Intravenous techniques in ambulatory anesthesia

Antoine Tesniere, MD, Frederique Servin, MD*

University Hospital Bichat Claude Bernard, Department of Anesthesiology, 46 Rue H Huchard, Paris, Cedex 18 75877, France

Recent advances in anesthetic and surgical techniques, combined with cost-containment concerns, have made day-case surgery increasingly popular. Day-case surgery differs significantly from classic in-patient surgery in that procedures are often shorter, less invasive, and less painful. Ambulatory anesthesia requires rapid recovery, good quality analgesia, decreased duration of care, and cost-effective techniques. Thus, anesthetic agents in day-case surgery should provide smooth and fast induction of anesthesia, rapid and pleasant recovery, and return to preoperative functional status with optimal postoperative analgesia and minimal side effects, such as postoperative nausea and vomiting (PONV). Several intravenous (IV) agents may fulfill these criteria and, therefore, ambulatory anesthesia can be achieved by a judicious combination of intravenous techniques, resulting in excellent postoperative outcome and comfort (Tables 1 and 2).

Because ambulatory patients expect to return to their preoperative functional state in the early postoperative period, anesthesiologists should strive to minimize discomfort. Obtaining patient satisfaction in this setting is an important objective for care providers. New techniques of administration have recently been developed to enhance patient comfort, reduce recovery times and length of stay and, therefore, outpatient surgery costs. Intravenous agents can be routinely used for induction and maintenance of anesthesia, for sedation, and for analgesia. This article reviews the pharmacology of intravenous anesthetic, sedative and analgesic agents, and the recent advances in the techniques of administration for ambulatory surgery.
Intravenous hypnotic drugs

Thiopental

Thiopental is a barbiturate, characterized by a rapid onset and a short duration of action after a single dose (5–7 mg.kg\(^{-1}\)). It has a low elimination clearance [1] and therefore cannot be used for maintenance of anesthesia. It may also delay early recovery without modifying intermediate and late recovery after short procedures when compared with propofol [2]. Thiopental usually provides a pleasant induction of anesthesia with pain rarely (2%) on injection and few excitatory movements [3]. Arterial pressure may decrease because of peripheral venodilatation, a reflex increase in heart rate, and a decreased cardiac output. Apnea is frequent, followed by a dose-dependent decrease in patient ventilation and in physiologic response to hypoxemia. Extravasation of a thiopental solution can cause pain, erythema, and tissue damage. Anaphylactoid reactions with thiopental are rare and mild. Thiopental is a cost-effective drug for induction of anesthesia.

Methohexital

Methohexital is also a barbiturate, and its pharmacological properties are close to those of thiopental. It is more potent, and the induction doses are therefore lower (1–3 mg.kg\(^{-1}\)). It is eliminated much more quickly than thiopental [1] and, as a consequence, can be used as a continuous infusion for maintenance of anesthesia. Unfortunately, the high incidence of unwanted side effects associated with methohexital administration is one of the main downsides of this drug: excitatory movements, PONV, hiccup, cough, or even laryngospasm have been reported in about 20% of cases [3].

However, the cost of methohexital is low, and its use for induction in day-case surgery is cost-effective when compared with propofol [4].

Table 1: Examples of dosing regimens for the various anesthetic I.V. agents during general anesthesia in the ambulatory setting

<table>
<thead>
<tr>
<th>Drug</th>
<th>Induction bolus dose</th>
<th>Maintenance infusion rate</th>
<th>Maintenance intermittent boluses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiopentone</td>
<td>5–7 mg/kg</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Methohexital</td>
<td>1–3 mg/kg</td>
<td>100–150 (\mu)g.kg(^{-1}).min(^{-1})</td>
<td>—</td>
</tr>
<tr>
<td>Midazolam</td>
<td>Not recommended as hypnotic agent in ambulatory general anesthesia</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Etomidate</td>
<td>0.3 mg/kg</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Propofol</td>
<td>2–3 mg/kg</td>
<td>6–10 mg.kg(^{-1}).h(^{-1})</td>
<td>—</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>50–100 (\mu)g</td>
<td>—</td>
<td>25–50 (\mu)g</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>0.5–1.5 mg</td>
<td>1–3 mg/h</td>
<td>0.2–0.5 mg</td>
</tr>
<tr>
<td>Remifentanil</td>
<td>1 (\mu)g/kg</td>
<td>0.1–0.25 (\mu)g.kg(^{-1}).min(^{-1})</td>
<td>—</td>
</tr>
<tr>
<td>Ketamine (analgesic)</td>
<td>0.1–0.2 mg/kg</td>
<td>5–10 (\mu)g.kg(^{-1}).min(^{-1})</td>
<td>—</td>
</tr>
</tbody>
</table>
Midazolam

