ANAESTHESIA · FOR ANAESTHESIA RESIDENTS

Pre-Anaesthetic Assessment

A Resident's Quick Reference

A Dr. Priyamvada Goel educational resource — for residents, students, and curious patients.

A compact, evidence-aligned reference for systematic pre-anaesthetic evaluation, common comorbidities, and risk stratification. Use it as a scaffold — not a substitute for local protocol.

History & examination

- A structured pre-anaesthetic history covers: presenting condition, past anaesthetic exposure (and reactions), cardiac and respiratory reserve (METS), drug history including herbal preparations, allergies, last meal, dentition, and a focused systemic review.
- Examination follows airway → cardiovascular → respiratory → neuro, in that order. Document baseline vitals, SpO_2 on air, and weight/height for accurate dosing.

ASA Physical Status

- I — A normal healthy patient.
- II — Mild systemic disease, well controlled (e.g. controlled hypertension).
- III — Severe systemic disease that is not incapacitating.
- IV — Severe systemic disease that is a constant threat to life.
- V — Moribund, not expected to survive without the operation.
- VI — Declared brain-dead, organs being removed for donor purposes.

Airway assessment

- Use multiple predictors; no single test is sufficient.
- LEMON: Look externally, Evaluate 3-3-2, Mallampati, Obstruction, Neck mobility.
- Document mouth opening, thyromental distance, Mallampati grade, neck movement, dentition, and prior difficult-airway history.

Cardiac risk

- Use the Revised Cardiac Risk Index (RCRI) for non-cardiac surgery: high-risk surgery, ischaemic heart disease, congestive heart failure, cerebrovascular disease, insulin-dependent diabetes, creatinine >2 mg/dL.
- Functional capacity ≥4 METS without symptoms generally requires no further cardiac testing for most non-cardiac surgeries.

Common comorbidities

- Diabetes: aim for reasonable peri-operative glycaemia; review hypoglycaemic agents and SGLT2 inhibitors specifically.
- Hypertension: continue most antihypertensives; consider holding ACEi/ARB on the morning of major surgery per local policy.
- COPD/Asthma: optimise inhalers, treat active exacerbation, plan for regional where suitable.
- OSA: screen with STOP-BANG; plan for caution with sedatives and post-op monitoring.

Fasting & premedication

- Standard adult fasting: 6 hours for solids/non-clear fluids, 2 hours for clear fluids.
- Premedication is increasingly minimal: anxiolysis only when clearly indicated; aspiration prophylaxis for at-risk patients.