

Who is responsible for premedication?

To the editor: Recently, I became aware of a practice whereby patients are routinely evaluated by specialist physicians prior to undergoing anaesthesia and surgery. The anaesthesiologists concerned subsequently paid a very brief visit to their patients immediately before surgery and examined the patients cursorily. I am unsure if this practice is widespread. Nevertheless, I am aware of a number of such cases.

In my view, this custom is not in the best interests of the patients, as well as the anaesthesiologists. I am not denying that, on occasion, referral to a physician may be necessary and that there is a significant role for the physician in the surgical healthcare team. However, I do object to the practice of preoperative evaluations being performed routinely by physicians.

Because of the nature of what we do, the patient's ability to care for himself or herself is removed. To expect a patient to blindly relinquish his or her personal control to someone who he or she has not had the opportunity to meet properly, is asking too much. If we expect patients to do so, we are guilty of unacceptable arrogance, as it also presupposes that patients do not have a choice. Meeting the patient and discussing the relevant issues remain the basis for establishing trust between patient and practitioner. Unfortunately, lack of trust is one of the primary drivers for litigation later, whether justified or not.

Relevant information needs to be obtained during the preoperative consultation that may impact on the safe conduct of the anaesthesia. Our speciality has its own unique insights and skills which we, as practising perioperative specialists, are well positioned to apply. The physician primarily deals with diagnoses and manages patients' conditions over the long term, while in general, the anaesthesiologist acutely manages patient physiology and pathophysiology.

The following examples illustrate the latter:

- Appropriately evaluating the airway.
- Determining the presence of malignant hyperthermia syndrome. This can be achieved by asking the right questions about the patient's family.
- Managing diabetes in the light of our knowledge of sulphonylureas and the adverse effects of hyperglycaemia. Both of these offset the protective effects of myocardial preconditioning.
- Understanding the effects of hypertension on organ dysfunction, coupled with our knowledge of autoregulation during anaesthesia.
- Understanding the pharmacology of angiotensin-con-

verting enzyme inhibitors and their effects on venous tone in relation to anaesthesia and surgery.

- Understanding the well-established role of beta-adrenergic blockers in protecting the potentially ischaemic myocardium in the perioperative period.
- Deciding whether regional or neuraxial blockade is preferable to general anaesthesia.
- Prescribing appropriate preoperative medications for sedation and management of the pre-existing pathophysiology, while taking into account the planned surgery.

An important consideration is: who would be held responsible in the event of an error or misjudgement? The professional conduct of the doctor is in question in matters that come before the Health Professions Council of South Africa, while in a court of law, the issue of causality is central. The latter implies that if there was an incident and damage during anaesthesia, and this can be shown to have a direct link to, for instance, a disorder that was missed during the premedication round, the anaesthesiologist, not the evaluating physician, would be at risk. It would be futile to blame the physician for not carrying out an appropriate preoperative examination as he or she would not be familiar with the potential errors that can occur during anaesthesia.

In the final analysis, the person who administers the anaesthetic is responsible. The consultation and interaction between doctor and patient is the basis for at least the moral contract (and I suspect in law, a proper binding contract) between patient and anaesthesiologist. Therefore, it is logical that anaesthesiologists should not submit to the practice of having the preoperative evaluation conducted by non-anaesthesiologists as this is an inherent part of the contract.

What are the implications of this practice for our professional standing? In a previous editorial, I made a plea for the anaesthesiology profession to re-establish itself as a first-class, scientific medical speciality.¹ If we delegate the preoperative evaluations to physicians, the profession will be vulnerable to the accusation that we are mere technicians. In addition, once again, we will be guilty of abandoning areas of medicine that fall naturally and squarely within the anaesthesiologist's domain. It is my view that the past withdrawal of anaesthesiologists from certain areas of patient care was not in the interests of patients or the science of medicine and medical practice in South Africa. As a group, we should be careful not to make this mistake again.