Midazolam is a potent benzodiazepine. It is characterized by a slower onset of action than diazepam [5], an intermediary clearance (approximately 500 mL/min/C0), and a short elimination half life (2 hours).

Sedative effects are variable among patients, and recovery from midazolam sedation can be prolonged, accompanied by delayed recovery of superior functions [6] and persistent amnesia after awakening [7]. Complete recovery requires approximately 90 minutes after a single dose of midazolam 0.1 mg.kg/C0.

As a consequence, midazolam is not used to induce or maintain loss of consciousness in outpatients, but rather as a premedication or in conscious sedation.

Cardiovascular side effects are rare and mild at the doses used for sedation, but can be significant for more important doses, specifically in hypovolemic patients.

Respiratory tolerance is usually acceptable, but delayed obstructive apnea may occur in some patients [9].

Etomidate

Etomidate is an imidazole derivative that provides good hemodynamic stability when used as an induction agent. Despite its suitable pharmacokinetic properties for day-case anesthesia [10], etomidate is seldom used in the ambulatory setting because of a high incidence of unwanted side effects. These include PONV [11], pain on injection, venous irritation, phlebitis, and excitatory movements. The incidence and severity of these effects can be partially reduced. Pain on injection can be prevented by prior injection of 1 to 2 mL of lidocaine 1% or the use of a lipid formulation, and abnormal movements may be attenuated by prior injection of fentanyl [12].

Propofol

Propofol is the drug of choice for induction and maintenance of day-case anesthesia and the most widely used intravenous agent for ambulatory anesthesia and sedation because of its favorable pharmacokinetic and pharmacodynamic properties in this specific setting. It can be used solely or as part of total intravenous anesthesia (TIVA), by intermittent boluses, or continuous or target-
controlled infusions (TCI). Propofol is characterized by a fast onset and a short duration of action. Equilibration half-life between plasma and effect site is less than 3 minutes [13]. Its short context-sensitive half-life, a high plasma clearance (equal or greater than liver blood flow), associated with a large volume of distribution, results in a fast awakening even after prolonged continuous infusions when propofol is used as sole anesthetic agent. In the absence of estimation of the decrement time, gross overdosage is possible and may delay recovery [14].

When used at subhypnotic doses, propofol provides an easily titrable level of sedation, with anxiolysis and amnesia similar to those of midazolam [15].

Hemodynamic effects of propofol are mainly consistent with a dose-dependent decrease in peripheral resistances, resulting in a decrease of approximately 30% in mean arterial pressure. They may partly be avoided by a slow speed of injection [16]. Its use is relatively contraindicated in hypovolemic patients.

Because of direct antiemetic properties [17], the incidence of PONV in the postanesthetic care unit (PACU) is low with propofol [18].

When propofol is used at low concentrations, its respiratory effects are moderate and allow spontaneous ventilation during maintenance of anesthesia and sedation.

Intraoperative analgesia

Blunting autonomic responses to noxious anesthetic and surgical stimuli with intravenous anesthetics alone requires high doses leading to increased cost and delayed recovery. The analgesic component of anesthesia is usually provided by specific drugs, mainly opioids, low-dose ketamine or local anesthetic agents. Opioids interact synergistically with hypnotics for sedation and hypnosis [19] but cause significant respiratory depression and increase the incidence of PONV [20]. Local and regional anesthetics, when available, are effective to suppress pain related to surgical procedures. Recent studies have also shown that a combination of propofol and ketamine infusion (9.4 mg.mL$^{-1}$ and 0.94–1.88 mg.mL$^{-1}$ for propofol and ketamine, respectively) was effective in decreasing opioid requirements without modifying recovery profiles for monitored anesthesia care [21].

