Abstract 35

To Intensive Care or Not?

Mona Lazar, DO[1]; and Peter Kallas, MD[2]
[1]Northwestern Memorial Hospital, Chicago, IL; [2]Northwestern University, Chicago, IL

Case Presentation: Patient is a 73-year-old gentleman scheduled for left total knee arthroplasty. His medical history is significant for myocardial infarction followed by a 4-vessel bypass in 2002. Patient had a preoperative stress test done at his outside cardiologist's office showing nonreversible ischemia with evidence of "preinfarct ischemia" in inferior lateral regions of the heart. Ejection fraction was 45%; this is "unchanged" from prior study.

In clinic visit, patient denies snoring and also tests negative for sleep apnea based on his responses to the Berlin Questionnaire. On subsequent phone conversation closer to surgical date, wife confesses her husband (patient) "stops breathing at night."

Exam:
Blood pressure: 140/80, heart rate 82 bpm
General: overweight but not obese
Cardiovascular: regular rate and rhythm, no murmurs
Lungs: clear to auscultation bilaterally
Extremities: no edema
Electrocardiogram: left bundle branch block, rate 82 bpm

Patient proceeded through surgery without complication, but postoperatively was desaturating to 85% on 2 L of nasal cannula. Patient was started on continuous positive airway pressure with autotitration in the postanesthesia care unit (PACU).

Discussion: The decision regarding transition of care out of the PACU was made with the internist as well as the anesthesia resident and the attending in recovery.

Patient had known coronary artery disease and likely has undiagnosed, never previously treated, obstructive sleep apnea.

Patient was felt to be at higher risk for arrhythmia, respiratory failure, and other adverse outcomes. The decision was made to send the patient to the surgical intensive care unit postoperatively for intense monitoring overnight.

Conclusion: Internists screening patients for surgery should have either a questionnaire or routine discussion with patients regarding signs and symptoms of sleep apnea prior to surgery, just as is routinely done for coronary artery disease in a preoperative setting.

Patients with coronary artery disease and undiagnosed, untreated obstructive sleep apnea should be routinely admitted postoperatively to intensive care overnight for monitoring for episodic hypoxemia, arrhythmia, and mental status changes.

Undiagnosed sleep apnea in postoperative patients remains an important issue regarding patient safety.