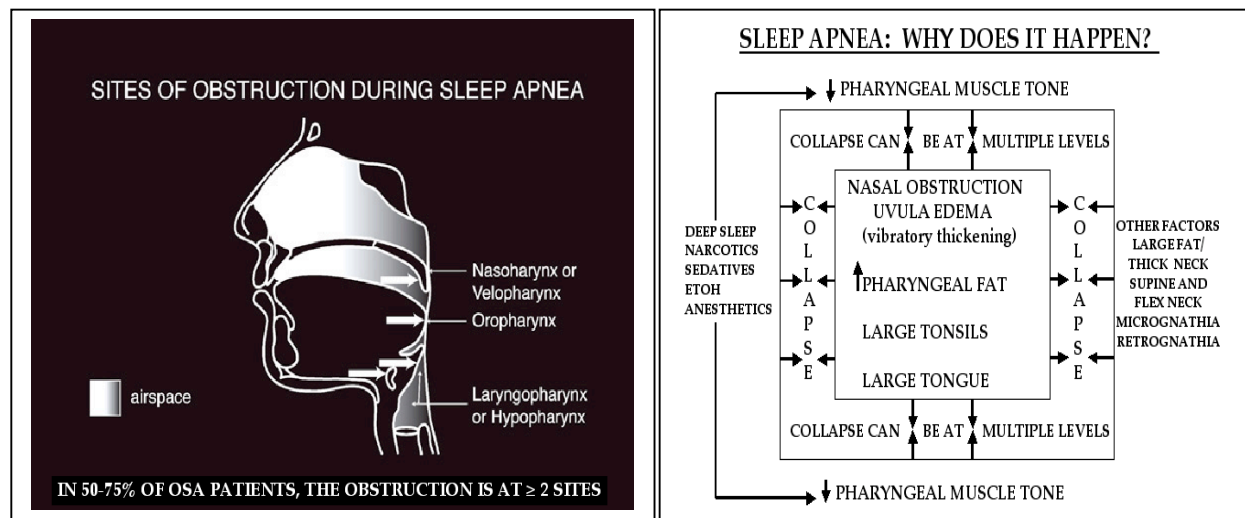
- I. **INTRODUCTON: MALPRACTICE
PROBLEM = MULTIDIMENSIONAL,
VERY LARGE, VERY SERIOUS**
- II. **CAUSATION: WHAT IS IT?
WHY DOES IT HAPPEN?**
- III. **DIAGNOSIS: LAST CAREGIVER → DX.
HOW? CLINICAL AND SLEEP STUDY.**
- IV. **THE ASA OSA GUIDELINE:
THE SPECIFICS**

