

## Evaluation of Cardiac Patients for the Non-Cardiac Surgery

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### Background

Cardiac patients in situation of our possibility in Herat Regional Hospital, internal medicine department is not sufficient as well as we do not have a cardiac center to transfer non cardiac patients to be evaluated before surgery in that center for more evaluation. Our internists do the job and evaluate the cardiac patients for those emergent and routine non- cardiac surgeries. Mainly, the nominated team see between 500 to 600 candidate patients for the surgery which 30-35% of them have cardiac diseases in their history and evidences. Them nominated team of consultancy do not lean to the history of patients that was taken by doctors from other disciplines, we mostly preform in accord to the guidelines we access to that [1,2].

### Method:

- Taking history is the main job of the consultant.
- Current evaluation of candidate patients for their comorbid diseases.
- The consultant has to differentiate in which category of operation the patient is put:
  - Emergency procedures
  - Urgent procedures
  - Time sensitive procedures
  - Elective procedures
  - Low risk procedures
  - High risk procedures.

Guideline definition for ACC/AHA			
Procedures	Risk of Defects	Time limitation	Type of Surgery
Emergency	Upper and lower limbs	Less than 6 hours	Abdominal aneurysm or hemi-colectomy for GIB
Urgent	Upper or lower limbs	6-24 hours	Colon perforation
Time sensitive procedure	Investigation for risk	1-6 weeks	Oncology procedures
Elective procedures	Semi urgent	Up to 1 year	Knee joint replacement
Low risk procedures	Less than 1% risk of MI		Cataract and plastic surgery
Elevated risk	More than 1% risk		

**Figure 1**

- Comparisons of old and new assays.
- Taking required action to eliminate catastrophic surgery and post-surgery events.

Perioperative Cardiac Medication	
Medication	Recommendation
Anticoagulants	<ul style="list-style-type: none"> <li>• Continue for minor surgery</li> <li>• DC in interval of major surgery</li> <li>• Consider for bridging in high risk patients of thrombotic cases</li> </ul>
Antiplatelet	<ul style="list-style-type: none"> <li>• Continue for minor surgery</li> <li>• DC Clopidogrel and Ticagrelor 5 days before and Prasugrel 7 days in advance of surgery ( recent stent is exception)</li> <li>• Aspirin 3-7 days before surgery</li> </ul>
Cardiovascular	<ul style="list-style-type: none"> <li>• Continue most agents</li> <li>• Consider beta blockers for high risk of cardiac morbidity patients</li> <li>• Withhold diuretic on the day of surgery if sign of volume depletion is present</li> <li>• Consider to stop ACE and ARB at least 12 hours ahead if there is no sign of HF</li> <li>• Stop tamsulosin before cataract surgery ( floppy iris syndrome)</li> </ul>
Lipid lowering	<ul style="list-style-type: none"> <li>• Continue statins and discontinue other agents</li> </ul>

Figure 2

## Results

- Mortality rate in post-surgery events are less than 1%.
- In 2018 we had only two MI cases after abdomen surgery procedures.
- The consultant cannot decree there is no risk in the procedure.
- Epidemiologic studies show 50.000 MI and 1.000.000 other cases of perioperative occur.
- Mortality rate of perioperative MI in hospitals goes to 10 - 15%.
- Consultants could play a better performance in the selective surgical procedures.
- More than 20% new pathology were detected from assays in perspective of perioperative evaluation.
- The consultants can only decree for emergency or urgency cases on the light of vital indication.
- HF mortality rate is estimated by the level of HF as the followings:
  - Asymptomatic diastolic of LV dysfunction.
  - Asymptomatic systolic of LV dysfunction.
  - HFpHF.

- HFrEF.
- Decompensated HFpEF.
- Decompensated HFrEF.
- Advanced HF.

**Decision making .....**

**Delaying surgery:**

- HFrEF patients delay for 3 months
- HFpEF patients delay surgery for 1 month
- DHF or HF requires semi urgent surgery need 2 days delay only
- HF patients who are not stable needs judgment of the team for delay

List of surgery with the risk of less than 1 %			
1. Superficial surgery	2. Eye surgery	3. Breast surgery	4. Plastic surgery
5. Thyroid surgery	6. Carotid surgery Asymptomatic	7. Minor gynecology	8. Meniscectomy orthopedic
9. TURP urology	10. Outgoing surgery	11. Endoscopy	12. Sedative administration

List of surgery with the risk of 1-5%		
1. Intra peritoneal procedures	2. Symptomatic Carotid surgery	3. Peripheral angioplasty
4. Endovascular repairing of aneurysm	5. Colo-rectal surgery	6. Head-neck surgery
7. Major orthopedic nerve	8. Major urology procedures	9. Kidney Transplantation
10. ENT	11. Intra-thoracic	

List of surgery with the risk of more than 5 %		
1. Aortic and major vascular surgery	2. Major emergent surgery	3. Prolonged cases with shifted of fluid and lose of blood
4. Revascularization , amputation and thromboembolic with open surgery	5. Peptic and pancreases surgery	6. Hepatic resection and bile duct
7. Esophagectomy	8. Repairing of intestinal perforation	9. Suprarenal gland resection
10. Urinary bladder total resection	11. Lung resection	12. Kidney or lung transplantation

Figure 3

## Conclusion

1. Lack of means are the main obstacles.
2. Patients records are still under questions.
3. A rectangular parties should be instituted to play the main role in the points of medical consultation (consultant + surgeon+ anesthiologist + patient).
4. Medical consultant can play a role of the science and the art.

## Bibliography

1. Ceicel medicine.
2. General medical consultation book.

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