

High risk surgery and shared decision making

Helping individual patients to make their choice for AAA surgery or Hip and Knee Replacement surgery

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Wrong patient surgery

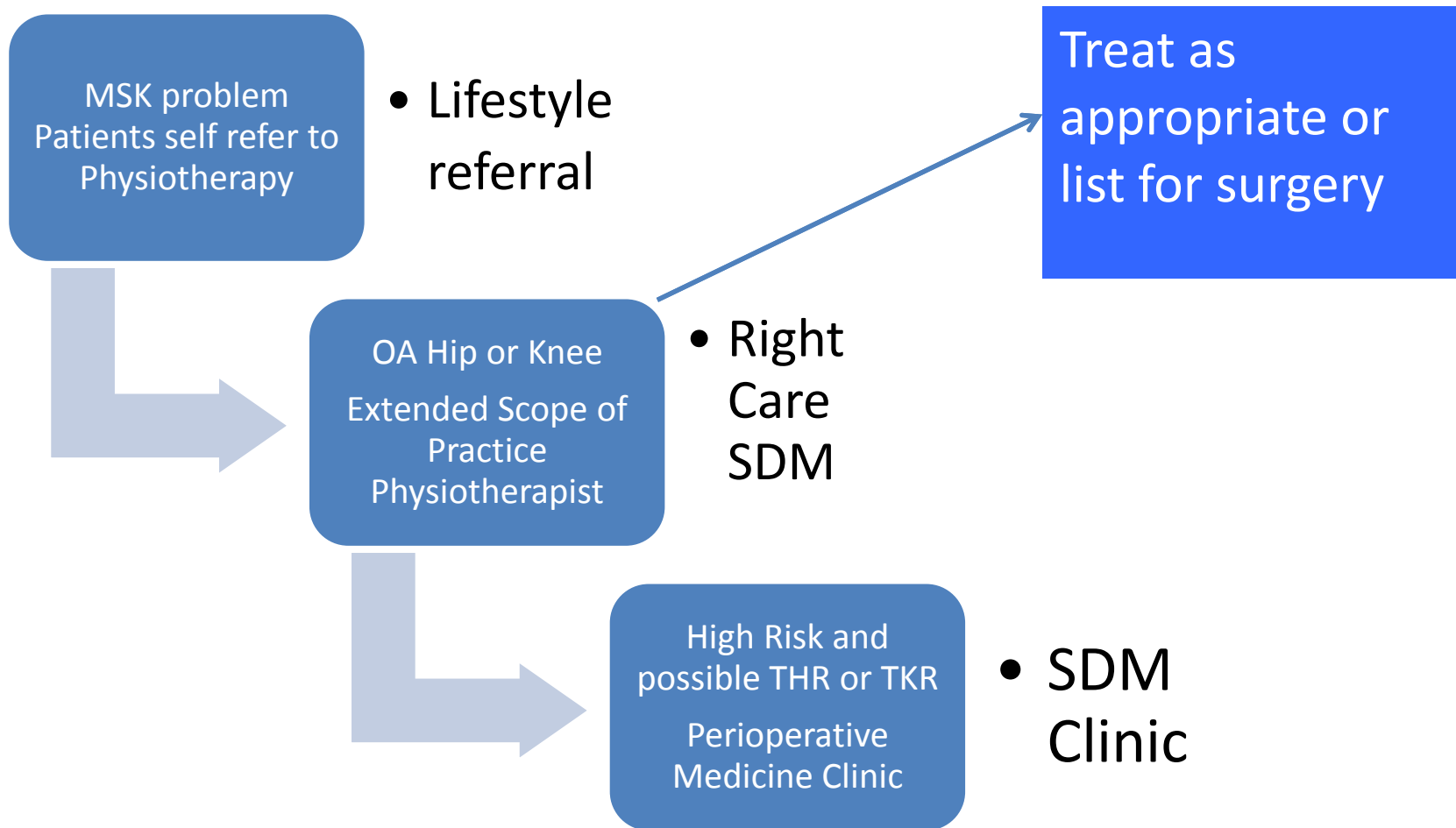
- Surgery prolongs life, removes pain and improves quality of life
- High risk surgical patients have an increased chance that surgery may shorten life, increase pain and worsen quality of life
- Identifying high risk surgical patients and shared decision making reduces wrong patient surgery