OBSTRUCTIVE SLEEP APNEA

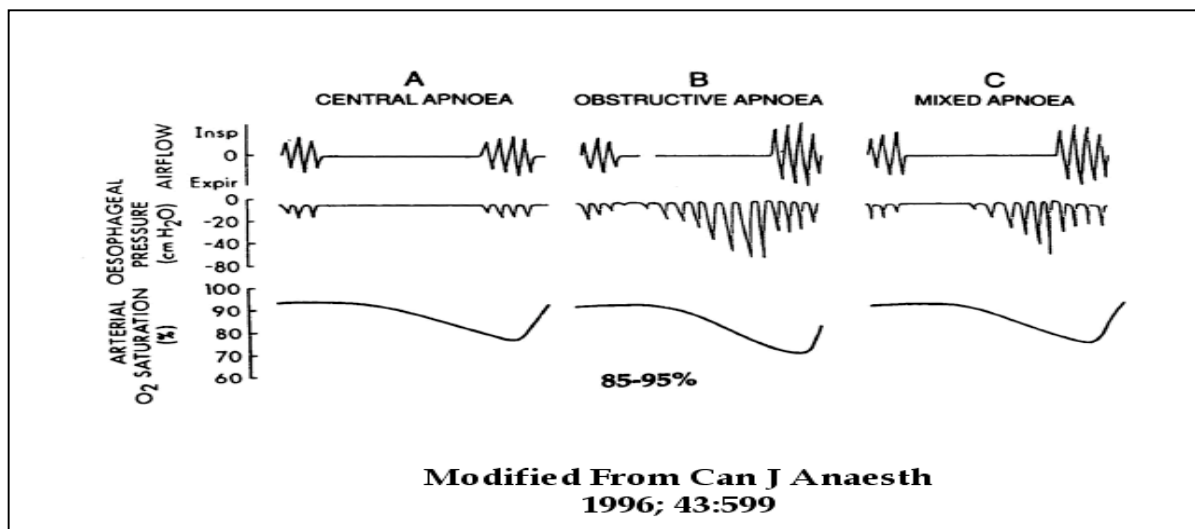
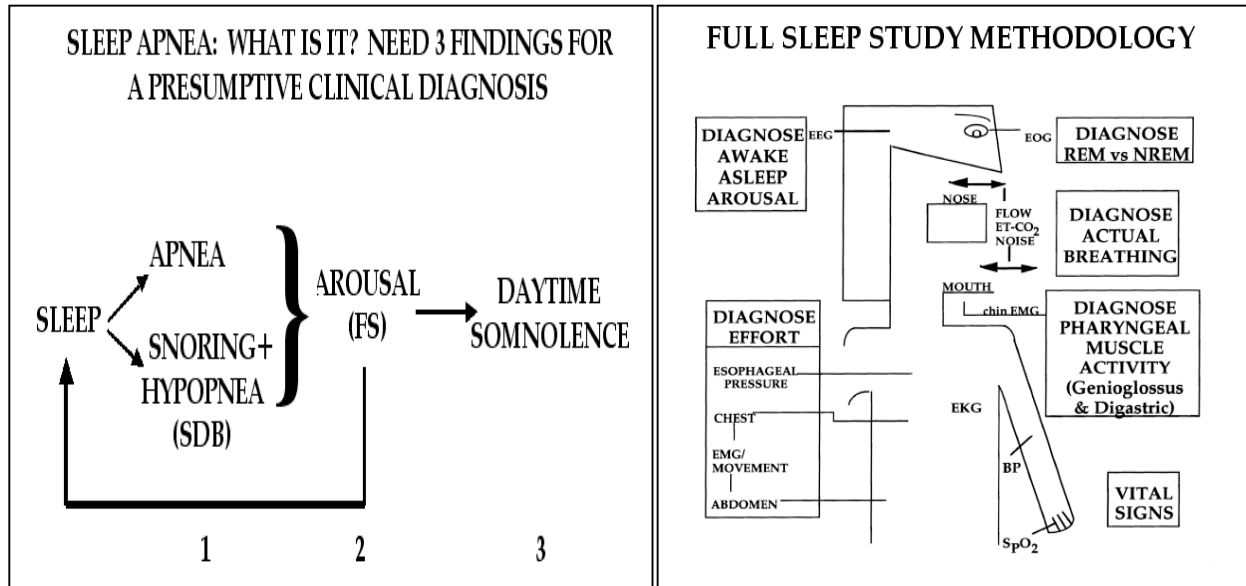
PROBLEM	REASON
MULTI-DIMENSIONAL	Intubation, Extubation, Pain Management Location Problems
POTENTIALLY VERY LARGE	2% Females, 4% Males Obesity Present in 60-90% Elderly ↑ Risk of ↑Wt & OSA All Sig. OSA Cases = 18,000,000
DANGEROUS, LIFE-THREATENING	Most cases are unrecognized; end-point for all 3 anesthesia problems is near death/death

