Goal-directed fluid therapy and opioid-sparing technique: Clinical guidance amid doubt and confusion

The BC Enhanced Recovery Collaborative (the Collaborative) was a multidisciplinary initiative with representation from all regional health authorities that sought to implement several evidence-based processes of care in the setting of colorectal surgery. The Collaborative was sponsored by the Specialist Services Committee, a partnership of the Ministry of Health and Doctors of BC.

Translating evidence-based medicine into processes of care that can be actualized at the bedside is an underestimated challenge. There are situations where the available evidence is unclear or conflicting, where the evidence applies to specific subsets of the patient population, where clinical subject experts differ in their opinions on the weight of the evidence, and where a process of care cannot be easily abstracted from the evidence.

The Collaborative took the stance that these challenges should not be barriers to progress and change. Instead, it adopted the position that a "community of practice" consisting of subject matter experts—front-line practitioners from multiple engaged disciplines—could develop a process to attempt to overcome these perceived hurdles and guide practice in the face of doubt and confusion. The deliberations were evidence-based, thorough, inclusive, and consensus-based; they resulted in a series of documents as first editions of an iterative process that have been reviewed widely and adopted as informal clinical practice guidelines.

The Collaborative's Anesthesia Community of Practice (Anesthesia COP) undertook an extensive review of current literature and practice patterns for goal-directed fluid therapy and opioid-sparing techniques for colorectal surgery. These clinical guidance notes have been reviewed and shared with the BC Anesthesiologists Society and the multidisciplinary members of the Collaborative.

Summary of clinical guidance

Optimal management of perioperative fluid therapy remains a highly debated topic. The purpose of optimal fluid management is to maintain or restore effective circulating blood volume during the perioperative period with the goal of maintaining effective blood volume and blood pressure to ensure adequate organ perfusion, while avoiding the risk of either organ hypo- or hyperperfusion.[1] There is wide variability of practice, both between individuals and institutions.[2] Intravenous fluids should be administered with the same rigor as with any other drug.[3] Fluid management within an Enhanced Recovery protocol should be viewed as a continuum through the preoperative, intraoperative, and postoperative phases. Each phase is important for improving patient outcomes, and suboptimal care in one phase can undermine best practice within the rest of the Enhanced Recovery protocol.[4] The Anesthesia COP recommends appropriate fluid be applied for all surgical patients, and intraoperative goal-directed fluid therapy be applied for select patients. Please refer to the full clinical guidance note on goal-directed fluid therapy at http://enhancedrecoverybc.ca/guidance-notes.

Postoperative pain remains an unsolved challenge; poorly controlled pain is reported in 10% to 50% of postoperative patients. Opioids are the mainstay of postoperative pain treatment, as approximately 95% of patients receive an opioid-based pain management strategy. However, opioids have many unwanted side effects, so the Enhanced Recovery After Surgery (ERAS) Society recommends minimizing opioid exposure and taking full advantage of multimodal analgesia regimens.[5] This includes traditional methods such as oral coanalgesics and appropriate selection for epidural analgesia, but also recommendations on the routine use of IV lidocaine and the benefits of IV ketamine infusions. The full clinical guidance note on opioid-sparing technique is available online (http://enhancedrecoverybc.ca/guidance-notes).

To access more resources on the Enhanced Recovery protocol, visit http://enhancedrecoverybc.ca.

—Kelly Mayson, MD, FRCPC
—Ron Collins, MD, FRCPC
—Mark F. Masterson, MD, MSc, FRCPC
—Jill Osborn, PhD, MD FRCPC

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References

1. Navarro LHC, Bloomstome JA, Auler JOC, et al. Perioperative fluid therapy: A statement from the International Fluid Optimization Group. Perioperative Med 2015;4:2-23.
2. Lilot M, Ehrenfeld JM, Lee C, et al. Variability in practice and factors predictive or total crystalloid administration during abdominal surgery: A retrospective two-centre analysis. Br J Anaesth 2015;114:767-776.
3. Minto G, Mythen MG. Perioperative fluid management: Science, art or random chaos? Br J Anaesth 2015;114:717-721.
4. Miller TE, Roche AM, Mythen M. Fluid management and goal-directed therapy as an adjunct to Enhanced Recovery

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After Surgery (ERAS). Can J Anesth 2015;63:158-168.
5. Gustafsson, UO, Scott MF, Schwenk W, et al. Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS) Society recommendations. Clinical Nutrition 2012; 31:783-800.

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6. British Columbia Centre for Disease Control. Radon Gas Measurements in BC Homes. 2007. Accessed 26 October 2016. www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/EH/RPS/RadononMainFloorinBC2007.pdf.
7. British Columbia Centre for Disease Control. Radon in Interior BC Schools. 2007. Accessed 26 October 2016. www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/EH/RPS/RadoninBCSchoolsSummarywith200BqJune07.pdf.
8. British Columbia Centre for Disease Control. Radon Testing in BC Schools Protocol. 2012. Accessed 26 October 2016. www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/EH/RPS/RadoninSchoolsTestProtocolNov2012final.pdf.
9. BC Housing. 2016/17–2018/19 Service Plan. February 2016. Accessed 26 October 2016. www.bchousing.org/resources/About%20BC%20Housing/Service_Plans/2016-19_Service_Plan.pdf.
10. BC Housing. 2015/16 Annual Service Plan Report. 2016. Accessed 26 October 2016. www.bchousing.org/resources/About%20BC%20Housing/Annual%20Reports/2016/2015-16-Annual-Report.pdf.
11. BC Lung Association. RadonAware. 2016. Accessed 26 October 2016. www.radonaware.ca.

Billing for new patients

It is common practice for physicians to get to know a new patient and learn of his or her health concerns and history by way of an introductory visit or what is known as a "meet and greet."

Recent audits have revealed that these meet and greet visits are being incorrectly billed as a counselling visit (fee item 00120). Intake/history of the patient *does not* constitute counselling. An age-related office visit would be appropriate to bill for an initial visit with a new patient.

In addition, interviews to determine whether to accept a new patient into the practice should not be billed.

The College of Physicians and Surgeons guidelines on Access to Medical Care states, "It is not acceptable for physicians to charge patients a private fee in order to access an initial medical visit."

Intake/history of the patient *does not* constitute counselling.

—Keith J. White, MD
Chair, Patterns of Practice Committee

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*