Surgical Hard Stops, Elective Sports Medicine, Outpatient/Inpatient, Guideline

Updated: August 31, 2020

Clinical algorithm: N/A

Clinical guideline summary

CLINICAL PATHWAY NAME: Sports Medicine Surgical Hard Stops

PATIENT POPULATION AND DIAGNOSIS: Sports Medicine Elective Surgeries

APPLICABLE TO: All Spectrum Health Sites

BRIEF DESCRIPTION: Establishing guidelines for surgical hard stops and optimization prior to elective sports medicine surgery. These are hard stops for elective surgery with some exceptions:
  - HgbA1C above 8.0%
  - Active tobacco/nicotine use – Active is defined as use of tobacco or nicotine replacement therapies (gum, patch, lozenge, vapors) more than twice a week. A negative urine nicotine 3 weeks after quit date is used to confirm cessation.
  - Use of >90 MME without attempt to lower dosage

OVERSIGHT TEAM LEADER(S): Kendall Hamilton Section Chief Sports Medicine SHMG; Sports Medicine Committee Chair Spectrum Health

OWNING EXPERT IMPROVEMENT TEAM (EIT): Ortho Sports Medicine

MANAGING CLINICAL PRACTICE COUNCIL (CPC): Orthopedic Health Clinical Practice Council

OTHER TEAM(S) IMPACTED (FOR EXAMPLE: CPCs, ANESTHESIA, NURSING, RADIOLOGY): Anesthesia, Surgical Optimization Center

IMPLEMENTATION DATE: 1/01/2020

LAST REVISED: 01/01/2020
Clinical pathways clinical approach

TREATMENT AND MANAGEMENT:

General Principles:
- Supported by evidence
- Specific to surgical patient subtypes
- Not absolute, but can only be overridden by a process of appeal

1. Orthopedics Sports Medicine – Elective Procedures
   - Elective (Non-Urgent/Emergent) – shoulder, knee, elbow, hip arthroscopy cases. This includes ligament reconstruction, meniscus repair, rotator cuff repair, sub acromial decompression, and labral surgery.
   - Shoulder replacement in the absence of fracture; dislocation
   - Total and reverse shoulder arthroplasty
   - Total elbow

2. Elective Ortho procedures for Sports Medicine

3. HgbA1C above 8.0%
   - Our study suggests that chronic hyperglycemia (A1C >8%) is associated with poor surgical outcomes (longer hospital LOS). Providing a preoperative intervention to improve glycemic control in individuals with A1C values >8% may improve surgical outcomes, but prospective studies are needed.¹

4. Active tobacco/nicotine use – Active is defined as use of tobacco or nicotine replacement therapies (gum, patch, lozenge, vapors) more than twice a week. A negative urine nicotine 3 weeks after quit date is used to confirm cessation. Surgical patients may benefit from intensive preoperative smoking cessation interventions. These include individual counselling initiated at least 4 weeks before operation and nicotine replacement therapy.²
   - The following urgent/emergent procedures would not be held to the tobacco/nicotine criteria:
     - Acute Tendon/Ligament/Muscle Ruptures
     - Functional Instability – Instability performing ADL’s
     - Fractures
     - Locked Joint

5. Use of >90 MME without attempt to lower dosage
Overdose risk increases in a dose–response manner, at least doubling at 50 to 99 morphine milligram equivalents (MME) per day and increasing by a factor of up to nine at 100 or more MME per day, as compared with doses of less than 20 MME per day. Overall, 1 of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years from his or her first opioid prescription; the proportion was as high as 1 in 32 among patients receiving 200 MME or higher. We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.

References:


2. Effect of preoperative smoking cessation interventions on postoperative complications and smoking cessation T. Thomsen, H. Tønnesen, A. M. Møller First published: 08 April 2009