INTRODUCTION

CAUSATION



DIAGNOSIS



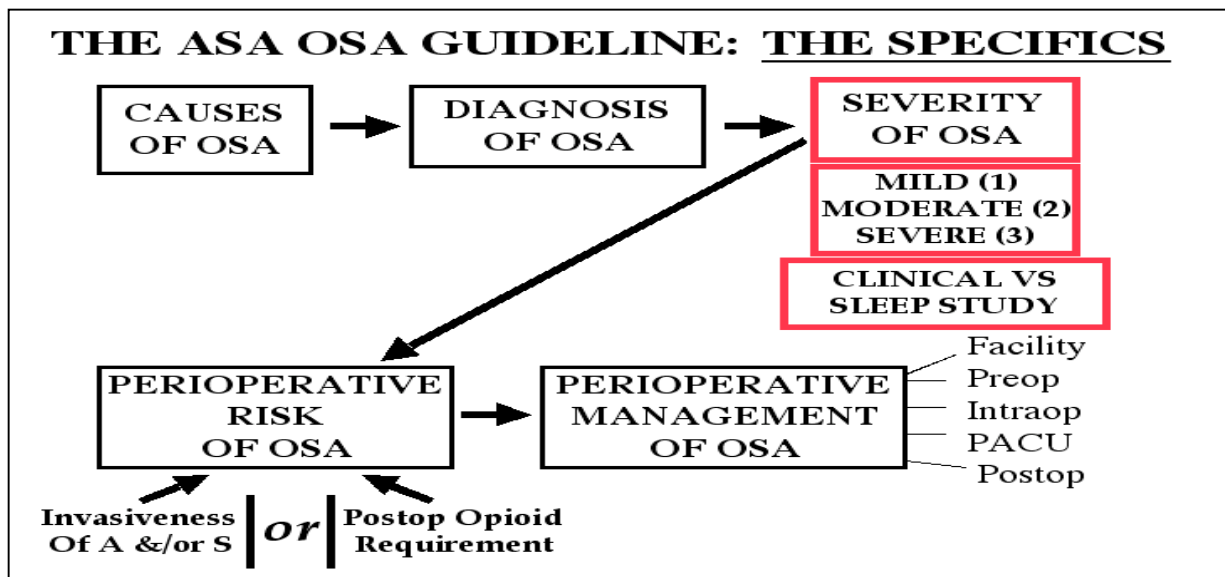
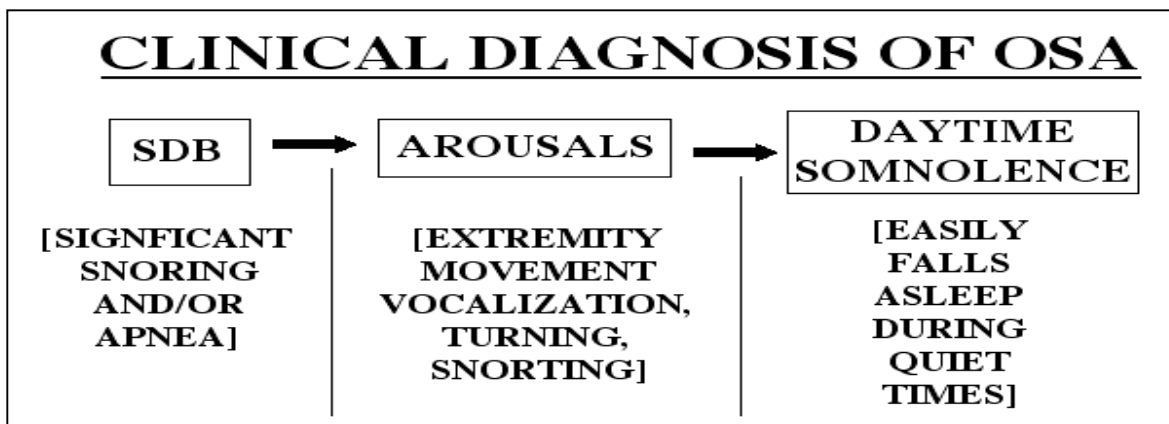
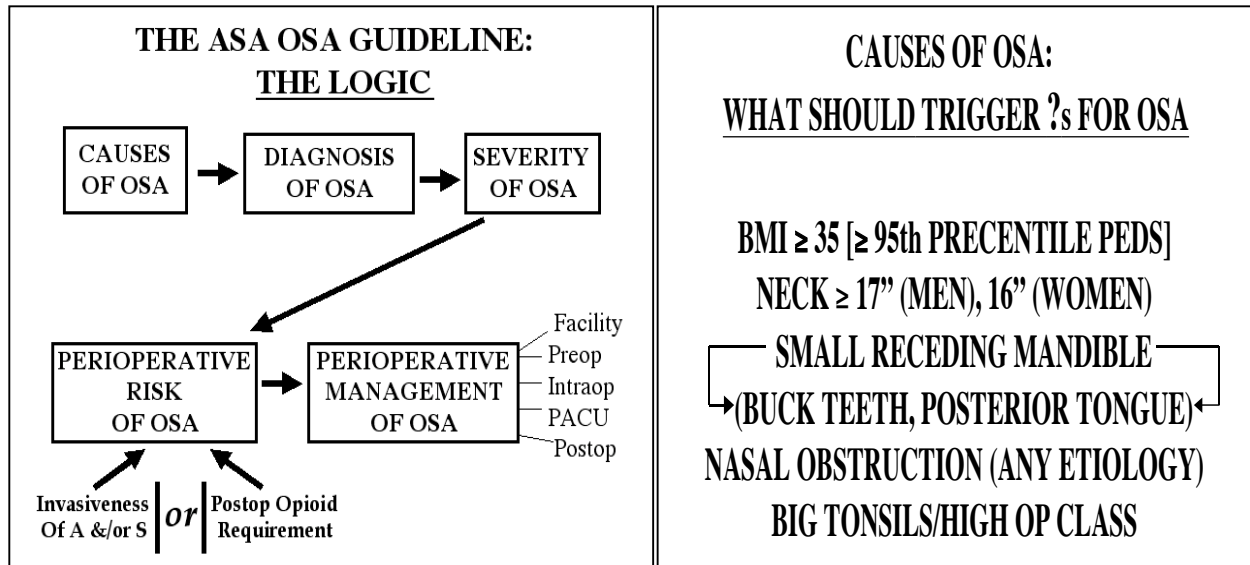
UNDERSTANDING THE SLEEP STUDY REPORT