Optimal opioid analgesia should provide a fast onset of the desired effect, an easy titration to the level of noxious stimulation, and allow a fast recovery after surgery without postoperative pain. Thus, optimal dose and timing of administration are important factors.

To maintain a continuous opioid effect, a constant concentration of opioid must be maintained at the site of action of the drug. The usual titration methods rely extensively on the use of clinical criteria to assess the adequacy of the analgesic state and on the pharmacokinetic properties of the drugs used.

Fentanyl and its congeners

Fentanyl is a widely used opioid for ambulatory anesthesia and monitored anesthesia care (MAC). Despite its cumulative potential, when used at low dosages
(25–100 μg) it does not unduly delay recovery and provides adequate early postoperative analgesia. It can also be used as rescue pain medication in the initial recovery phase, providing analgesia long enough to allow nonopioid analgesics with a slower onset to exert their effects. Like all opioids, it should be used by titration, taking into account its slow onset (time to peak effect 4 min) under close respiratory monitoring.

The main advantage of alfentanil is its rapid onset (time to peak effect 1.5 min), which facilitates titration based upon respiratory rate in spontaneously breathing patients. In this situation, a continuous infusion produces less perioperative unwanted effects than intermittent boluses [22]. In outpatients, alfentanil induces less PONV than fentanyl [23].

Sufentanil has a longer time to peak effect (around 6 min) than fentanyl. As a consequence, its titrability is low, and it offers no advantages over fentanyl in ambulatory anesthesia.

Remifentanil is a potent opioid analgesic with a short onset similar to that of alfentanil and a high metabolic clearance. Its main advantage in the ambulatory setting is a short context sensitive half-time (3–5 min), independent of the duration of infusion. Because of the relative absence of residual opioid effect, its use requires adjunctive analgesics to maintain adequate postoperative analgesia after painful procedures. This is often best achieved with a combination of nonopioid analgesics (multimodal analgesia) administered well before remifentanil discontinuation, often at induction of anesthesia or toward the end of surgery. Remifentanil can be administered as intermittent boluses or as a continuous infusion. Use of continuous infusions (0.025–0.15 μg.kg.min⁻¹/C₀) in patients undergoing extracorporeal lithotripsy provided better intraoperative comfort but was associated with a higher rate of hypoxemia when compared with intermittent boluses (25 μg) [24].

**Ketamine**

Ketamine is a dissociative IV anesthetic that plays a significant role in analgesia and sedation for ambulatory surgery, mainly as an adjunct to other hypnotic drugs. It has sedative hypnotic properties resulting in a light dissociative sleep, but also has potent analgesic properties. Its clinical effects are mediated by noncompetitive antagonism at the N-methyl-D-aspartate and opioid receptors. Ketamine has a high plasma clearance of 17 ml.kg⁻¹.min⁻¹, with an elimination half-life of 153 minutes and is essentially metabolized to norketamine by the hepatic microsomal enzymes (CYP450). Norketamine is an active metabolite of ketamine, which is 30% as potent as ketamine, and hence can produce prolonged effects [25].

Ketamine has direct analgesic properties at plasma concentrations significantly lower than those producing loss of consciousness (100–200 ng.ml⁻¹ for analgesic effects, corresponding roughly to a 5–10 μg.kg⁻¹.min⁻¹ infusion) [26]. Ketamine can be safely administered at low doses (2–4 μg.kg⁻¹.min⁻¹) with continuous infusions of propofol during monitored anesthesia care for
ambulatory procedures, allowing a reduction in opioid doses and unwanted effects. Moreover, ketamine may attenuate propofol-induced hypoventilation and provide earlier recovery of cognition [27]. Adjunctive use of ketamine during propofol sedation provides significant analgesia and minimizes the need for supplemental opioids when given at subhypnotic doses [21]. Simultaneous use of small doses of ketamine with morphine enhances opioid pain relief [28]. Given before the end of surgery in ambulatory procedures, ketamine allows a reduction of approximately 40% in morphine requirements without altering the recovery profile [28].

Intravenous techniques

Appropriate administration techniques are important to fully benefit from the pharmacological properties of the intravenous agents.