THR and TKR reduces pain, improves mobility and may prolong life

- 8/10 better, 1/10 no change, 1/10 worse (PROMS)
- 120,000 primary THR and TKR per year (BOA)
- 12,000 patients worse per year
- Bad outcomes are bad for individual patients
- Bad outcomes are bad for all of us

South Devon and Torbay CCG

Torbay and South Devon Foundation Trust



Torbay Hospital Perioperative Medicine Clinic

Assessment for Hip and Knee Joint Replacement Surgery

RISK	1	2	3	
	Nurse Consultation	Refer for Notes Review	Anaesthetic Clinic	Shared Decision Making Clinic +/- CPET
	Age <75	Age 75-84		Age >85
Investigations		Abnormal Investigations (ECG, Bloods)		
CVS		CABG or coronary stents Angina		MI/NSTEMI Frequent or concerning angina Heart Failure Peripheral arterial disease
Respiratory		Problems with SOB		
Renal		Abnormal creatinine		Cr>130
Neurological		TIA Dementia History of postoperative delirium Recurrent falls Frailty		CVA 2X TIA Dementia Post operative delirium
Haematological		PE		
Oncology		Malignancy		
Surgical Factors				Revision Surgery Bilateral Surgery
Anaesthetic Factors		Recent ICU admission (within 6-12 months)	Airway issues Intraoperative complications	
Patient Factors		Previous perioperative issues Patient worried Patient request	Patient worried Patient request	Previous post operative metaraminol
Any other concerns from		e.g. Sleep apnoea, malnourished, BMI >45		Concerns around 'Frailty'