Routine referral to a physician also constitutes an unnecessary consultation and extra fee. Furthermore, with regard to the cases to which I was privy, I was surprised at

the battery of special examinations that had been ordered by the physicians, despite the fact that there were no clinical or scientific reasons to do so. Perhaps owing to the nature of the physician's practice, and in terms of other considerations, the tendency to conduct a multitude of tests could be justified, but for perioperative management, these tests were unnecessary, as there was no valid clinical reason for ordering them.

It could be argued that patients benefit from a check-up by a physician. However, this is a weak argument, because such a check-up is either mandated by clinical signs and symptoms, or because of risk stratification. Furthermore, anaesthesiologists are perfectly capable of performing the check-up by taking an appropriate history and examining the patient properly. Hence, we can act as gatekeepers to ensure that patients who have appropriate signs and symptoms, or who have a specific risk profile, are referred to specialist physicians or are subjected to appropriate special examinations when necessary. Subscribing to the notion of routine physician evaluation merely adds to the ever-increasing costs of medicine.

We practise an important and interesting speciality. It is not confined to the administration of anaesthesia. It extends to perioperative patient care. Primarily, we maintain physiology and manage pathophysiology. I have yet to encounter any other speciality that can perform this as effectively and safely as we can. Why delegate sections of this positive and successful profession to the relatively uninformed? It is not in the interests of our patients and certainly not in the interests of our speciality.

André Coetzee, MBChB, MMed, FFA(SA), FFARCS, MD, PhD
Professor and Executive Chairman
Department of Anaesthesiology and Critical Care
Faculty of Health Sciences
University of Stellenbosch
Tygerberg
E-mail: arc1@sun.ac.za

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A technique to facilitate lung collapse in the presence of an occlusive endobronchial tumour

To the editor: We report on the occlusion of the bronchus of a non-ventilated lung by a bronchial carcinoid tumour. This prevented the collapse and atelectasis of the corresponding lung. Lung collapse was facilitated by guiding an epidural catheter past the lesion.

A 20-year-old man (American Society of Anesthesiologists physical status II) was diagnosed with a bronchial adenoma of the right lung. An endobronchial mass that obstructed the right upper and middle lobe bronchus, and that was encroaching on the right main stem bronchus, was identified on tomograms (Figures 1a and b).

The patient was scheduled for right upper and middle lobectomy and primary sleeve resection with bronchoplasty. After induction of general anaesthesia, a 39 French-gauge, left-sided, double-lumen tube (Broncho-Cath™ Endobronchial Tube, Covidien, Massachusetts) was inserted. Correct left endobronchial placement was confirmed using a slim FI-10P2 intubation fibrescope, distal diameter 3.4 mm (Pentax Europe, France). After thoracotomy, occlusion of the tracheal lumen did not result in the expected lung collapse. Repeat fibre-optic bronchoscopy revealed no displacement of the double-lumen tube. However, we noticed that the tumour mass completely occluded the right main bronchus. We tried to direct a 10 French-gauge extra-long suction catheter, provided with the double-lumen tube, past the tumour mass. We were unsuccessful. We then introduced a sterile 18G epidural catheter (Portex®, Smiths Medical ASD, Kent, UK) through the working channel of the fibrescope. Under fibrescope guidance, the epidural catheter was advanced past the tumour mass through a small opening between the tumour and the inner wall of the right main bronchus. The proximal end of the epidural catheter was attached to the epidural connector and was left exposed to the atmosphere. The surgeon immediately reported a complete collapse of the right lung and the surgical procedure proceeded uneventfully.

