

Kongress: 11th Int. Congress of Cardiothoracic and Vascular Anesthesia
Name: Guido Panduri
Abstract Nr.: 55
Kategorie: Anesthetic methods
Vortragssprache: E
Vortragsart: P
Erstautor: dr. Guido Panduri, A.O. Ospedali Riuniti di Ancona, Torrette di Ancona
Coautoren: dr. Christopher Munch, A.O. Ospedali Riuniti di Ancona, Torrette di Ancona
Abstracttitel: Using Ultra fast-Track anesthesia in all patients undergoing cardiac surgery

Purpose: To study the outcome of ultra fast-track anaesthesia in non selected cases in adult cardiac surgery (without regional anaesthesia techniques).

Methods: A prospective, observational study in a tertiary community hospital in Italy. We studied 74 consecutive patients (mean age 67.6 ± 9.1 years, mean Euroscore 6.7 ± 3.1) undergoing non-emergency cardiac surgery and treated by the same anaesthesiologist. A standard anaesthesia protocol was provided using sevoflurane, fentanyl and propofol (during CPB). If hemodynamically stable and without evidence of bleeding at the end of surgery the patient was extubated in the operating theatre. The time needed for extubation, reintubation rates, blood losses at 12 hours and blood product transfusions, ICU and hospital length of stay (LOS), and the pain score trend at 0, 6, 12, 24 and 48 hours were recorded. Postoperative ICU and in-hospital complications were registered. We measured pH, paCO_2 , PaO_2 , arterial lactates and troponine T.

The results were compared retrospectively to the data obtained from a previous group of 74 randomised, non-emergency patients in our hospital.

Results: The extubation rate was 79% (51 patients), the mean time interval to extubation was 6.2 ± 9.6 minutes, the mean LOS in intensive care unit (ICU) was 25.8 ± 26.5 hours (vs. 52 ± 99 hours in the control group), while the mean LOS in hospital was 8.3 ± 4.2 days (vs. 9.6 ± 6.8). Reintubation rate was 2,7% (2 patients had to be reintubated for surgical re-exploration). The average amount of blood loss at 12 hours was 412 ± 234 ml (vs. 482 ml) and 41% of patients have been transfused (vs. 55% in the control group). Complications in the ICU were: 2 cases of bleeding that needed re-exploration and 1 case of generalised seizures. Hospital complications were: restlessness (4 cases), pneumothorax (1 case following thoracentesis), acute renal failure with creatinine increase up to 2,5 mg% (1 patient), atrial fibrillation (7 patients). The mean pain score has been always lower than 1,5/10. Ultra fast-track patients needed less inotropes and presented with stable hemodynamics, comparable to the patients in the standard anaesthesia group. ICU and hospital LOS were reduced in the fast-track group, as were atrial fibrillation rates (10% vs. 23% in the control group).

Conclusions: The ultra fast-track technique was safe, easy to learn, cost saving and very well accepted by the patients. Fast track anaesthesia was also possible in patients with more severe comorbidities, in complex cardiac surgery cases and with CPB times > 3 hours. ICU and hospital length of stay could have been even shorter if fast-track patients could follow specific in-hospital pathways.