GI Anesthesia Mini-Handbook
Last revision 4-20-18

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Purpose: This mini-handbook serves as a quick reference for navigating anesthesia cases in GI, including general information, workflow conventions, case-specific tips, and recovery period guidelines.

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General Information

- An updated case schedule will be available in the procedure rooms each morning. Please check for overnight changes.
- The pre-op computer board will display anesthesia patients and pre-op bay location in pink highlighting.
- All providers will write their full name and contact number on their room's white board in the morning.
- Each anesthesia team (attending and APP) should huddle with the room's GI team in the morning prior to starting the first case to set expectations and flag concerns for the day's schedule.
- Drug bags may be dropped off in a lock-box located in the GI med-room between cases.

Workflow

- Hi-Tech (Rooms 14, 15, 16, 17)
    - APP is responsible for patient transport to the room and to PACU.
    - Do not take the patient back until the bedside checklist is complete. If the checklist is incomplete, then contact the in-room RN.
    - Always double-check DNR status.
    - The in-room RN (not the pre-op RN) is the source of truth for taking the patient back to the procedure room.
    - To contact the in-room RN/circulator by phone, dial the Vocera system at x87200 and say "call {first and last name}."
- Fast-Track Luminal (Rooms 3 and 6)
    - Patients are screened to be ASA 1 or ASA 2.
    - APP is responsible for patient transport to PACU. RN will bring patient to the room.
    - Anesthesia attending should complete preops and consents in the main GI preop area.
    - There is no anesthesia machine in the procedure rooms, but basic airway supplies (bag/mask, oral airways, nasal trumpets) are available.
    - Badge-access med carts are available for drug security in the procedure rooms.

Luminal cases (EGD, colonoscopy)

- These cases may be performed with IV sedation and standard monitors.
    - Propofol alone (+/- cetacaine spray) is the ideal anesthetic for these cases.
- Complex patients will be scheduled in rooms 14-17
    - Consider airway protection (i.e. endotracheal tube) when the patient has any of the following comorbidities (not an exclusive or exhaustive list):
        - Severe uncontrolled GERD
        - Nausea/vomiting/persistent symptoms of gastroparesis
        - Features of a difficult airway
        - Significant respiratory disease
        - Pulmonary hypertension
        - Obstructive sleep apnea
        - Morbid obesity
        - Unstable vital signs/critically ill patient
        - Pregnancy
        - Severe renal or liver disease(i.e. dialysis dependent or presence of ascites)

Hi-Tech cases (EUS, ERCP)

- Patients typically have significant comorbidities.
- Generally these cases will proceed with an ETT due to length and complexity.
- In exceptional cases (anticipated to be less then 1 hour in duration and performed on relatively healthy patients), sedation may be considered.
    - This decision will be guided by patient comorbidities (including those listed above) as well as patient preference.
- What to expect:
    - ERCP/stent:
        - Position: sloppy prone/lateral
        - Average duration: 1.5-2 hrs
        - Specific considerations:
            - Positioning can be a challenge and you may need to obtain positioning devices from AOP/AIP for larger patients.
            - Glucagon for GI tract spasmolysis
            - Some patients may receive PR indomethacin; in such cases, avoid additional IV NSAIDS (e.g. toradol)
    - EUS/dilation
        - Position: supine/lateral
        - Average duration: 1-2 hrs
        - Specific considerations: Communicate with GI MD for specific case requirements (cyst drainage, plexus injection, etc.)

- POEM (Peroral Endoscopic Myotomy)
  - Position: supine
  - Average duration: 2 hrs
  - Special considerations: RSI for full stomach/aspiration risk, pneumothorax risk, NDNB/paralysis for case duration

Recovery Period

- When patients have an invasive monitor, make arrangements to recover in AIP PACU.
- For patients requiring infusions of pressors, make arrangements to recover in AIP PACU or directly to ICU.
- The GI recovery area can manage patients on CPAP provided you have filled out the proper orders