

Pre-anesthesia ward for optimization of co-morbid illnesses of high-risk surgical patients: The time is now

Dear Editor,

Suboptimal optimization of high-risk surgical patients leads to either cancellation of surgery or post-operative complications if taken up for surgery. More than 10% cases have been reported to be cancelled on the day of surgery.^[1] Cancellation of cases imposes psychological stress to patients and their relatives along with wastage of time and resources. This is much of our concern because it also leads to a breach of trust between anesthesiologist and patients or surgical specialists and can be quite frustrating for all concerned.

Optimization of all co-morbidities can't be achieved through only a pre-anesthetic checkup (PAC) clinic, as close follow-up

is always an issue. Interestingly, it is not that such co-morbid patients are not admitted in ward for optimization, they are admitted but under surgical departments, where the interest and expertise of care provider is different. Sometimes it also happens that the primary specialist, i.e., the surgeon assumes that the patient has been optimized optimally just on ground that the process of optimization has been started quite before. When anesthesiologist examines the same case, he/she finds that despite the long duration of optimization, there is no or only little improvement in co-morbid conditions. The reason behind this discrepancy is different perception and targets of optimization for surgical and anesthesia specialists. Another concern is variable preparedness and unpredictable follow-up of pre-operative orders related with medical comorbidities before surgery. In the interest of perioperative safety of comorbid patients, it is better to involve the anesthesiologist as the in-charge of optimization and not just assessor of optimization.

Looking from another angle, if we talk in terms of teaching and training of anesthesiology postgraduates, they are taught much about the theory of optimization of comorbidities, but

they hardly get an opportunity to get it done by themselves. Inpatient anesthesia ward is a place, where anesthesiologists can be better trained about comorbidities and their optimization. They can optimize their patients at the best and monitor closely the progress of optimization. It will also give an opportunity to introduce anesthesiologists to the patients and society in a much better way. Anesthesiology residents will get an opportunity to interact with other specialist physicians like cardiologists, pulmonologists, nephrologists, etc., during their visit to pre-anesthesia ward and can get enriched with finer details. Ahmed has raised similar concern emphasizing the need of a preoperative optimization ward, particularly in hospitals of developing countries, where the logistics and other infrastructure of general wards are very poor.^[2] Need of high-end monitoring and some intensive therapy has also been suggested for optimization of high-risk surgical patients.^[3]

Setting a pre-anesthesia ward is similar to a post-operative unit both in terms of location and logistics. Such a ward should be located in the vicinity of operation theater complex so that high-risk patients can be transferred to operation theater with safety. Such wards should be equipped with oxygen outlets, non-invasive and invasive ventilators, suction equipment, point of care tests facilities, portable USG machine with linear, curvilinear, and echo probes, and mobile X-ray unit. All beds needs to be made monitored bed with multipara monitors with some high-end monitors for invasive monitoring. Facilities for the placement of invasive lines should be available. As this ward accommodates surgical patients, facilities and equipment for part preparation must be available. This ward needs to be manned by anesthesiology residents with round the clock availability under direct supervision of anesthesiology consultant.

Along with various advantages, Pre-anesthesia ward may carry certain limitations that cannot be ignored. First, there is a possibility of getting the sickest patients of hospital admitted in Pre-anesthesia ward for optimization. But there is nothing new as the sickest patients are always referred to anesthesiologists either in ICU or HDU. Second, the primary admitting unit, that is surgery will have to come for regular consultation in a different area outside their own ward. Of course, it may bring little inconvenience on account of inertia, but with time and advantages, it may come in routine. Third, there is a wide age spectrum of co-morbid surgical patients, ranging from small pediatric patients to fragile geriatric patients. In Pre-anesthesia ward, we can admit adult patients only to begin with, most of which will definitely be from geriatric group. Infrastructure cost for ward and logistics is also an issue but it is secondary to all mentioned before and can be justified in the interest of patient safety and teaching-training.

Considering all perspectives, perhaps this is the high time to develop Pre-anesthesia wards if we are sincere enough in our efforts to make the anesthesia even safer and produce the next generation of more accomplished perioperative physicians.

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Conflicts of interest

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