Abdominal Aortic Aneurysm

Diagnosed by screening program or fortuitous

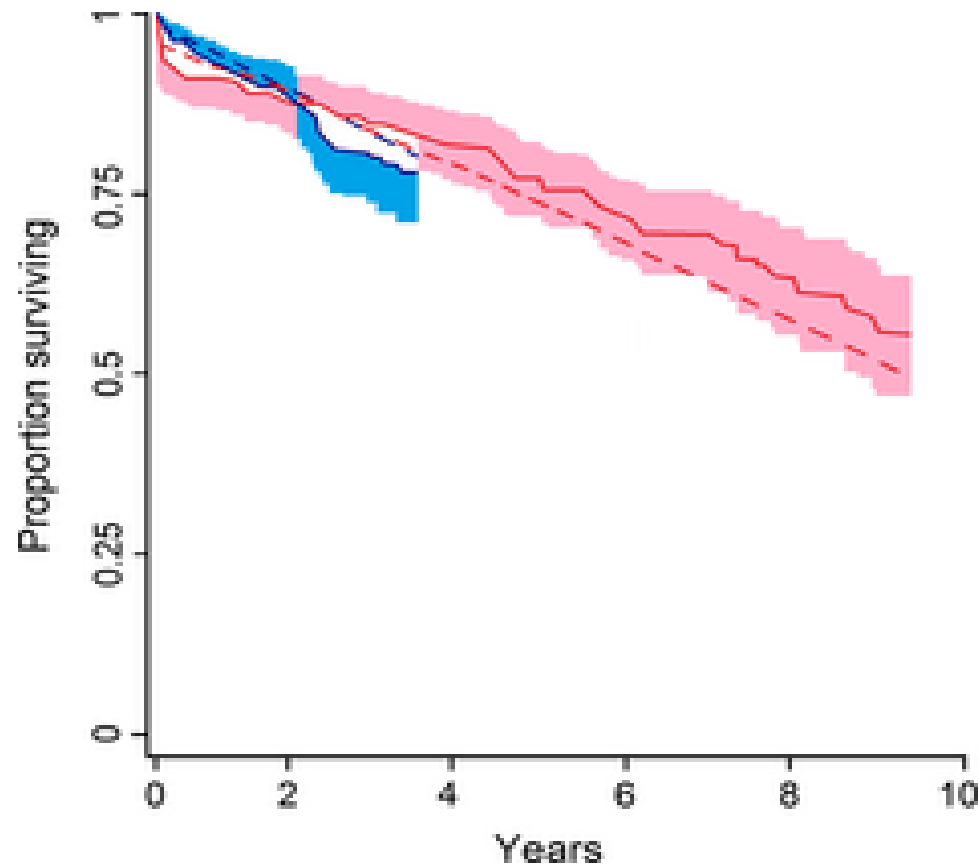
Operation: consider when >5.5 cm

Aim: to prevent death by rupture

EVAR: reduced short term mortality/morbidity

Open: reduced follow up and additional surgery

Survival (solid line) after AAA surgery (936 patients)
Red Open, Blue EVAR, Shaded area 95% CI



