4 Pre-Operative Surgical Assessment of Cancer Patients

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4.1 Introduction

We know preoperative assessment is an important aspect of the management of cancer patients.

Surgeon has to play the key role in the whole process, as surgeon would be solely responsible for his/her own operated patients. It's a fact.

So, I believe 30–35% surgical outcomes depend on pre op assessment and preparation only.

4.2 General Principles

When we see the patient and decide the patient needs surgery then and there we should start prehabilitation.

We see the general condition of the patient, i.e. performance status in the form of ECOG or Karnofsky score.

We advise to quit smoking, alcohol, tobacco, maintain hydration, hygiene, high protein diet, have haematinics do some exercise, yoga, meditation, and respiratory exercise by spirometry.

Do tests to confirm the diagnosis, then staging and general workup.

Next step is to send the patients to Anaesthetist to get the preanaesthetic check-up (PAC) done!!

They usually advice for optimization of comorbid conditions like hypertension, diabetes, COPD, etc. to reduce the risk.

One important thing we have to take care that we should talk to the patients and the caregivers very politely. We should empathical for their mental agony and financial barden because of the disease!

4.3 Preoperative Judgement and Final Decision

Three important questions to be re-assessed (re-evaluated)

- Does the patient adequately investigated for the operation?
- Does the patient really need the operation?
- How much patient is counselled for the operation and what the patient's choice?

Re-assess the medical history, re-visit the CVS and respiratory system.

Medication, Thromboprophylaxis Re-anaesthesia check-up.

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Final discussion with the team and anaesthetists.

4.4 Identifying High Risk Factors

Age > 65 years, severity of the disease, disease burden, systemic disease, co-morbidity chronic kidney disease, stroke, angina are independent predictors of prognosis following surgery (Lee et al. 1999).

4.5 Peri Operative Medications

Aspirin: Usually to be stopped 5 days back. Now a days or low does aspirin 75 mg can be continued, particularly when the chance of bleeding is less.

Clopidogrel—to be stopped 7 days before surgery.

Antihypertensives—to be continued at the early morning in the day of surgery.

Hypoglycaemics: Oral hypoglycaemics like Metformin to with draw 48 hours prior to surgery.

Thyroxin to be continued even in the early morning of surgery with sips of water.

4.6 Pre op Advice to the Patients

Talk to patient and next of Kin minimum 5/10 min. Answer their queries, questions politely. Sometime we may get irritated because of their irrelevant questions but we should not get annoyed to take them in confidence.

We have to remember one thing clearly that our attitude towards the patient is everything. And truly speaking that is more than the successful outcome of surgery.

4.7 Pre op Optimization

Prehabilitation and pre op optimization are two most important tools for surgical success.

Before taking final decision for surgery once we should go through the history, investigations, and final diagnosis. Anything missing or any alternative treatment is better for the patient in that scenario is to finalize!

Even in operation theatre follow surgical check list and final surgical plan.

Talk to Anaesthesiologist once. Tell them your final opinion about the patient.

Team work is the better approach for the management of onco surgical patients always.

Conclusion Pre op assessment and optimization are aims to improve better surgical outcome. Surgeon has to play the most important part in this process because ultimate responsibility comes on to the surgeon only.