EVENTS	INDEXES
Apnea = No airflow > 10 Sec Hypopnea = TV <50% >10 Sec Desaturation = SpO ₂ ↓ >4% Arousal = clinical or EEG	Events/hour; AHI, ODI, AI Severity of sleep apnea is f(AHI): 6-20 = mild; 21-40 = moderate; >40 = severe

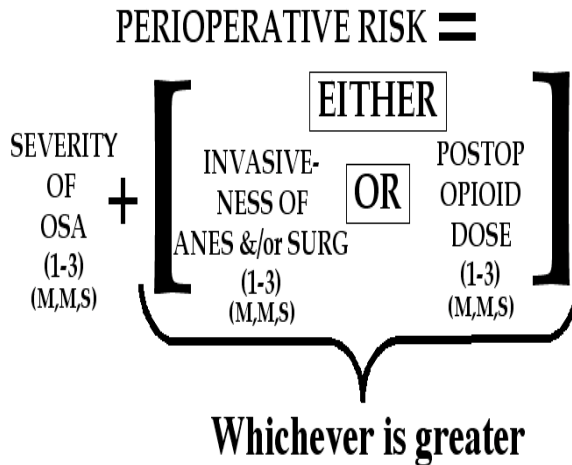
SpO₂ data also # of events per 60-69%; 70-79%; 80-89%;
Extremes in heart rate and changes in EKG
are usually narrative descriptions

REPEAT THE ABOVE WITH CPAP TITRATION

THE ASA OSA GUIDELINE



EXAMPLE/METHOD FOR DETERMINING PERIOPERATIVE RISK



PERIOPERATIVE MANAGEMENT OF OSA: **FACILITY:** OUTPATIENT VS INPATIENT

RISK = 4 (INCREASED RISK): ANY FACILITY SHOULD HAVE

1. Emergency Difficult Airway Equipment
2. Resp Care Rx = Nebulizes, CPAP, Ventilators
3. Portable Chest X-ray and EKG Capability
4. Clinical Lab for ABGs, Electrolytes, H/H
5. Transfer Arrangement to Inpatient Facility in Place
6. No Outpatient Surgery on UPPP, Tonsil < 3 yrs of age, Upper abdominal Laparoscopy