Common causes of failure with collapsing the non-ventilated lung include obstruction of the airway, malposition of the lung isolation devices and bronchial secretions or blood.^{1,2} Other causes in that region include extraluminal compression or intraluminal invasion by the tumour.^{3,4} Endobronchial tumours can cause unique problems during one-lung ventilation. These tumours can infiltrate the lumen and act as a ball valve during the initial positive-pressure ventilation, resulting in expiratory air being trapped and the eventual failure of deliberate lung collapse, even after proper placement of the lung-isolation devices.⁵ Extra-

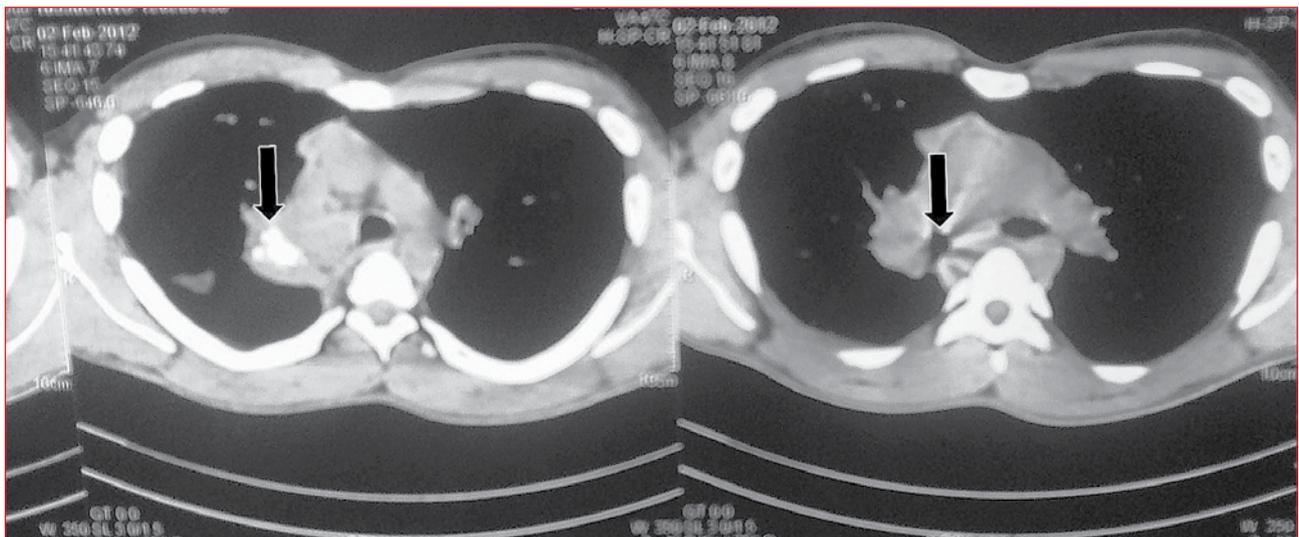
long suction catheters, supplied with double-lumen tubes, may solve this problem if passed distal to the tumour mass to deflate the lung. But, as we observed, these suction catheters can kink while negotiating the tumour mass. Moreover, their thickness may mitigate against their being able to pass through the small opening that may be present with endoluminal tumours. By contrast, thinner epidural catheters may easily bypass an endoluminal tumour, even though minimum space is available between the tumour and the bronchial wall. In addition, these thinner catheters come into minimal contact with the friable tumour mass, obviating possible chances of bleeding. These catheters have added advantages in that they easily pass through the working channel of the fibroscope (a channel diameter of 1.4 mm), and can be guided by the fibroscope with great ease. The length of epidural catheters (915 mm) is adequate to direct them down the working channel (a working length of 600 mm) of the fibroscope.

We suggest that epidural catheters can help to achieve lung deflation in the presence of occlusive endoluminal tumours. We are of the opinion that special catheters should be manufactured for this purpose.

Kapoor D, MD, FCCP, FACEE, FCCS, Assistant Professor
Kaushal S, MD, Senior Resident
Anand LK, MD, FIMSA, FCCP, MAMS, Associate Professor
 Department of Anaesthesia and Intensive Care
 Government Medical College and Hospital
 Chandigarh, India
Dalal U, MS, Associate Professor
 Department of Surgery
 Government Medical College and Hospital
 Chandigarh, India
 E-mail: kapoor.dheeraj72@gmail.com

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Figures 1a and b: The arrows indicate narrowing of the right principal bronchus on a computed tomography scan