



## **Selection Criteria for Patients in Free Standing Ambulatory Surgery Centers**

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## Disclaimer

- The guidelines we will discuss are not intended or designed to substitute for the reasonable exercise of independent clinical judgment by qualified anesthesia practitioners.
- Guidelines apply to populations of patients, but each patient's needs should be considered on an individual basis to design an appropriate treatment plan.

## ASA Physical Status Classification System (October, 2014)

ASA PS  
Classification

Definition

Examples, including but  
not limited to:

ASA I

A normal healthy patient

Healthy, non-smoking, no  
or minimal alcohol use

ASA II

A patient with mild systemic  
disease

Mild disease only without  
significant functional  
limitations. Examples  
include (but not limited to):  
current smoker, social  
alcohol drinker, pregnancy,  
obesity ( $30 < \text{BMI} < 40$ ),  
well controlled DM/HTN,  
mild lung disease

## ASA Physical Status Classification System Continued...



ASA III

A patient with severe systemic disease

Significant functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI > 40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (> 3 months) of MI, CVA, TIA, or CAD/stents.

## ASA Physical Status Classification System Continued...

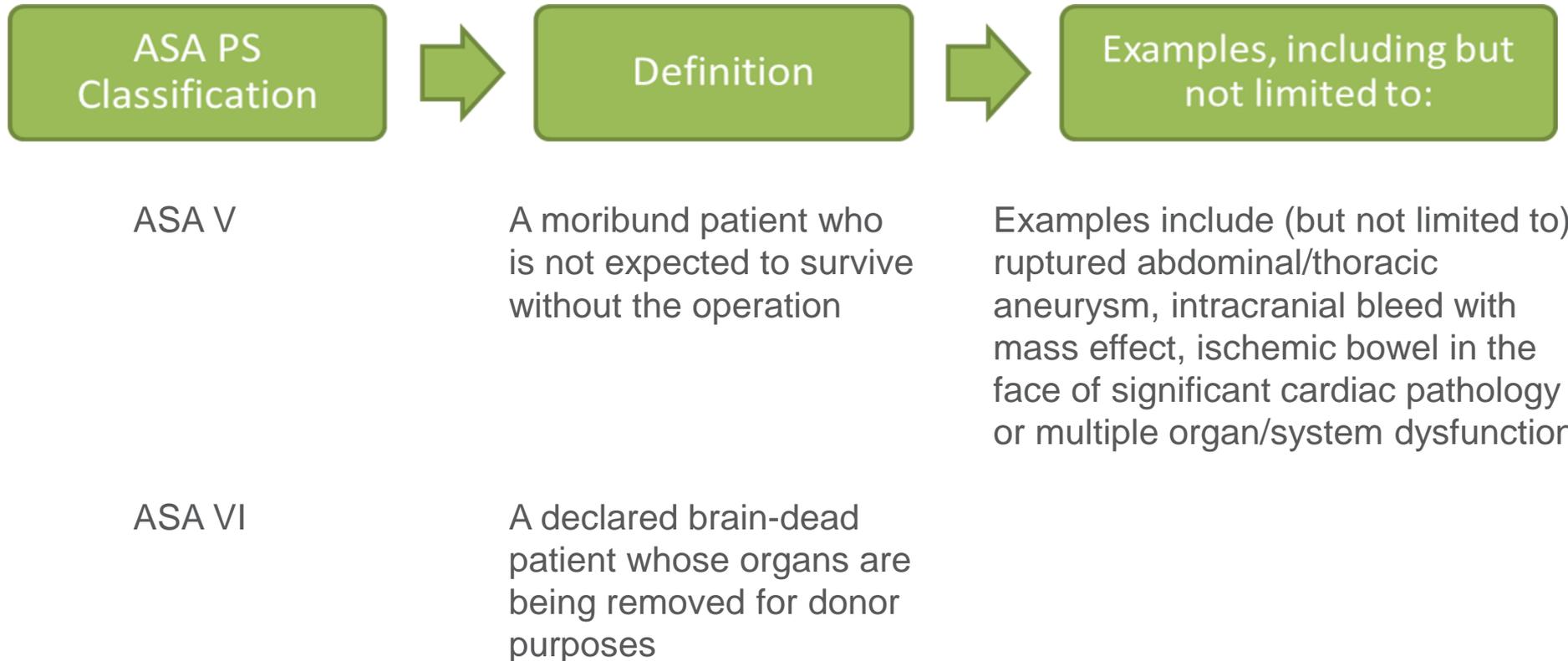


ASA IV

A patient with severe systemic disease that is a constant threat to life

Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis

## ASA Physical Status Classification System Continued...



**\*The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to significant increase in the threat to life or body part)**

