CPAP recommendations for Preoperative Evaluation on the Geriatric Trauma Service

- Patients with any of the follow high-risk conditions usually require intensive preoperative evaluation and/or management prior to surgery. A cardiology consult may be required.
    - Unstable or severe angina (angina with any of these features: new, increasing in frequency or severity, occurring with minimal activity or at rest)
    - Myocardial infarction within 1.5 months. Also myocardial infarction within 1.5-12 months unless seen by cardiology or medicine and recommended management was implemented.
    - New or worsening heart failure symptoms
    - Significant arrhythmias (2^{nd} or 3^{rd} degree AV block, ventricular arrhythmias, ventricular tachycardia, HR<45, SVT, atrial fibrillation/flutter with ventricular rate >100)
    - Severe valve stenosis. Severe valve regurgitation if accompanied by new or worsened symptoms.
- Targeted lab/diagnostic assessment (selected tests and common preoperative indications in GTS population)
    - Basic labs – CBC; BMP; T&S or T&C per procedure (ensure floor completes check sample); INR for warfarin, liver disease, or nutritional impairment; PTT if unexplained and unusual bleeding history with tissue trauma or surgeries; CMP if liver disease history; BNP if clinical suspicion for acute CHF
    - ECG – known cardiovascular, peripheral arterial, or cerebrovascular disease; symptoms including poor functional capacity, tachycardia, bradycardia, irregular rhythm, chest pain, or dyspnea
    - CXR – suspicion for CHF, orthopnea, PND, significant peripheral edema, rales, unexplained dyspnea, tachypnea, new or increasing oxygen requirement, concern for pneumonia
    - TTE – evaluate cardiac function in patients with current heart failure or prior heart failure with worsening dyspnea, as well as those with dyspnea of undetermined origin, evaluation of an new/undiagnosed grade III systolic murmur, evaluation of diastolic murmurs, reevaluation of known significant valvular disease (moderate or greater) if no recent study available (within 2 years) or concerning symptoms
- Continue/restart home medications ASAP, particularly: aspirin (but do not restart if prescribed for primary prevention or if ongoing major bleeding), beta-blockers (unless hypotensive, bradycardic, or acutely symptomatic reactive airway disease), statins, and respiratory medications. Consider restarting ADP antagonists (i.e., clopidogrel, prasugrel) in patients with drug eluting stents within 6 months or bare metal stents within 1 month (first contact attending, IPAP service, or cardiology for input).
- Retrieval of records from most recent cardiac evaluation (echo, stress test, cardiac cath report, cardiologist note) can prevent delay of surgery for studies that may otherwise not need to be repeated
- Cardiac devices – must determine brand and type (pacemaker vs. pacemaker plus AICD). If possible, determine indication for implantation and pacemaker dependence. Call device company (or Electrophysiology) for device interrogation if dysfunction suspected, if recent ICD shock, or if no interrogation in >3 months.

Note: These recommendations are intended to facilitate subsequent preoperative evaluation by the Anesthesiology team.

***Primary reference**: 2009 ACCF/AHA Focused Update on Perioperative Beta Blockade Incorporated Into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery. Circulation. 2009;120:e169-e276*