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Perioperative resources for GPs

INTRODUCTION

For patients undergoing surgery, GPs have a major role in the perioperative medicine pathway, identifying causes of increased morbidity with the opportunity to optimise chronic medical conditions, while providing vital continuity of care and advice postoperatively.

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) has for many years produced consensus guidelines covering a wide range of perioperative topics. These guidelines are free to download at https://www.aagbi.org/publications/publications-guidelines, and are also published in the AAGBI's journal *Anaesthesia*. The AAGBI and other professional bodies also produce information for patients undergoing surgery and related treatments. The aim of this article is to draw attention to AAGBI guidelines and other resources that may be useful to GPs for the clinical management and counselling of surgical patients.

DIABETES (2015)

Glycaemic control should be checked at time of referral for elective surgery. Changes in diabetes management can be made concurrently with referral to ensure diabetes is well controlled before surgery (HbA1c <69 mmol/mol). This reduces morbidity and delays in surgery due to poor control. To ensure patients with diabetes are identified early in the preoperative pathway, information from primary care should be made available in the referral along with HbA1c results, where available, to avoid duplication of tests (for example, duration, type, treatment, and complications).[1]

HYPERTENSION (2016)

GPs should refer patients for elective surgery with mean blood pressures in primary care in the past year of <160 mmHg systolic and <100 mmHg diastolic. Patients may be referred for elective surgery if they remain hypertensive despite optimal treatment or if they decline antihypertensive treatment. Blood pressure reduction in primary care is based on evidence that rates of cardiovascular morbidity (particularly stroke) are reduced over years. Poor control of hypertension is associated with labile blood pressure under anaesthesia and increased morbidity.[2]

PREOPERATIVE ASSESSMENT AND PREPARATION (2010)

Primary care can help improve patients' fitness before surgery by offering guidance on smoking cessation, exercise, and weight reduction. By optimising treatment of chronic conditions, for example, diabetes and anaemia (female <12 g/dL, male <13 g/dL), this decreases perioperative mortality and morbidity, and shortens hospital admission. Anaesthetist-led preoperative services should form working partnerships with GP practices. This could take the form of accessing smoking cessation clinics, dietary advice, intravenous (IV) iron clinics, and exercise regimens. Pathologies that predictably progress from medical to surgical treatment, for example aortic aneurysm and osteoarthrosis, would be particularly suitable for early attempts to optimise health.[3]

DO NOT ATTEMPT RESUSCITATION (2009)

Patients with Do Not Attempt Resuscitation (DNAR) decisions from the community having surgical, palliative, or interventional procedures will have their status reviewed before surgery and adjusted for the perioperative period. A review of the DNAR decision by the anaesthetist and surgeon with the patient, proxy decision maker, or relative is essential before proceeding with surgery and anaesthesia.[4]

ACCIDENTAL AWARENESS DURING GENERAL ANAESTHESIA (AAGA): NAP5 (2014)

[This is a report rather than a guideline, but

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Submitted: 23 January 2017; **Editor's response:** 2 February 2017; **final acceptance:** 12 April 2017.

©British Journal of General Practice 2017;
67: 529–530.

DOI: https://doi.org/10.3399/bjgp17X693437

it includes some useful recommendations].[5] It would be useful when counselling patients with a fear of anaesthesia or caring for patients post-awareness from anaesthesia. The estimated incidence of reported AAGA is 1:20 000.

AAGA encompasses a broad range of experiences: from hearing a voice to feeling pain when paralysed. This has a variety of psychological consequences. Active early support may offer the best prospect of mitigating the impact of AAGA, and a structured pathway to achieve this is proposed. All reports of AAGA should be treated seriously, even when sparse or delayed, as they may have serious psychological impact. If reported to someone else, every attempt should be made to refer the case to the anaesthetist responsible.

PAIN RELIEF IN LABOUR AND ANAESTHESIA FOR CAESAREAN SECTION

Multilanguage leaflets summarise the alternatives for pain relief during labour, caesarean section, and postdural puncture headache. It has been written by a group of doctors, midwives, and mothers, ensuring access to trustworthy, unbiased, and evidence-based information. It also covers the risks and benefits of spinal and epidural anaesthesia, treatment of postdural puncture headache, and information about the problems associated with obesity.[6]

ANAESTHESIA EXPLAINED (2015)

This booklet offers patients, relatives, and carers an explanation of how they may receive anaesthesia and pain relief for an operation.[7]

ANAESTHESIA FOR CHILDREN (VARIABLE DATES)

This is a list of patient information leaflets specifically prepared for children and young people, written by a team of parents, play specialists, and doctors, with advice from hundreds of children aged 4 years and upwards.[8]

INTENSIVE CARE SOCIETY

This is an excellent resource to pass on to patients and relatives who are coping with admissions to intensive care. It contains patients' stories and general information about admission to the ICU and how to find and give support.[9]

BRITISH PAIN SOCIETY

Contemporary guidance, supported by available evidence, on clinical and other pain matters including understanding/managing long-term pain, pain management programmes, and managing cancer pain.[10]

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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