

Anesthetic Management of 76 Year Old Male Posted for THR Surgery with Ongoing Tachyarrhythmia

Dr. Anjali Unadkat¹, Dr. Mehna Solia², Dr. Vidhdhi Baldania³

Anesthesiology Department, GMERS Medical College, Junagadh

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.*

Keywords: Total Hip Replacement, Anesthetic Management, Neuraxial Anesthesia, Comorbid Patient, Postoperative Outcomes

1. Objective

To give view of Anesthetic management in Comorbid patient of ischemic heart disease posted for THR surgery and its impact on intra - op & Post - op outcome.

2. Introduction

Total Hip Replacement surgery is one of the cost- effective surgeries. It provide better result for patient suffering from Degenerative disease of Hip like Osteoarthritis, a vascular 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.

3. Case Report

Case History:

- 76 year old patient posted for THR I/v/o Rt NOF fracture.

Past History:

- H/o IHD with HEART FAILURE with AF (patient is on medication since 15 days tab sacubitril (24 mg) + valsartan (26 mg) BD, tab torsemide (10 mg) OD, tab clonazepam (0.5 mg) BD).
- H/O blood transfusion on 24, 25, 30 November.

Famiy History:

- Not significant

Personal History:

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

General Examination:

- O/E - There is no Pallor, Icterus, Cyanosis, Clubbing, Edema & Lymphadenopathy.

4. Methodology

Pre – op Condition:

- PR – 88/min (irregular), BP – 130/82 mmHg, Spo2 – 98% on RA,
- RS–left LZ AE decreased +nt, CVS – S1, S2 +nt,
- CBC, LFT - NAD, RFT: urea: 60, creatinine: 1.2
- ECG – AF with RBBB, CXR –NAD
- HBsAG, HIV –NR
- ELECTROLYTES: normal
- PT: 14.5, D DIMER: 1700
- 2D ECHO: LVEF: 35 - 40%, RVSP: 40 mmHg, Bi atrial enlargement, sclerotic aortic and mitral valves, moderate MR and TR, moderate PAH.

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

Inside Operation theatre Patient was monitored with Electrocardiography, 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 26 G spinal needle 2.8 ml Heavy ROPIVACAINE plus 25 microgram fentanyl given and effect achieved at T6 level.

During intraoperative period Total blood loss 1500 ml which is replaced with IV fluid Crystalloid 500ml (1 pint Ringer Lactate) 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.

5. Discussion

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

Why we avoided General anesthesia

To avoid Multiple Drug usage and Respiratory Complications

6. 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.