Individual Survival Prediction

<http://sites.google.com/site/informrisk>

Age, sex, operation

Heart attack, stroke, kidney failure, heart failure, PAD

Aerobic fitness

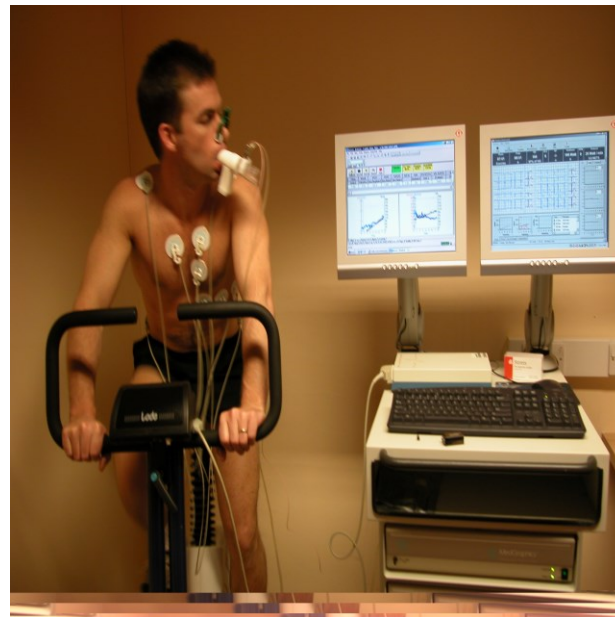
Dementia

Frailty

Liver failure

Low weight

Anaemia



Perioperative Medicine

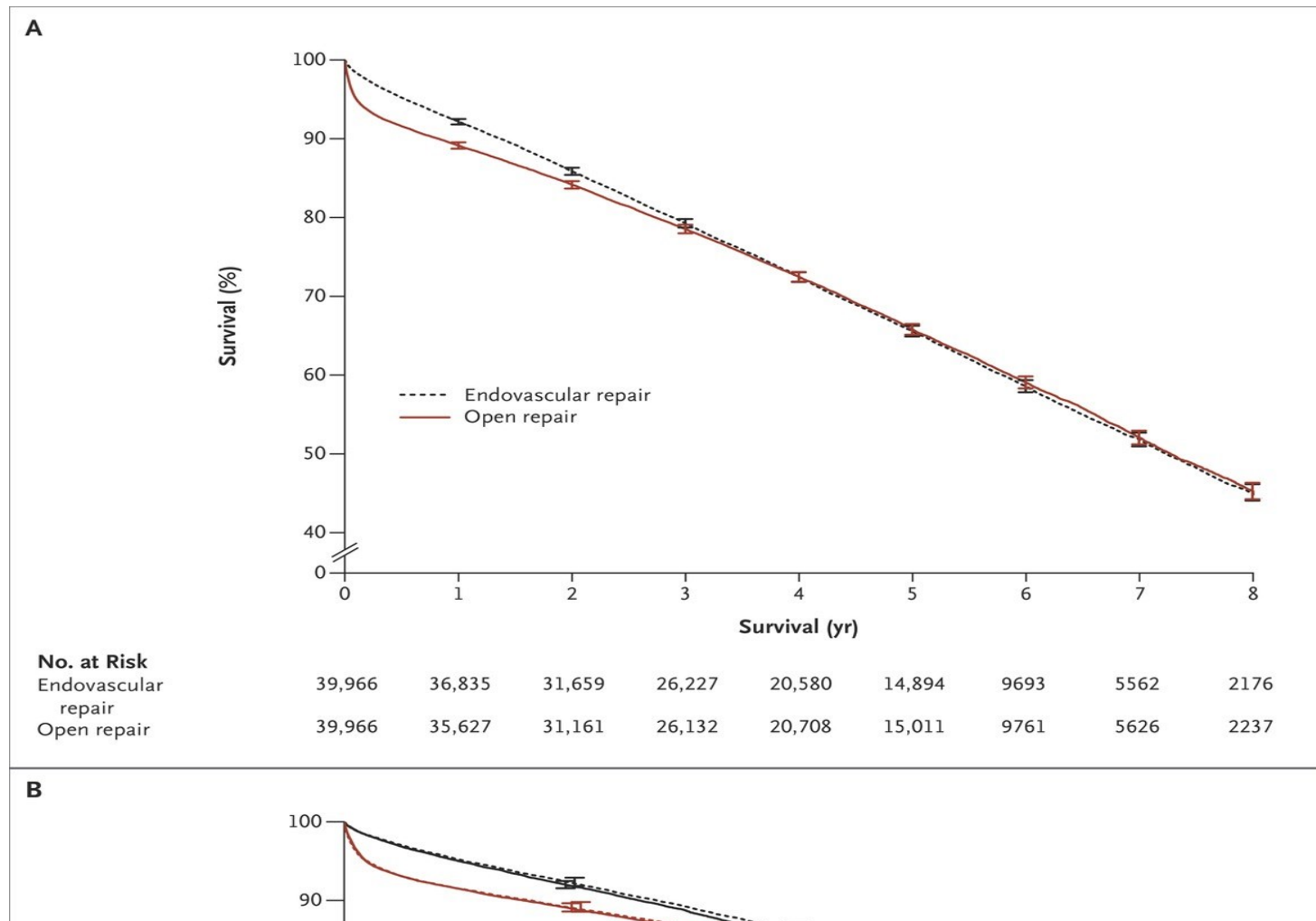
Shared Decision Making Clinic

- Individual survival with or without surgery
- Identify patients expectations from surgery
- Identify patients personal preference
- Usually focus on morbidity and quality of life



Thank You: michael.swart@nhs.net

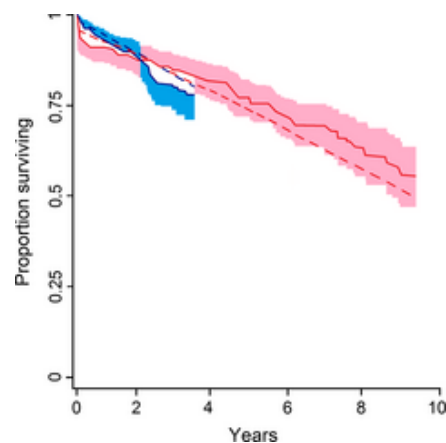
Long term survival after AAA surgery (39,966 matched pairs NEJM 2015:373;238-38)