Total intravenous anesthesia (TIVA)

Total intravenous anesthesia (TIVA) involves induction and maintenance of anesthesia with intravenous drugs alone. In TIVA, hypnosis can theoretically be achieved with many agents (barbiturates, benzodiazepines, etomidate, ketamine, or propofol). Because of its superior pharmacokinetic and pharmacodynamic properties, propofol has gained increased popularity for TIVA in ambulatory surgery. Propofol TIVA provides the ability to enhance patient’s satisfaction when compared with inhalational techniques, and results in a clinically relevant reduction in PONV when compared with isoflurane/nitrous oxide anesthesia [29].

TIVA is often associated with the administration of nitrous oxide, which does not delay recovery and may be used to decrease the requirement for the more expensive intravenous drugs. Nitrous oxide has been accused of increasing the incidence of PONV, but this assertion has recently been challenged [30]. Because nitrous oxide inhibits the NMDA receptor, it might reduce tolerance and hyperalgesia caused by opioid administration and thus improve postoperative pain control [31].

The objective of any form of administration is to maintain an appropriate concentration of anesthetic drugs at the site of action in the CNS. Choosing an appropriate method of administration is important in TIVA. Intermittent bolus injections of drugs may result in high peak plasma concentration, and therefore high concentrations at effect site, with possible unwanted effects. Depending on the drug administered and the time intervals between boluses, boluses can also result in significant accumulation. With continuous infusions of short-acting drugs, anesthesia can be maintained with a high degree of safety, precision, and titratability.

Propofol administration may be guided by the results from population studies that indicate the infusion rates needed to sustain a constant plasma or effect site concentration [19]. Infusion rates requirements decrease over time as muscle and
fat tissue depots equilibrate with a given plasma concentration. Various monitors, such as the bispectral index (BIS™), may further guide infusion rates. Its use allows a downtitration of hypnotic drugs doses and may promote earlier awakening [32].

**Target-controlled infusion (TCI)**

New techniques of continuous infusions use pharmacokinetic models to predict the patient plasma and effect site concentrations from the infusion scheme and allow the anesthesiologist to target a chosen concentration, the device calculating the appropriate infusion scheme to achieve this concentration [33]. Thus, the anesthesiologist deals directly with the concentration/effect relationship.

TCI rapidly achieves and maintains a predefined plasma or effect site concentration of the anesthetic drug. Appropriate target concentrations change with interindividual pharmacodynamic variability and with the nature of the surgery. When an appropriate target concentration for achieving the desired clinical endpoint is chosen, TCI delivery systems perform better than manual systems [34]. Currently, TCI devices are approved in many countries, but only for propofol administration.

**Monitored anesthesia care**

Monitored anesthesia care (MAC) is used for patients who require supervision of vital signs and administration of sedative/anxiolytic drugs to supplement local infiltrations or regional anesthesia, or to provide sedation during unpleasant diagnostic procedures. It usually describes an anesthetic state ranging from conscious sedation to deep sedation without airway control.

MAC is most often achieved with IV drugs, alone or in combination, which can easily produce a range of hypnotic states from anxiolysis to loss of consciousness without major hemodynamic and respiratory depression. A wide variety of IV drugs have been used during MAC, including barbiturates, benzodiazepines, ketamine, propofol, opioid and nonopioid analgesics, and nitrous oxide.

Methohexital provides excellent intraoperative conditions with a rapid recovery when administered by intermittent bolus injections (10–20 mg) or as a variable rate infusion, but its use is associated with adverse effects, such as pain on injection, excitatory movements, antianalgesic effects, and PONV [35].

Benzodiazepines, mainly midazolam, are widely used during MAC because of their sedative, anxiolytic, and amnesic effects. Ketamine has been used alone in MAC, but its administration has been associated with a great incidence of side effects, including psychic disturbances, varying from 5% to 30% [36]. Benzodiazepines have been used in combination with ketamine, and have proved their effectiveness in attenuating the psychomimetic effects of ketamine. This combination also provided effective intraoperative analgesia [37].
Propofol is probably the most suitable IV agent for MAC. Propofol as an induction agent offers better conditions for immediate awakening and faster recovery of cognitive function, with no significant differences at 24 and 72 hours when compared with thiopental [2]. When compared with midazolam infusions for sedation during procedures under local anesthesia, propofol use was associated with a more rapid recovery of cognitive functions and less postoperative sedation, drowsiness, and confusion [38]. Moreover, the quality of early and intermediate recovery after propofol sedation was superior to that obtained after benzodiazepines associated with flumazenil [8].

