ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

AUSTRALIAN SOCIETY OF PLASTIC SURGEONS

POSITION PAPER

OFFICE BASED PROCEDURES IN AUSTRALIA

(Excluding Liposuction and/or Fat Transfer)

INTRODUCTION

The Royal Australasian College of Surgeons (RACS), the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Plastic Surgeons (ASPS) are all committed to promoting patient safety. This position paper provides guidance specifically for those procedures performed in an unlicensed office based setting where it is deemed unnecessary for a dedicated sedationist/anaesthetist to be in attendance. It is intended to sit alongside the recommendations within the 'Day Surgery in Australia Position Paper'.

Liposuction and Fat Transfer have special considerations as office-based procedures and are therefore considered in a separate position paper "Office-based liposuction and/or fat transfer procedures in Australia".

The recommendations below need to be considered in the context of local jurisdictional regulations, which vary from region to region.

DEFINITIONS

1. **Office-based Procedures:** Do not necessarily fall under the criteria for Day Surgery Procedures. Office-based procedures are those performed:

    1.1. With low doses of local anaesthetic such that any dose given into a single location is insufficient to cause systemic toxicity if inadvertently given intravenously, or a dose which is not likely to reach toxic levels by absorption; and,

    1.2. Without intravenous sedation.

2. **Minor procedure facility:** Some rooms / offices which are, by definition, not at the level of Day Surgery / Day Procedure Facilities, none-the-less provide a safe and satisfactory environment for minor procedures. Noting that currently there is no single accrediting body that defines a minor procedure facility, implied are elements such an ability to employ sterile technique and a suitable environment for the storage and administration of local anaesthetics for minor procedures.

3. **Procedural Sedation**: If anxiolysis is required, sedation may be provided that minimally impairs conscious state. Intravenous sedation should not be used. Practitioners need to be alert to the potential for the unintentional transition of conscious sedation to deep sedation or even anaesthesia.

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3.1. Conscious sedation is defined as a drug-induced reduction of consciousness during which patients respond semi-purposefully to verbal commands or light tactile stimulation. Interventions to maintain a patent airway, spontaneous ventilation or cardiovascular function may occasionally be required if conscious sedation is inadvertently exceeded.

3.2. Deep sedation is defined by lack of purposeful response to verbal or physical stimuli. It may be associated with loss of the ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. It has similar risks to general anaesthesia, and requires an equivalent level of care.

4. **Joint Position Paper:** A statement of opinion issued collaboratively by more than one entity, where none of the entities represented presumes to claim expertise in each of the statements presented, though collectively do so.

POSITION

The five standards endorsed by RACS, ANZCA and ASPS are set out as follows:

1. Procedures

Many procedures are best performed in a Day Surgery or hospital setting because they are likely to require intravenous sedation or anaesthesia, but also for reasons of infection control, expected duration of procedure, risk of complications, post-operative pain control, anticipated recovery period, proximity of complex care services and the availability of a range of health care professionals. Procedures not suitable for office based settings include, but are not limited to:

- Cardiac Catheterisation
- Gastrointestinal endoscopy
- Abdominoplasty
- Belt lipectomy
- Brachioplasty
- Breast augmentation or reduction
- Buttock augmentation, reduction or lift
- Calf implants
- Facial implants that involve inserting an implant on the bone or surgical exposure to deep tissue
- Mastopexy or mastopexy augmentation
- Neck lift
- Pectoral implants
- Penis augmentation
- Rhinoplasty
- Facelift
- Vaginoplasty

2. Local Anaesthetic

Whilst local anaesthetic toxicity is uncommon, its sequelae are potentially life-threatening, especially in an environment where there is no regulatory requirement for resuscitation equipment or medications.

For this reason, RACS, ANZCA and ASPS believe that great care should be exercised in calculating the dose of local anaesthetic to be administered in an office-based setting. Caution should be exercised with doses administered particularly in comparison to a hospital or accredited Day Surgery environment in which resuscitation equipment and staff support are mandated.

- Office-based procedures should be limited to those that require only low doses of local anaesthetic such that any dose given into a single location is insufficient to cause systemic toxicity if inadvertently given intravenously, or a dose which is not likely to reach toxic levels by absorption.

- Systemic absorption of local anaesthetic agents is dependent on the dose administered, the specific agent, the patient's weight, the speed and site of injection and the addition of other drugs to the local anaesthetic to reduce uptake into the circulation. As such, absolute "maximal safe doses" are difficult to define, being dependent on multiple factors. Practitioners should be familiar with the Product Information of agents being used, notwithstanding that a maximum recommended dose (in mg/kg) is not stated for all local anaesthetic agents.

- The health practitioner administering the local anaesthesia should, at a minimum:

    - Be registered with AHPRA as a qualified medical or dental practitioner (other than in the case of topical local anaesthetic cream)
    - Have a good understanding of local anaesthetic dose calculation and toxicity profiles
    - Be trained and certified competent in basic life support, with immediate access to appropriate resuscitation equipment

It should also be noted that a health practitioner, other than a doctor or a dentist, can legitimately administer local anaesthetic. Tumescent anaesthesia is not covered in this section – see "Office-based liposuction and fat transfer procedures in Australia".

3. Procedures without sedation or local anaesthetic

Procedures such as injections of fillers or other similar substances should be supervised by a named AHPRA – registered medical or dental practitioner, and consideration should be given to the need for that practitioner to be within the same building at the time of the procedure.

4. Risks of Patient related complications

RACS, ANZCA and ASPS recommend that all patients have appropriate pre-procedure consultation with assessment and documentation of medical conditions, regular medications, and allergies before undergoing an office-based procedure.

The American Society of Anaesthesiologists (ASA) publish a widely used, five-category, physical classification system, used to assess fitness for surgery (defined below). Patients being considered for office based procedures should be ASA Physical Status I or II, or medically stable (meaning no recent decompensation) ASA III or IV.

- ASA I: A normal healthy patient.
- ASA II: A patient with mild systemic disease.
- ASA III. A patient with severe systemic disease, such that causes substantive functional limitations. Examples would include COPD, implanted pacemaker, moderate reduction of ejection fraction, End Stage Renal Disease requiring dialysis, history (> 3months) of MI, CVA, TIA, or CAD/stents.
- ASA IV: A patient with severe systemic disease that is a constant threat to life. Examples would include recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischaemia or severe valvular dysfunction, severe reduction of ejection fraction.

Maximal acceptable patient weight for any facility will be determined by factors including mechanical ratings of equipment and fixtures to allow safe manual handling, care of the patient and transport within the health-care facility.

5. Informed consent

The patient should be informed of the risks of the procedure and accompanying local anaesthesia and sedation where used. Patient consent (including financial consent) should be obtained prior to the procedure.

KEY WORDS

Office-based Procedures, Procedural sedation, Local anaesthetic, Patient care.

REFERENCES

Day Surgery in Australia Position Paper
Office-based liposuction and fat transfer procedures in Australia
PS02 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia
PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation
PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures
PS15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery
RACS Position Paper – Informed Consent (2014)
RACS Position Paper – Informed Financial Consent (2014)
NSW Health – Cosmetic Surgical Procedures by Registered Medical Practitioners

ADDITIONAL INFORMATION

ANZCA Professional Documents available at:
http://www.anzca.edu.au/resources/professional-documents

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