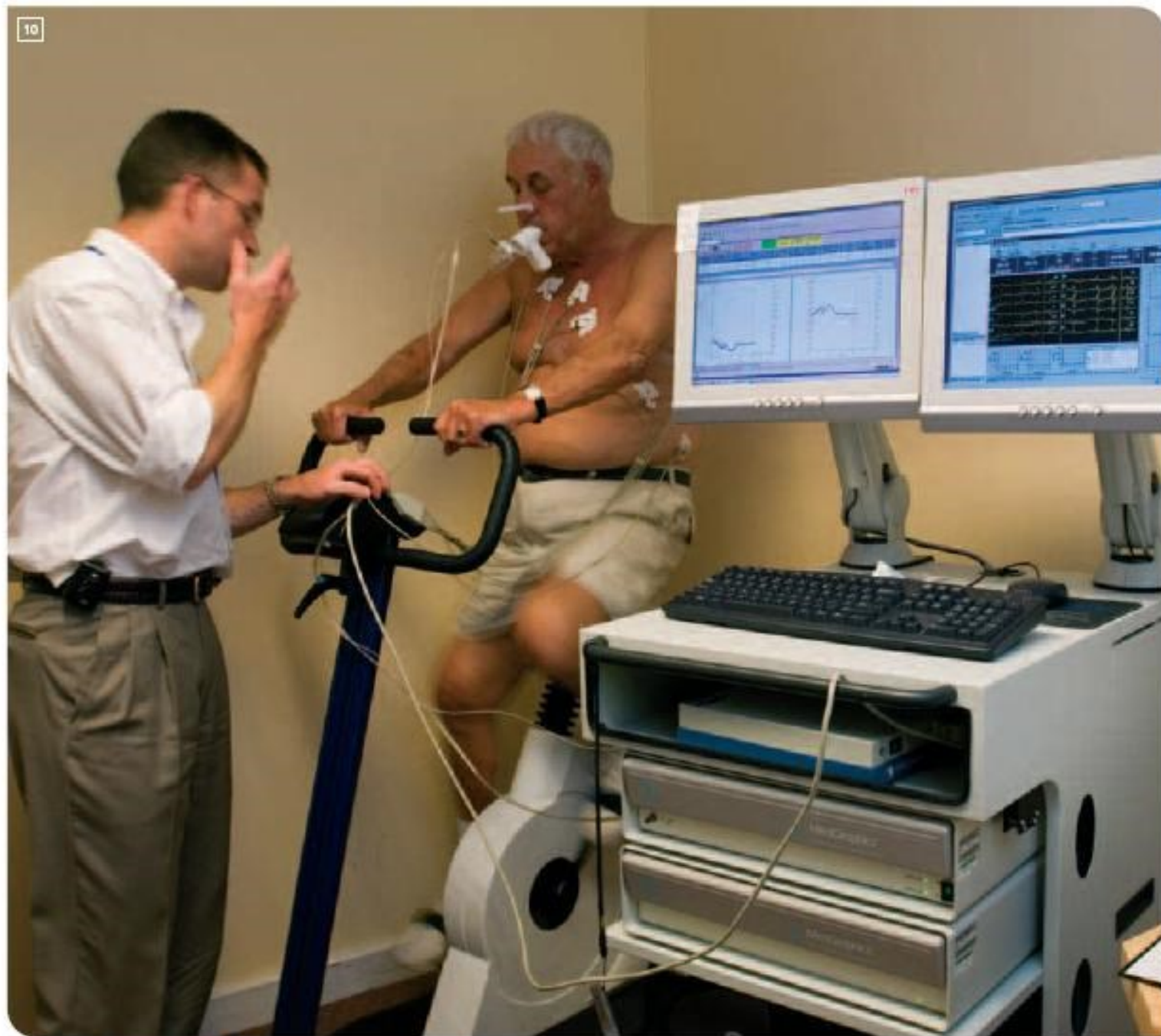


Perioperative Medicine and Shared Decision Making Clinic

- Age >85
- MI/NSTEMI
- Frequent or concerning angina
- Heart Failure
- Peripheral arterial disease
- Cr>130
- CVA
- 2X TIA
- Dementia
- Post operative delirium
- Revision Surgery
- Bilateral Surgery
- Previous post operative metaraminol
- Concerns around 'Frailty'

Validation of long-term survival prediction for scheduled abdominal aortic aneurysm repair with an independent calculator using only pre-operative variables