Propofol can depress the hypoxic ventilatory response and therefore coadministration of oxygen is usually recommended. The combination of propofol and small dose ketamine ($3.7 \pm 1.5 \text{ \mu g.kg}^{-1}.\text{min}^{-1}$) during MAC provides a reduction in the incidence of propofol-induced hypoventilation with a significant improvement in quality of recovery [27]. It also provides effective analgesia [39] and significant decreases in pain scores after discharge.

Although propofol has direct amnesic effects, a bolus of midazolam (2 mg IV) may be useful to enhance postoperative amnesia and anxiolysis without altering recovery profile [40]. Midazolam acts synergistically with propofol [41] and thus may reduce the propofol induction requirements. Nevertheless, this technique may impair postoperative recovery of swallowing reflexes more than propofol alone [42].

For office-based anesthesia, the use of propofol compared favorably with that of sevoflurane, with an improved recovery profile, greater patient satisfaction, and lower costs [43].

MAC is a cost-effective technique for outpatient surgery. Use of regional anesthesia as part of MAC for unilateral inguinal herniorrhaphy is associated with the shortest time to home readiness, lower pain scores at discharge, highest satisfaction at 24 hours follow-up, and the lowest costs when compared with general and spinal anesthesia [44].

In conclusion, MAC has become widely used throughout the world because of its efficacy in providing optimal intraoperative conditions, favorable recovery profile, pain management, and patient satisfaction with lower costs than general anesthesia.

**Conscious sedation**

Conscious sedation, defined as any degree of sedation ranging from anxiolysis to sleep with preservation of eyelash reflex and purposeful reaction to verbal or mild physical stimulation, allows many medical or surgical procedures with good perioperative anxiolysis and amnesia and without requiring mechanical ventilation. Subanesthetic doses of intravenous drugs are often used to provide sedation for procedures performed under local or regional anesthesia. As such, conscious sedation is part of MAC.

Sedation, which is a specific form of TIVA, can be achieved with many IV drugs.
The interest of propofol for conscious sedation was demonstrated at the early stages of clinical use of that drug. Mackenzie et al [45] studied the adequacy of propofol in sedation combined with local anesthesia and found that continuous infusion at subhypnotic doses ($3–4$ mg.kg$^{-1}$.h$^{-1}$) was safe, efficient, and accompanied by an impressively rapid awakening with low incidence of postoperative side effects. In patients requiring general anesthesia during these procedures, the infusion rate was increased ($10$ mg.kg$^{-1}$.h$^{-1}$) to induce loss of consciousness.

Sedation with propofol can be achieved with intermittent boluses ($10$ mg), continuous infusion ($25–100$ μg.kg$^{-1}$.min$^{-1}$), or TCI ($1–2$ μg.ml$^{-1}$). The overall quality of sedation, intraoperative conditions, and clinical recovery profiles are similar with the three techniques, but the use of infusions (manually controlled or TCI) decreases the number of interventions necessary to administer supplemental doses and therefore allows more time to monitor the patients [46].

Patient-controlled sedation

During day-case surgery, patients’ anxiety, level of stimulation, and type of procedures vary widely, thus inducing a broad range of sedative dosage requirements. New techniques of administration for IV sedation during MAC have thus been developed to meet this interindividual variability. Patient-controlled sedation (PCS) devices deliver a predefined bolus of IV drug during a defined time, with or without a lockout interval (eg, propofol $0.3$ mg.kg$^{-1}$ over $5$ sec, without lockout period) [47].

Ng et al [47] compared anesthesiologist-controlled administration of midazolam and patient-controlled administration of propofol. The results of this randomized study showed that PCS administration of propofol was associated with a better cooperation of patients and a higher endoscopist satisfaction. Time for awakening and discharge was shorter with propofol than with midazolam, with a higher overall patient satisfaction in the PCS group.

When compared with TCI administration of propofol, PCS showed similar quality of sedation, intraoperative conditions, and high levels of patient satisfaction in a crossover study during dental procedures in anxious patients [48].

