



# Bariatric EGD

| PRE-OPERATIVE   |  |   |
|---|--|---|
| <b>Medications</b><br><input type="checkbox"/> Glycopyrrolate | Pre-oxygenate with Panoramic (POM) O2 mask | <b>Lines</b><br>Must have adequate IV access, utilize ultrasound if necessary |



| INTRA-OPERATIVE   |   |                  |
|---|---|------------------|
| <b>Induction</b><br><input type="checkbox"/> Glycopyrrolate 0.1-0.2mg<br><input type="checkbox"/> Lidocaine 100mg<br><input type="checkbox"/> Midazolam<br><input type="checkbox"/> Ketamine (0.5mg/Kg up to max 50 mg.<br><input type="checkbox"/> Propofol 10mg boluses (if needed) | <b>Maintenance</b><br>Patient should spontaneously breath throughout procedure, titrate small boluses of propofol as needed | <b>Emergence</b> |



| POST-OPERATIVE |  |  |
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### **Case Specifics**

Bariatric EGD patients are morbidly obese. It is imperative to titrate medications slowly to maintain a spontaneously breathing patient. Patients should maintain their own airway reflexes. Patient may cough when scope is introduced into esophagus & past cords.

The majority of the EGDs are diagnostic and very quick procedures.

Table of bed is turned 180 degrees away from anesthesia machine.

Ketamine is the preferred medication for these patients unless contraindicated.

Administer Glycopyrrolate preoperatively.

Titrate Midazolam prior to Ketamine.

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### **Surgeon Specifics**

Bariatric EGD are generally 5-10 minute cases.

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### **Medication Notes**

Any special medications you should have handy not listed on the first page

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### **Positioning**

Left Lateral position with bolster behind back to maintain position.

Dr. Halbert does these cases with patient in supine position.

# Bariatric EGD

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## Anesthetic Technique

MAC anesthesia with spontaneously breathing patient. Ketamine is preferred in the Bariatric patient to maintain spontaneous respiration. Clinical judgement is the guiding principle and careful and judicial planning is appropriate. If Ketamine is not an appropriate anesthetic discuss in conjunction with the anesthesia team and communicate with the surgeon.

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## Monitoring

Standard ASA monitors

Consider alternative locations for blood pressure cuff (forearm, calf) if unable to obtain accurate measure due to arm circumference

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## Patient Profile

Bariatric surgery patients have comorbidities associated with morbid obesity. This patient population is likely to have obesity related respiratory changes, obstructive sleep apnea, hypertension, diabetes, gastroesophageal reflux disease, asthma, deep vein thrombosis, depression, hypothyroidism.

- **Obesity related respiratory changes-** Increased oxygen consumption, decreased functional residual capacity (FRC), decreased expiratory reserve volume (ERV). Preoxygenate preoperatively, consider sniffing position, obtain necessary difficult airway equipment, ensure that videoscope is readily available in room.
- **Obstructive Sleep Apnea-** Pre- O2 with (POM) face mask, observe closely with preoperative sedation. Avoid or minimize opioids. Consider shorter acting and minimally fat-soluble agents to allow for rapid recovery of consciousness, protective reflexes, and mobility.

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## Preoperative Considerations

- **Difficult IV access-** Utilize ultrasound, if necessary, to ensure adequate IV access.
- **Airway Obstruction**
  - Apply (POM) **O2 face mask**, preoperatively if possible or as soon as they enter the GI suite. Be aware of increased potential for airway obstruction.
  - **Glycopyrrolate** preoperative to counteract side effect from ketamine.
  - **Midazolam** start with small dose and titrate as needed.
  - Discuss MAC anesthesia with patient. Explain to patient that they will be spontaneously breathing and may drift in and out of consciousness.
  - Explain potential for science fiction like dreams to patient (related to Ketamine.)

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## **Induction**

Pre-oxygenate

Titrate medication slowly.

Patient may seem awake with Ketamine but not aware.

Have alternative airway equipment available, including LMA, oral airways, video scope

Titrate medications slowly to achieve desired effect.

Avoid narcotic, utilize ketamine

Plan case in close conjunction with anesthesiologist, if desaturation starts to occur, ask circulator (GI RN) to initiate anesthesia stat ASAP. These patients have decreased reserve and can decompensate quickly.

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## **Maintenance**

Continue careful titration of medications.

Patient may seem awake due to the Ketamine, but not aware.

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## **Emergence**

Ensure a spontaneously breathing patient throughout.

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## **Surgeon Specifics (Detailed)**

Maintain careful communication with the surgeon about when to begin and about true MAC anesthesia with spontaneously breathing patient.