Factors associated with survival after resection of colorectal adenocarcinoma in 314 patients Carlisle BJA 2012

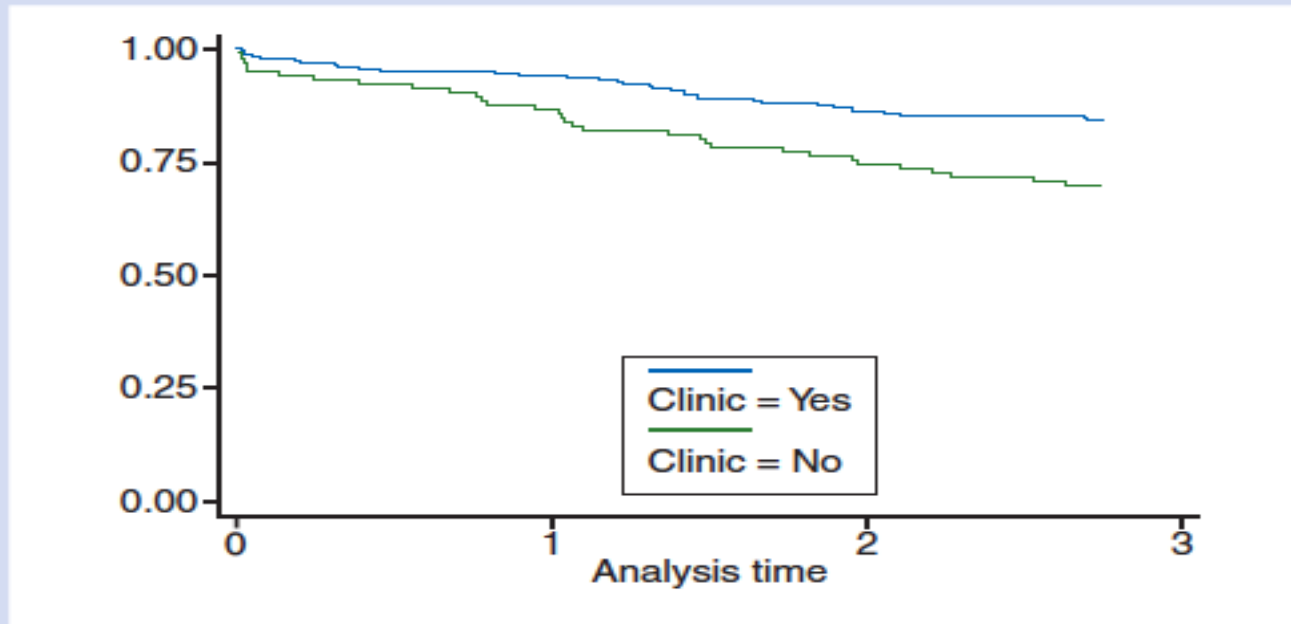
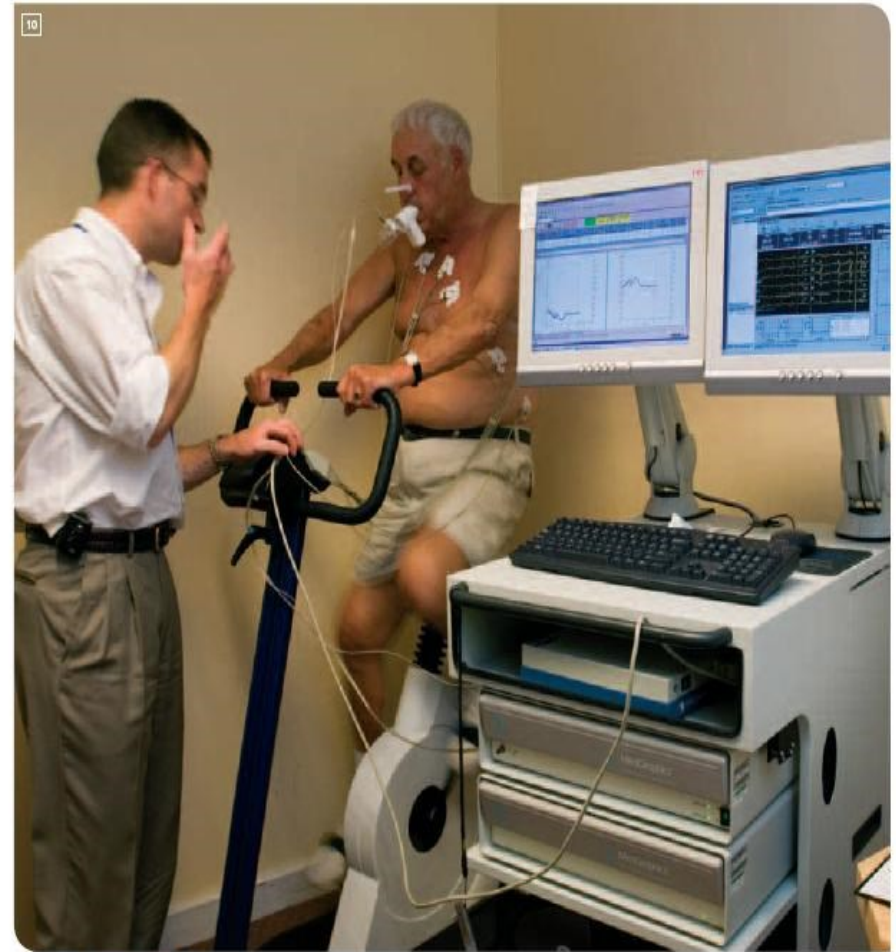