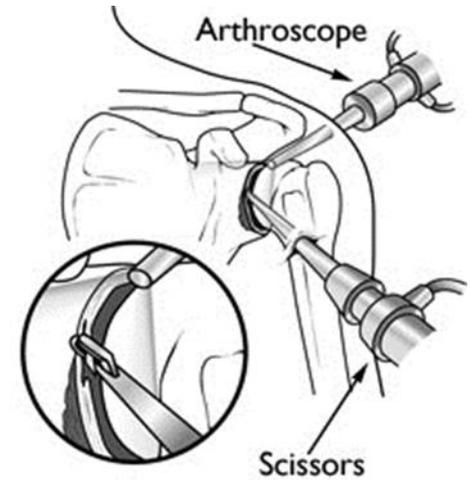
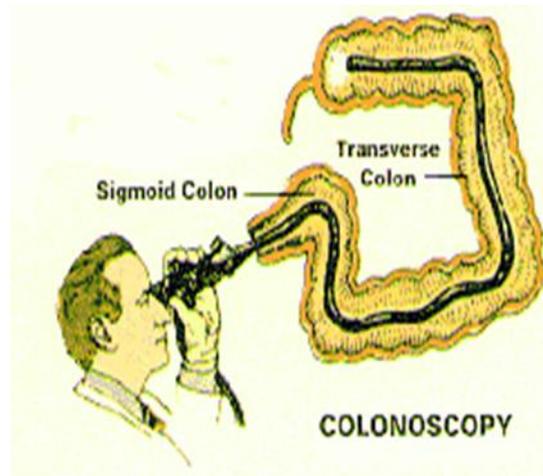
## Acceptable Patients and Procedures

- ASA I, II and III patients as long as all preexisting medical conditions are well controlled.
- ASA IV patients may be acceptable for minor procedures requiring minimal or no sedation.
- Non-emergent surgery
- Extensive blood loss requiring blood transfusion is not anticipated.
- Surgery does not involve an open major body cavity or blood vessels.
- Postoperative discharge to home is anticipated.
- All patients receiving intravenous sedation or general anesthesia have a responsible adult to accompany them home and be available if needed.

## Contraindications

- Any acute illness
- Acute drug or alcohol intoxication
- Pregnancy
- Acute tuberculosis or other infectious diseases
- Unstable or poorly controlled chronic medical conditions
- Known history of a difficult airway (unless approved by the anesthesia provider/Medical Director)
- Presence of any open wound unless medical therapy is currently in process and there is no risk of contamination
- Acute myocardial infarction, CVA or TIA < 3 months prior to surgery

# Not All Surgery is Equal



Minor

Major

# Special Considerations

## Weight/Size

- In patients with BMI's less than 50, weight alone is not an independent risk factor for perioperative complications.
- Patients with Morbid Obesity (BMI > 40 and < 50) may be acceptable candidates as long as their comorbid conditions (HTN, DM, COPD, etc.) are well controlled and stable.
- Many stretchers and OR tables have a weight limit of 350 pounds.

# Obesity

Not all obesity is created equally



**BMI = 45**



**BMI=45**

## **AIRWAY – AIRWAY – AIRWAY**

- All obese patients should be thoroughly evaluated with respect to airway management, the nature of the surgery and the risks of anesthesia.
- If the patient has a known history of Obstructive Sleep Apnea, he/she should be compliant with the use of CPAP.
- If the patient has suspected history of Obstructive Sleep Apnea but is not on any therapy, the risks of the procedure and anesthesia must be evaluated.

## Stop-Bang Evaluation

- Snoring
- Tiredness
- Observed periods of apnea
- Blood Pressure elevation
- BMI > 35
- Age > 50
- Neck Circumference > 40 cm (15.7")
- Gender – Male
- Greater than 6 positives – High likelihood of OSA

## Obstructive Sleep Apnea in an ASC

- Comorbid conditions must be optimized.
- Pain should be controllable with minimal use of narcotics – multimodal analgesia.
- Patients should be well monitored for several days post-op.
- Patients should be compliant with the use of CPAP.
- Patients should be advised against sleeping in the supine position.

## Cardiac Disease

- All cardiac conditions including HTN must be well controlled.
- Any severe or unstable conditions make the patient an ASA IV and should only be considered for minor procedures with minimal or no sedation.
- Patients with Bare Metal Stents must remain on anticoagulants for at least 6 weeks.
- Patients with Drug Eluting Stents must remain on anticoagulants for at least 1 year.

## Cardiac Disease Continued...

- Patients with Pacemakers and ICD's may be considered if no EMI is used within 6 inches of the device.
- Surgery should be postponed at least 60 days after an MI for minor procedures and 90 days for larger procedures.

## End Stage Renal Disease

- By definition, patients are ASA III if well controlled on dialysis or ASA IV if poorly controlled.
- Electrolyte abnormalities are common and ASC's do not have the ability to perform electrolyte testing.
- Fluid imbalance, particularly immediately before or after hemodialysis is common and could result in perioperative complications.
- Surgery should be limited to minor procedures with minimal sedation.

## End Stage Renal Disease Continued...

- Surgery should be scheduled on the day after dialysis and the results of the post-dialysis potassium should be available.
- Bowel preps can exacerbate fluid imbalance and electrolyte abnormalities.
- GI procedures are better suited for an inpatient setting where electrolyte measurements and appropriate post-operative care is available.

# Diabetes

- Patients should be well controlled.
- Blood sugars should be maintained in the patients' normal range.  
**There is no absolute cutoff for blood glucose level.**
- Hyperglycemia is associated with dehydration which can result in perioperative hypotension.
- Oral hypoglycemic therapy should be held on the morning of surgery.
- Management of insulin on the day of surgery is controversial.

## Diabetes Continued...

- Chronic hyperglycemia can result in poor wound healing and post-operative infections.
- Blood glucose should be measured preoperatively and in the PACU and treated accordingly.
- Patients should resume their normal diet and diabetic therapy upon discharge.

# Parting Thought:

**Laughter isn't the best  
medicine.**

# Propofol Is!