Hip Arthroscopies at OSC

In order to have optimal operating conditions and contribute to a good patient outcome, I suggest the following:

1. Do NOT consent the patient for a pre- or post-op regional block or discuss the possibility of a block with the patient or family without first discussing it with the surgeon.
2. Hip arthroscopies can be painful post-operatively. I suggest gabapentin plus any other multimodal drugs of your choice pre-op. Intra-op, acetaminophen, Toradol, plus opioids. Some also use ketamine.
3. Do not turn on the Bair Hugger until all prepping and draping is completed.
4. Patient must be intubated and paralyzed. I intubate on rocuronium and during the time out, I give a second full intubating dose. Positioning, distracting the hip joint, and prepping and draping can take more than 45 minutes. By this time, the initial rocuronium is wearing off. At time of incision, response to a nerve stimulator TOF should be zero. We have Sugammadex.
5. Give appropriate antibiotics before the time out.
6. I usually give fentanyl 100-200 mcg before the incision, plus a Propofol drip to control the BP, along with sevo. I deepen the patient and generally do not give more muscle relaxant (we have sugammadex if you need it at the end.) I try to get dilaudid 1-2 mg on board as well.
7. Maintain SBP at 100 mm +/- 10 mm. Most patients can autoregulate their cerebral blood flow and maintain their coronary artery perfusion at this SBP, and will not have an issue. If you feel like there is a safety issue and the blood pressure should be higher throughout the case, communicate this to the surgeon.
8. When traction comes down, there is usually 20-40 min until the case ends. I use this time to get the patient breathing spontaneously, titrate final opioids, and reverse any residual muscle relaxant.
9. If there is a brace, the patient should remain asleep until the brace is on and secure.
10. Unless contraindicated, I extubate deep, making sure that the patient has a patent airway and can maintains an O2 sat > 95% with supplemental oxygen by rebreather mask and unassisted respiration for two minutes, and if so, I transport the patient if the O2 sat trend is either level or up. I do not spend 15-30 minutes in the OR waiting for the patient to wake up.

These are just suggestions. There is no one way to accomplish the anesthetic goals for these hip cases. You need to do what you are comfortable with and what is safe.

Do not hesitate to discuss any issues with me or ask for help if you need it.

David

David I Kaufman, M.D., M.P.H.
Clinical Associate Professor
Dept. of Anesthesiology, Pain, & Perioperative Medicine
Stanford University School of Medicine
Anesthesia Medical Director, OSC
kaufmadi@stanford.edu
650 464-9422