Fig 2 The Kaplan-Meier survival curves for patients who were (207) or were not (107) assessed in the preoperative high-risk clinic. Patients were referred to the clinic by surgeons or specialist nurses. Patients assessed in the high-risk clinic were significantly older and had higher ASA grades.

CT Scan



CPET



Our website is at www.sdhct.nhs.uk

Assess perioperative risk

- Age
- 1.5 X Heart failure, MI, Stroke, PAD, Renal failure
- 1.25 X TIA, Angina
- Reduced aerobic fitness
- Type of surgery
- Low Hb, low weight, delirium, blood loss

Risk Calculator (John Carlisle)

- <http://sites.google.com/site/informrisk>
- You do still need to think

Communicating risk

- Use a clear and consistent lexicon
 - *Benefit*
 - *Harm*
 - *Uncertainty*
 - *Risk* has a statistical meaning for most clinicians; the meaning for most patients is *possible threat*
 - *Chance or likelihood* preferable for patients

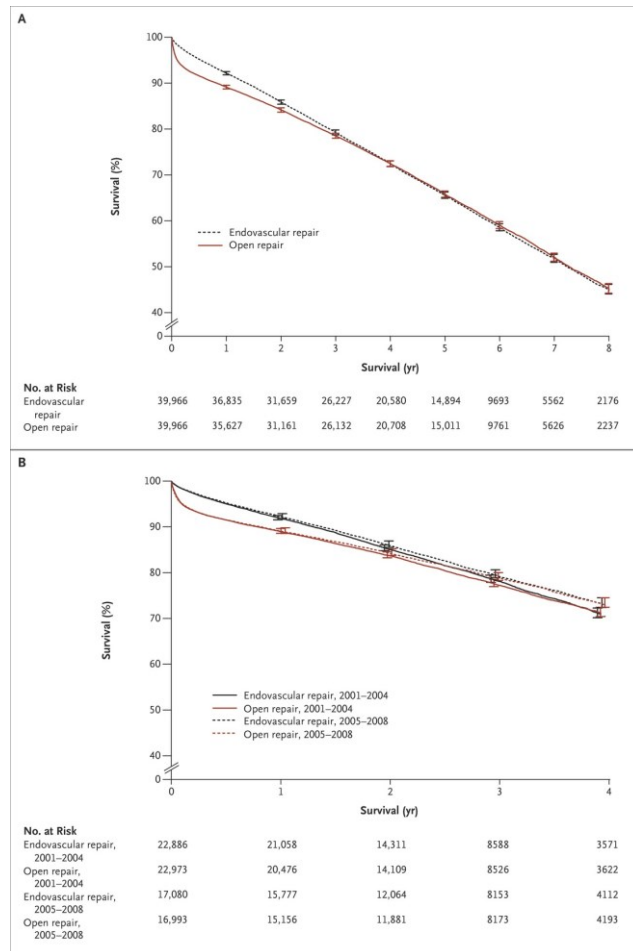
Shared Decision Making

- Not new, its just good medicine
- Across all medicine
- Decision aids <http://sdm.rightcare.nhs.uk/>
- Reduced procedures and less decisional conflict

High Risk Surgery Shared Decision Making

- risks and benefits of available options
- limits of scientific knowledge
- patients values and preferences
- guidance or coaching in deliberation, improve the patient's involvement in the decision making process

What is CPET



PERSPECTIVE
Redesigning Surgical Decision Making for High-Risk Patients

Laurent G. Glance MD, Turner M. Osler MD and Mark D. Newman MD

N Engl J Med April 10 2014; 370:1379-1381



The NEW ENGLAND
JOURNAL of MEDICINE

Questions and Listening

- Closed questions are for diagnosis
- Open questions are more likely to find the patients views or perspective
- Maintain eye contact, put pen down and ignore the computer when listening
- Watch the body language
- Involve friend or relative
- Pause and ask if they have questions

“Unlocking” the patients thoughts

- Use your own individual style or props
- The size of the room
- Date of birth and day of birth
- Origin of their surname or accent
- Find something that connects you to the patient that is not their medical or surgical problem

Dealing with upset or anger

- Acknowledge
- Give an apology
- Ask for permission to ask why they are upset or angry
- This can take time or may result in ending the consultation

Is the patient is making the wrong choice?

- Explore why they are making that choice
- Go over the consequences (morbidity)
- Involve family, friends, GP and then bring them back
- Get a second opinion

Conclusion of consultation

- Review the decision and the chance of harm and benefits
- State what you will do next
- State what the patient will do next
- Offer telephone consultation on the letter they will receive
- A final “do you have any other question?”
- End on something positive

THR and TKR Triage

ELECTIVE HIP AND KNEE REPLACEMENT PREOPERATIVE ASSESSMENT: TRIAGE			
RISK	1	2	3
Age	< 78	78 - 82	> 82
IHD		Angina (no MI)	MI/NSTEMI
Heart Failure			Heart Failure
Creatinine	<90 µmol/L	91-149 µmol/L	>150 µmol/L
TIA/stroke		One TIA	Two TIAs or one stroke
Diabetes		NIDDM	IDDM
Short of breath		SOB	
Confusion		Confusion	
CABG or Stents		CABG or Stents	
PE		PE	
Previous problem		Previous problem	
Malignancy		Malignancy	
Patient request		Patient request	
Worried		Worried	
Falls		Falls	
Revision surgery		Revision surgery	
Bilateral surgery		Bilateral surgery	
ASSESS	NURSE	NURSE + ANAESTHETIST	CPX CLINIC
Creatinine	Look for current and previous blood results. If raised in past use highest measurement.		
TIA/CVA	Transient ischaemic attack or cerebrovascular accident		
Diabetes	Consider duration of diabetes, control of blood sugar and other organ damage		
Short of breath	Shortness at breath at rest or minimal exercise		
Confusion	Currently confused or history of confusion or dementia		
Previous problem	During previous admission that may recur.		
Worried	Any concern that needs discussion.		



30/06/2011

Communicating risk

- 1 in 200 is better than 0.5%
- Framing: Risk of death 1 in 200, risk of survival 199 in 200
- Pictures: house, street, village, town, city
- Mental models: clinicians use data, patients use stories
- Uncertainty: Denial or Catastrophise
- Ask – Tell – Ask