Patient-controlled TCI may be a further interesting step in the delivery of sedation: when the patient activates the TCI device, the target is increased (eg, by $0.2$ μg.ml$^{-1}$ steps). If the patient has not activated the device for a certain time, the target concentration drops automatically. The advantages of such a system would be a stable level of sedation and an almost ideal control with nearly no risk of oversedation [49].

Advantages of intravenous techniques

Advantages of intravenous anesthesia in ambulatory surgery can result from the administration technique or the pharmacological properties of the IV drugs, specifically propofol.
When only intravenous drugs are used, specifically with conscious sedation, no sophisticated anesthesia machines or vaporizers are required, and the respiratory equipment can be kept at a minimum. If inhalational techniques are used, the cost of the less-soluble volatile agents and the necessity to maintain a low level of pollution in the operating theater require a circle circuit with online measurement of volatile anesthetic end tidal concentrations.

Propofol effect site concentration as estimated by TCI devices is a good predictor of loss of consciousness [50], whereas blood concentration and a fortiori end tidal anesthetic concentrations are not good predictors unless a steady state is reached, which is seldom the case with short ambulatory procedures [51]. If effect site anesthetic drug concentration is not available, hypnosis level may be estimated through analysis of spontaneous or evoked EEG activity.

Monitoring the hypnotic component of anesthesia has undergone recent changes with the analysis of the bispectral index of the EEG (BIS™, Aspect Medical Systems, Newton, MA). BIS™ has demonstrated a significant correlation with the level of responsiveness and the loss of consciousness during anesthesia with propofol, midazolam, and isoflurane [52]. Moreover, BIS monitoring proved its effectiveness in reducing anesthetic drugs consumption when compared with standard general anesthesia for propofol and sevoflurane [53]. When used during propofol and alfentanil TCI, it allowed a significant reduction of propofol doses without intraoperative modifications, compared with standard clinical practice, and a faster recovery [32].

BIS™ value is a better predictor of the level of sedation than end tidal sevoflurane concentration [51]. Therefore, BIS™ monitoring for day-case surgery is an effective way to reduce anesthetic drugs doses and delayed awakening and to improve recovery. However, the economy of reduced drug costs achieved with BIS™ monitoring must be balanced with the price of the disposable sensors, and the result may differ in various countries as well as in the duration of surgery [53].

Preventing PONV is one priority in ambulatory patients, as PONV has been rated by patients and anesthesiologists as the second and third most frequent and important adverse effects to avoid [54], and has also been recognized as one of the main factors contributing to prolonged stay after ambulatory surgery [55] or unintended return to hospital [56]. Still, PONV incidence remains high in ambulatory surgery, and is responsible for increased costs, delays in home readiness, hospital return, and patient discomfort.

Several studies have demonstrated the antiemetic effect of propofol when used as an induction bolus or as a maintenance agent for general anesthesia or MAC. Eriksson et al [57] showed that propofol used by continuous infusion provided a lower incidence of PONV than an association of desflurane and prophylactic ondansetron (20% versus 40%) for outpatient gynecological laparoscopy. Similarly, propofol administered through patient-controlled devices at repeated doses of 20 mg in PACU [58] has proven its effectiveness to treat PONV.

This ability to reduce the incidence of PONV allows indirect savings by improving speed and quality of recovery and avoiding the use of adjuvant drugs and
thus may counterbalance the higher acquisition costs of propofol when compared with inhalational agents [59]. The difference in direct drug cost has been narrowed by the marketing of propofol generic formulations [60].

Patient satisfaction is a major concern for the anesthesiologist in ambulatory surgery, especially when short and minor surgical procedures are performed. The quality of recovery offered by propofol and the pleasant mood described by the patients may be directly related to the pharmacological action of the drug. Pain and colleagues have found that propofol, unlike methohexital, induced a pleasant affective state in rats at subanesthetic doses and during recovery from anesthetic doses [61]. D’Haese et al [62] showed that the use of propofol was associated with higher mood status scores in female patients when compared with methohexitone. This positive change in mood after propofol administration remains only partly understood, but is certainly an important point contributing to the patients’ well-being and satisfaction after ambulatory procedures.

