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Preoperative investigations

As an anaesthetist, I read the article 'Preoperative assessment: a cardiologist's perspective' (Aust Prescr 2014;37:188-91) with much interest. The statement that 'risk assessment before surgery aims to minimise potential perioperative complications' is likely correct, although there is regrettably little evidence to substantiate this claim. However, I dispute the authors' view that for emergency surgery 'preoperative assessment uncommonly alters the course or outcome'.

The 2014 American College of Cardiology/American Heart Association guidelines recommend that, even for emergency surgery, clinical risk stratification should be undertaken, and that patients' morbidity and mortality risk can be estimated with the use of validated tools (www.riskcalculator.facs.org and www.riskprediction.org.uk/pp-index.php). Discussion of morbidity and mortality risk enables shared decision making, including the possibility that patients may decline surgery.

High-risk surgical patients have been described as those with a predicted postoperative mortality of greater than 5%.[1] A 2011 report from the UK National Confidential Enquiry into Patient Outcome and Death suggests that high-risk surgical patients should be carefully considered for postoperative high-dependency or intensive care.[2]

Disturbingly, in Australia (unlike New Zealand) good data on system-wide postoperative mortality are not collected and publicly reported. Clearly, not all postoperative morbidity and mortality is cardiac.

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Austin Ng and Leonard Kritharides, the authors of the article, comment:

We stand by our statement that 'for emergency non-elective surgery, preoperative risk assessment uncommonly alters the course or outcome of the operation as the urgency of the surgery takes precedence'. However, we did not intend for the statement to suggest not conducting preoperative assessments for emergency non-elective surgery. As stated by Dr Sutherland and in our article, 'identifying high-risk conditions such as class IV congestive heart failure, unstable coronary syndromes, or severe valvular heart disease (by conducting a preoperative assessment) can impact upon perioperative and postoperative management' from a cardiologist's perspective. Moreover, we agree that using validated surgical risk assessment tools will identify other non-cardiac high-risk factors. An appropriate risk assessment can then be presented to the patient or relatives for an informed decision. More research is clearly needed as the evidence behind preoperative assessment remains poor.

Data informs debate

The editorial 'Data informs debate' (Aust Prescr 2015;38:38-9) describes the uncertainties around the efficacy and safety of new medicines entering the market. It outlines the role that increased access to clinical trial data may have in informing assessments about the appropriate place of new drugs in clinical practice.

Just as it is important to consider new drugs, it is also important to consider the use of currently available drugs in new markets, or new populations. Populations vary, for a variety of reasons, in their response to specific drug therapies.[1,2]

Australia has a unique population in its Aboriginal and Torres Strait Islander people. This population may not have been included in clinical trials, so further analysis of trial data will often not be informative. Substantial uncertainty exists regarding