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ANESTHETIC MANAGEMENT OF 36 YEAR OLD OBESE 147 KG MALE POSTED FOR THR SURGERY

Anaesthesiology

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ABSTRACT

In Recent Time Demand of Total Hip Replacement(THR) Surgery is Increased. Affected population is associated with increased Comorbidity and Serious Complication. So, Anesthetic management can affect Both Intra-op and Post-op outcome. For this Different Techniques & Approaches used to give anesthetic and analgesic care to patient Undergoing THR Surgery. **Objective** To Give view of Anesthetic management in Comorbid obese patient posted for THR surgery and it's Impact on Intra-op & Post-op outcome .

KEYWORDS

INTRODUCTION

Total Hip Replacement surgery is one of the Cost-effective Surgery. It provide better result for patient suffering from Degenerative disease of Hip like Osteoarthritis, avascular necrosis of Hip specifically for Relief of Pain, Functional capability and Improvement of Quality of life.

Post operative THR surgery is extremely Painful therefore Neuraxial (Spinal + Epidural) anesthesia is used over General anesthesia with advantage of better Post-operative Pain relief, In addition to this there is less Respiratory complication, Avoiding Multiple Drug usage, Reduction in Blood loss and Transfusion Requirement.

Case Report

Case History :

- 36 year old obese patient posted for THR I/v/o Rt Hip AVN.

Past History :

- H/o HTN since 1 month (on Tab. Telmisartan 40 mg POBD),
- H/o OP poisoning one and half month ago for which 2 days Hospitalization,
- H/o COVID 19 2 yrs ago for which ICU admission for 20 days with O2 Mask.

Famiy History :

- Not significant

Personal History :

- H/o Tobacco chewer
- Sleep & Appetite Unaltered, Bowel & Bladder Function Normal.

General Examination :

- Pt is Obese with BMI – 44.3 (Class 3 Obesity)
- O/E – There is no Pallor, Icterus, Cyanosis, Clubbing, Edema & Lymphadenopathy .

METHODOLOGY

Pre-op Condition :

- PR – 80/min, BP – 140/90 mmHg, Spo2 – 98% on RA,
- RS - Clear BLAE +nt, CVS – S1,S2 +nt,
- CBC,LFT,RFT – NAD
- ECG – WNL, CXR – NAD
- HBsAG, HIV – NR

Possible complication of Spinal + Epidural anesthesia were explained and consent was taken.

Inside Operation theatre Patient was monitored with Electrocardio graphy, Non invasive blood pressure and pulse oximetry measurement.

Intravenous access was secured with 18G cannula and Patient preloaded with Ringer Lactate. Patient received Inj. Glycopyrolate 4microgram/kg and Inj. Ondansetrone 0.15mg/kg as a premedication. Patient was given oxygen via Nasal cannula 4L/min.

Under all aseptic and antiseptic precaution 2% Lignocaine given in L3-L4 space and Epidural anesthesia given using 18G Epidural needle in L3-L4 Space in Sitting position via Median approach and Epidural catheter fixed at 7.0 cm. Then spinal anesthesia given using 23 G spinal needle 3 ml Heavy Bupivacaine given and effect achieved at T6 level.

During intraoperative period Total blood loss 1500 ml which is replaced with IV fluid Crystalloid 2000ml (3 pint Ringer Lactate, 1 pint Normal saline) Colloid 500 ml (1 pint Pentacele) and 1 unit Blood. Total urine output 1100 ml.

Then, Patient safely transferred to post anesthesia care unit where patient observed for vitals and after confirming hemodynamic stability patient was shifted to ICU and then in Post-op period inj. Tramadol 50 mg given 12 hrly 3 times and Epidural catheter removed after 36 hr,on Day 5 patient was Discharged.

DISCUSSION

After considering all risk benefit ratio mode of anesthesia preferred was Spinal + Epidural anesthesia.

Why we avoided General anesthesia

- As patient obese with Short neck there is Difficult intubation
- To avoid Multiple Drug usage and Respiratory Complications

CONCLUSION

As There is better Postoperative pain relief, Early Mobilization, Less Respiratory complications, Reduction in blood loss and transfusion requirement, Avoiding Multiple Drug usage we preferred Spinal + Epidural Anesthesia.