Glucagon-Like Peptide-1 (GLP-1) Agonists may Warrant Revival of Preemptive Pharmacologic Prokinesis Preoperatively till Bring Your Own Ultrasonographic Stethoscope (BYoUS) Policy Becomes the Norm

Glucagon-like peptide-1 (GLP-1) agonists are here to stay to pharmacologically mitigate the increasing prevalence of diabetes mellitus and morbid obesity.[1] Just like the increased prevalence of anticoagulant use, antiplatelet use, antithrombotic use, and thrombolytic use led anesthesiologists to devise corresponding peri-anesthesia guidelines, anesthesiologists are finally catching up with peri-anesthesia guidelines to meet the eventuality of increased prevalence of GLP-1 agonist use.[2] Quantifying delayed gastric emptying in preoperative patients is unpredictable, especially if guided only by the presence of fullness-nausea as symptoms and retching-vomiting as signs. Moreover, it is yet to be comparatively quantified whether delayed gastric emptying due to non-pharmacological gastroparesis had been as worse as delayed gastric emptying due to pharmacological gastroparesis assuming that patients with diabetes mellitus with non-quantified gastroparesis may have been receiving sedation with unprotected airways in the absence of specific guidelines advising

a potentially increasing need for general anesthesia with protected airways among patients with diabetes mellitus. Point-of-care gastric ultrasound comes in handy nowadays to quantify gastric volume and contents preoperatively. However, institutional ultrasound may not be readily available during high turnover and personal ultrasound may not be logistically allowable under institutional policies.[3] Moreover, it will be a learning curve for anesthesiologists before they can confidently recommend a change of anesthesia plan from sedation with unprotected airways to general anesthesia with protected airways based on their personal assessment of preoperative gastric volume and contents with point-of-care gastric ultrasound.[4] The questions about inherent risks of general anesthesia and increased costs with general anesthesia may come into play that may lead to either increased rescheduling of elective surgical procedures or post-hoc deeming of general anesthesia as unnecessary intervention, especially if concurrently scheduled esophagogastroduodenoscopy finds neither food nor fluid in stomach despite preoperative gastric ultrasound's interpretation to the contrary. Now, the question becomes whether, rather than awaiting evidence for interactions between GLP-1 agonists and prokinetic medications, preemptive pharmacologic prokinesis preoperatively may get revived to counter the residual effects of GLP-1 agonists. Only time will tell whether personal ultrasound just like personal stethoscope becomes the norm rather than the exception after Bring Your Own Device (BYOD) institutional policies evolve into Bring Your own Ultrasonographic Stethoscope (BYoUS) institutional policies so that patients' pathophysiological safety gets enhanced without compromising patients' privacy or providers' medicolegal protection during their exploration of new avenues for personal revenues.[5] Although the questions related to BYoUS policies may be moot when institution and provider are one and the same, they may come into play everywhere else thus deterring providers from investing into personal ultrasound until and unless proactive BYoUS policies are already in place at their institutions. For everyone else, the revival of preemptive pharmacologic prokinesis preoperatively may become the easy way out to save the day for anesthetized patients with suspected pharmacological or non-pharmacological gastroparesis and for anesthesia providers not confidently interpreting gastric ultrasounds to convincingly change the plan of anesthesia from sedation with unprotected airways to general anesthesia with protected airways even after reactive BYoUS policies have become the norm rather than the exception at their institutions.

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