In reviewing the numerous studies published over the past few years, propofol has obviously become an extremely valuable agent for diagnostic and therapeutic procedures performed in the ambulatory setting.

**Limits of intravenous techniques**

Intravenous techniques in ambulatory anesthesia have limitations that need to be clearly understood to prevent their consequences.

The use of a specific equipment, such as pumps able to deliver very low (less than 1 ml/h) and very high (greater than 1000 ml/h) infusion rates, is mandatory to ensure a proper titration of anesthesia. Dead space between the stopcock and the indwelling catheter should be as small as possible, and a one-way valve will best avoid a backflow of the anesthetic agent in the main infusion line. It is not possible with intravenous agents to keep the same syringe for successive patients and therefore drug waste will frequently occur.

Other limitations are mainly the result of pharmacokinetic properties of the agents and to the fact that direct drug concentration measurements are not available. The relationships between infusion rates and adequate effect-site concentrations are not readily available and, even in the presence of predicted concentrations, a good understanding of the pharmacokinetic model implemented in the device and of its covariates is necessary to adapt the dosage to the individual patient. A good example is the elderly patient, in whom initial distribution of drugs is impaired, leading to concentrations higher than expected, and therefore to an increased incidence of overdosage at induction of anesthesia. This overdosage may increase the incidence of hemodynamic unwanted side effects [63]. Therefore, propofol induction doses should be reduced in elderly patients by approximately 40%, even for achieving conscious sedation [64]. When using TCI, if age is not a covariate incorporated in the model used, the initial predicted concentrations will be grossly underestimated in elderly patients.
One way to overcome this problem is to monitor spontaneous or evoked EEG
parameters when titrating IV hypnotics.

Changes in volume of distribution and redistribution of drugs after prolonged
continuous infusion may lead to a significant accumulation in obese patients.
This redistribution may result in unpredictable delay in awakening after pro-
longed continuous infusion, and, therefore, continuous infusion of propofol may
not be the optimal anesthesia regimen for this specific population [65].

Macario et al [54] have shown that pain on propofol injection, and behavioral
troubles such as fatigue, confusion, and somnolence were ranked highly as
clinical outcomes to avoid.

Pain on injection with propofol occurs in 28% to 90% of patients [66], even
with low-dose propofol infusions used for sedation. The use of a low dose of
lidocaine reduces the pain resulting from propofol injection. Despite contradic-
tory results [67], it seems that doses as low as 0.1 mg/kg lidocaine are effective in
reducing the incidence of propofol pain on injection [68]. This dose was equally
effective when given simultaneously with propofol or as a pretreatment dose
20 seconds before the injection of propofol. Pain on propofol injection should be
systematically prevented to avoid patient discomfort because effective and low-
cost techniques exist.

Costs related to propofol use in TIVA have often been considered a major
drawback when compared with inhalational techniques, especially desflurane and
sevoflurane [69]. To reduce excessive costs related to propofol use in TIVA, a
concomitant administration of 65% nitrous oxide has been evaluated. In office-
based surgery, this adjunct allowed a reduction in propofol requirement, without
increasing PONV or altering recovery profiles [70]. The use of a propofol/nitrous
oxide combination is therefore a cost-effective alternative to propofol alone in
ambulatory surgery. This association has also shown its effectiveness to improve
recovery profiles and patient satisfaction and to decrease costs when compared
with inhalational techniques with a sevoflurane/nitrous oxide association in fast-
track office-based anesthesia [43].

Summary

The growing importance of ambulatory surgery during the past decade has led
to the development of efficient anesthetic techniques in terms of quality and
safety of anesthesia and recovery. In these challenging objectives, intravenous
techniques have played an important role, as they provide safe, efficient, and
cost-effective anesthesia in the ambulatory setting. Among the numerous intra-
venous drugs, propofol, with its fast and smooth onset of action, short duration of
action, and low incidence of postoperative side effects appears to be the
anesthetic of choice in this situation.

The recent development of new techniques of administration (such as TCI,
monitored anesthesia care, or patient-controlled sedation) and monitoring (such
as the BIS™ and the availability of “hit and run” drugs such as remifentanil) will
further optimize intraoperative conditions and recovery, thus allowing faster home readiness in the ambulatory setting.

References


