Letters to the Editor

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Physicians Should Consider Indications Before Ordering Preoperative Cardiac Testing

Original Article: Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations

Issue Date: March 15, 2013

See additional reader comments at: http://www.aafp.org/afp/2013/0315/p414.html

TO THE EDITOR: I appreciated Dr. Feely and colleagues' article on preoperative cardiac testing recommendations. My golden rule for ordering cardiac testing before noncardiac surgery is that the patient should have an indication for testing independent of the planned procedure. I do not order preoperative cardiac tests because the patient is having surgery. If a patient needs cardiac testing, then he or she has an indication, whether or not surgery is planned. This principle greatly simplifies the preoperative cardiac tests that are ordered—or better yet, not ordered.

One recommendation I would add is to obtain a preoperative creatinine level before any procedure that requires the use of intravenous contrast media.

Finally, I offer a caveat about the recommendation to forego preoperative testing before cataract surgery, which was based on a large randomized trial.[1] One fact about this study that is rarely mentioned is that patients were excluded if they received general anesthesia. Many cataract surgeries are done under general anesthesia with endotracheal intubation. Therefore, the risk of complications in patients receiving general anesthesia with intubation would be higher even in this low-risk surgery, and may indicate the need for specific preoperative testing.

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1. Schein OD, Katz J, Bass EB, et al.; Study of Medical Testing for Cataract Surgery. The value of routine preoperative medical testing before cataract surgery. *N Engl J Med.* 2000;342(3):168-175.

IN REPLY: We thank Dr. Thompson for his thoughtful comments regarding preoperative testing in noncardiac surgery. Although his suggested golden rule would be appropriate in most circumstances, the recommendations in our article are based on published evidence and guidelines.

We respectfully disagree with the recommendation to obtain a serum creatinine level before any procedure that requires intravenous contrast media. The decision to obtain a preprocedural creatinine level should be based on the clinical likelihood of occult renal failure and the risk of the procedure. In a prospective cohort study published in 2000, risk factor assessment predicted 97% of patients with abnormal serum creatinine levels.[1] On the other hand, preprocedural measurement of serum creatinine may be warranted even in healthy patients undergoing high-risk procedures that require a large intravenous contrast bolus, or a prolonged procedure that carries a high risk of concomitant hypotension in addition to the use of intravenous contrast media. Physicians should base the decision to test on the patient's risk assessment and on the procedure being performed.

Dr. Thompson is correct that in the major randomized controlled trial that was the basis for our recommendation against preoperative testing in routine cataract surgery, planned general anesthesia was an exclusion criterion.[2] However, it is rare that patients require general anesthesia for cataract surgery. In a national survey of U.S. Veterans Health Administration chiefs of ophthalmology, the mean prevalence of general anesthesia in cataract surgery was only 3.7%.[3] In almost all of these cases, general anesthesia was used because the patient was unable to remain still for the procedure. ▶

Such an unusual occurrence should prompt physicians to reevaluate the perioperative risk assessment and consider how the guidelines apply to the specific situation. Even with general anesthesia, however, cataract surgery is still a low-risk procedure, and perioperative testing is likely not indicated in most cases.

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2. Schein OD, Katz J, Bass EB, et al. The value of routine preoperative medical testing before cataract surgery. Study of Medical Testing for Cataract Surgery. *N Engl J Med.* 2000;342(3):168-175.
3. Chen CK, Tseng VL, Wu WC, Greenberg PB. A survey on the use of general anesthesia for cataract surgery. *Graefes Arch Clin Exp Ophthalmol.* 2010;248(7):1051-1052.

Corrections

Incorrect description of tendons comprising the anatomic snuffbox. The article "Evaluation and Diagnosis of Wrist Pain: A Case-Based Approach" (April 15, 2013, p. 568) contained an error in the paragraph under the "Background" heading for "Case 3. De Quervain Tenosynovitis" (p. 572). The first two statements indicated that the extensor pollicis brevis and abductor pollicis longus tendons comprise the medial and lateral borders of the anatomic snuffbox. However, the lateral border of the anatomic snuffbox is actually comprised of the extensor pollicis brevis and abductor pollicis longus, and the medial border is comprised of the extensor pollicis longus. The statements should have read as follows: "Two major dorsal tendons of the thumb are involved: the extensor pollicis brevis and the abductor pollicis longus (Figure 5). These tendons comprise the lateral border of the anatomic snuffbox, with the extensor pollicis longus medially and the scaphoid bone at the bottom." The online version of this article has been corrected.

Incorrect size of urethral plugs. The article "Clinical Management of Urinary Incontinence in Women" (May 1, 2013, p. 634) contained an error in the first sentence of the second paragraph under "Devices" (p. 638). The statement indicated that urethral plugs are devices measuring about 5 cm. Urethral plugs are actually available in two lengths: 3.5 cm and 4.5 cm. The sentence should have read: "Urethral plugs are devices that are inserted into the urethra to prevent urine loss during activities that cause stress incontinence (e.g., running). They are available in two lengths: 3.5 cm and 4.5 cm." The online version of this article has been corrected. ■