Setup - Shoulder Replacement – Murrell – St George Private

QuickRef:

Call to Anaesthetic Bay – don't wait for me!!! / Do we have the side arm supports etc for the Bed in sitting position / ETT 7F 8M - C-Mac 3F 4M (not D) blade – use brown Leukoplast dog legs to attach; extension / 2 x purple pole clips and 2 x IV poles / Arterial Line - Pink with Metal Hub; if fail use black Arrow; if fail use Ultrasound; use Transpore and fluid bag to position on table / Interscalene Block 50mm Stimuplex – 0.75% Naropin, 2% Lignocaine for Infiltration; Ultrasound opposite side bed / 18g IVC cannula / 2 Syringe Drivers / Pump Set with Chook Foot / Drugs - 1 midaz / Fentayl (500mcg) / Remi (2mg) / Bridion (200mg) / Transexamic Acid / INVOS – Cerebral Oximetry Machine (in Fluid Room, ask a friend) + 2 Tags on Head / Call ME if problems I don't bite. 😉

Detailed:

Please get the patient to anaesthetic bay – <u>do not wait for me</u> as I usually know them well. Once they arrive I'll put on the two head probes for the INVOS machine (like the BIS), cannulate them (18g IVC) and give a bit of midazolam. We then put on a Hudson mask and Sats monitor given I have now sedated the patient. I then do an arterial line using 2% lignocaine as infiltration (5mL syringe, 25g needle) and use the pink cannula with the metal hub (just get the trolley). I tape their arm to the bed using clear Transpore tape and a 500mL fluid bag to position their wrist. If I fail with the pink cannula (metal hub), I try the black arrow cannula, and if that fails I try with the ultrasound again with an arrow; at that point I will give up and do asleep. Once the cannula is in I connect it just to the end of the arterial line giving set kit with 10mL of saline in a syringe connected; we attach it to the rest of the kit inside theatre. Please don't discard the normal saline so I can confirm the contents of the syringe.

Next step is the block - I will position the patient on the side with the arm to be blocked UPwards, and often remove the pillow; the bed is head up slightly and at the level of my waist. I am facing their back, and the ultrasound is on the opposite side of the table to me (patient and myself facing the ultrasound). I inspect the site with the ultrasound and some gel. Once I'm happy I'll infiltrate some 2% lignocaine in their back and use two cholorhexidine dolly sticks to make it clean. I'll then use the 50mm stimuplex needle and a 20mL syringe of 0.75% Naropin to do the block; I use only the ultrasound and not the nerve stimulator. I may get you to pull the arm down to improve visualisation or otherwise encourage the sedated patient to stay still.

Once that's done we go into theatre. Patient on table. Connect the INVOS machine. Connect the arterial line. Induce and then intubate. The C-MAC is on the L side of bed, you are on R side of bed. We'll position the table after intubation so the arm to be operated on is away from the machine (Theatre 14). One intubated I use Leukoplast tape with dog legs to affix the tube. We then put the legs UP, and THEN go into the semirecumbant sitting position; we do it slowly. Have the Face Mask for the Table available; we affix the straps after going into sitting position. The arm boards should be available to place the arm, and the side boards to keep the body steady (ask the Porters). I will put the sensor of the arterial line at ear level. I may also ask for a EAR Sats monitor; so I can measure Sats at ear level. I run an Armamine and Remi infusion and keep patient asleep with Sevo/N2O/O2; at the end I reverse with Bridion. The patient will be routinely given an Oxycodone PCA (or Fentanyl PCA if they do not like Oxycodone). I don't usually send to HDU, ICU unless they are particularly complex.

In day surgery environments they are usually healthy enough not to need an arterial line; otherwise the process is the same.