PERIOP MANAGEMENT OF OSA: **FACILITY:** OUTPATIENT VS INPATIENT

RISK ≥ 5 (SIGNIFICANTLY INCREASED RISK):

THESE PATIENTS ARE:

“GENERALLY NOT GOOD CANDIDATES FOR SURGERY
IN A FREE STANDING OUTPATIENT FACILITY”

PERIOPERATIVE MANAGEMENT OF OSA PATIENTS: CONSULTANTS AGREEMENTS: **PREOP & INTRAOP**

PREOPERATIVE PREPARATION WITH CPAP OR BIPAP IMPROVES PHYSICAL STATUS

THE AIRWAY IN GENERAL: FOLLOW THE ASA DIFFICULT AIRWAY ALGORITHM

(IN 35% OF INDUCTION CVCI LAW SUITS → PATIENT IS BD/D)

THE AIRWAY IN SPECIFIC: EXTUBATE AWAKE, SEMIUPRIGHT, IF POSSIBLE

(IN 90% OF EXTUBATION LAW SUITS → PATIENT IS BD/D)

Self-Evident/Obvious Statements re Intraoperative Care	Moderate/Deep Sedation → Use CO ₂ Monitoring
	GA + Secure Airway > Deep Sedation + No Airway
	RA for Peripheral Surgery > GA &/or Opioids

PERIOPERATIVE MANAGEMENT: CONSULTANT
AGREEMENTS: **PACU DC TO UNMONITORED SETTING**

“OSA PATIENTS SHOULD BE MONITORED FOR A MEDIAN OF 3 HOURS LONGER THAN THEIR NON-OSA COUNTERPARTS”,
AND IN AN UNSTIMULATED ENVIRONMENT,
ROOM AIR S_pO_2 = BASELINE AND AROUSE APPROPRIATELY

IF EPISODE OF SIGNIFICANT OBSTRUCTION
OR HYPOXEMIA ON F_iO_2 = ROOM AIR
MONITOR FOR A MEDIAN OF 7 HOURS LONGER

NEED TO BE WATCHED

POSTOPERATIVE MANAGEMENT OF OSA PATIENTS:
CONSULTANTS AGREEMENTS

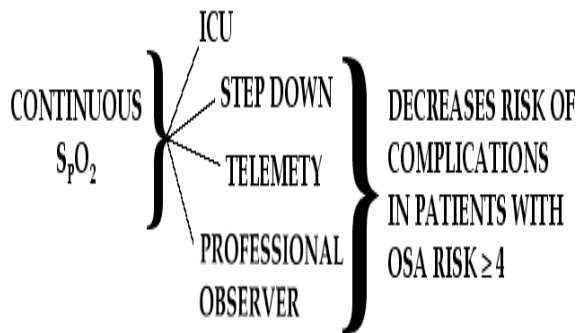
↓ Exposure to opioids is good;	Regional Analgesia ↓ s adverse outcomes
	Consider exclusion of opioids from neuroaxis
↑ Exposure to opioids is bad	NSAIDS → ↓ s opioid use → ↓ s adverse outcome
	Avoid Basal PCA rates

ADMINISTER CPAP OR BIPAP AS SOON AS FEASIBLE POSTOP IF ON CPAP OR BIPAP PREOP

(EQUIVOCAL WHETHER APPLIANCE SHOULD BE IN PLACE WHEN NOT AMBULATING)

(PERSONALLY - YES)

PERIOPERATIVE MANAGEMENT: CONTINUOUS OXIMETRY
CONSULTANT AGREEMENT



= NEED TO BE WATCHED

Cost of Implementation
= \$100,000 per year
per SurgiCenter or Hospital

An Ounce of Prevention is Better than a Ton of Treatment

Preop = Sleep Studies
 Periop = CPAP, 12-EKG
 Chest Xray, ABG
 PACU DC (RN Time)
 Postop (ICU Time)

< 10% } Medical { One Death
 < 1% } Legal {
 < 1% } Cost { One Brain Death