Anesthesia Guidelines

Please refer to the medical guidelines for additional details

The anesthesia providers work with the surgeons and nurses to provide high quality, safe cleft care. The lead anesthesiologist should be designated prior to the start of the mission. Ideally, that individual is a pediatric anesthesiologist – one who is fellowship trained and who has extensive experience with pediatric patients, particularly those under the age of two. Anesthesia providers may include physician anesthesiologists, nurse anesthetists and senior anesthesia trainees or pediatric anesthesia fellows. Nurse anesthetists and trainees may not be the "float" anesthesia provider, take call, or work alone in the operating room.

Safety is our first priority, and, to that end, you should not attempt procedures or blocks that are not a routine part of your practice. One exception is the administration of a transnasal sphenopalatine ganglion block utilizing a soft catheter or cotton-tipped swab as described in the literature, which is extremely safe and easily taught.

1. **Clinic Screening and operating room set-up**. Historically, an anesthesiologist has been assigned to a specific surgeon and evaluates the patient for anesthesia risk and suitability for surgery during the surgical evaluation. Our preoperative anesthesia screening is now typically carried out in collaboration with the pediatrician, who shares similar objectives in determining appropriateness for surgery. We have found that this improves the efficiency of the pediatric screening and allows for consultation as needed to address clinical concerns. The other anesthesiologist(s) are responsible for preparing the operating room for surgery, assuring that all the equipment is functioning properly and that medications and supplies are available for surgery the next day. The lead anesthesiologists will make the assignments for clinic day and assure that the controlled substances and intravenous fluids have been acquired from the hospital. Because of the variation in distribution and accounting of controlled substances, the lead anesthesiologist will confirm with hospital staff the appropriate monitoring measures that should be taken and assure that physician and nursing staff understand these guidelines. Good recordkeeping is essential. Preoperative NPO guidelines should be reviewed by the pediatrician and lead anesthesiologist on clinic day.
2. **Perioperative care of the patient**. The anesthesiologist is responsible for assuring that the NPO status is optimal and that there are no new concerns regarding appropriateness for surgery. Preoperative analgesia and sedation should be administered as needed. Although individual provider preferences should be respected, we should bear in mind that we rarely have time to establish rapport with preschool-aged patients and we are very strange and scary looking to many ethnic groups. The float anesthesiologist should insure that premedications are

administered in a timely fashion and that the patients are subsequently observed by a skilled care provider prior to transport to the operating room. We rarely have infusion pumps or ventilators for intraoperative care. Our routine practice may need to be adjusted to accommodate these limitations. Upon arrival in the PACU, the anesthesia provider is responsible for the immediate postoperative care of the patient and should assure that the airway is adequate and appropriate analgesia had been administered and orders written for additional medications that may be needed prior to discharge to the ward.

Most of the time, intravenous cannula are placed after induction of anesthesia. However, local customs may dictate that the IV is placed on the ward prior to surgery. The anesthesia providers must be aware that the IV placed in the OR should be stabilized in such a way that it remains secure once the patient is transferred to the ward. Tegaderm and Coban are useful in securing the IV and "no-no's" can provide effective restraints. Nonetheless, IV challenges persist. Be mindful that the small 24 gauge catheters are not kinked at the hub, which can actually be caused by the application of tape or Tegaderm. We value the operating room nurses assistance, but you remain responsible if their placement or dressing of the IV is inferior. Any potential problems should be addressed before leaving the OR. Despite all best efforts, the occasional patient presents behavioral challenges that can compromise the IV. When physical restraints are not effective, consider pharmacological ones. Benadryl 1 mg/kg, dexmedetomidine to effect, ketamine up to 1 mg/kg may save the IV and provide respite for the child's parents and caregivers.

3. **Emergency care** It fortunately is unusual for patients to require surgical intervention once they have been discharged from PACU. However, occasionally a patient may return to the operating room for evaluation of persistent bleeding. A more common occurrence is the need for prolonged respiratory support, particular supplemental oxygen and bronchodilator therapy, as well as interventions to relieve airway obstruction. Most of this care can be administered in PACU, obviating the need for PICU/ICU except in rare circumstances. Persistent postoperative concerns can be managed overnight with the presence of a PACU RN, anesthesiologist, and pediatrician or surgeon immediately available. A determination regarding transfer to an ICU and/or to another hospital must be made prior to the start of next-day surgery when ongoing care is necessary necessary.