

Peri-operative fasting

Previous work done in the department has highlighted patients are at risk of excessive fasting prior to surgery. Fasting is recommended to reduce the risk of pulmonary aspiration of gastric contents. A traditional approach was to instruct that patients should be 'nil by mouth from midnight' however this is no longer considered necessary and excessive fasting may increase insulin resistance and the surgical stress response ^(1,2).

Consensus guidelines from the American Academy of Anaesthesiologists recommends; six hours minimum for food and two hours for clear fluids, this includes water, fruit juices without pulp, clear tea and black coffee ⁽³⁾.

In order to facilitate the drive to reduce fasting periods, catering staff have ensured snack boxes and pre-operative carbohydrate drinks are available at all times, which can be particularly useful for those patients admitted later in the evening. Pre-op carbohydrate drinks can be prescribed routinely for 6am on the day of surgery. Patient information sheets are available on each ward (copy included in the induction pack) and we encourage you to give these to everyone awaiting surgery. When the list is prepared for the morning meeting, please ensure the list order is as accurate as possible. We appreciate this may be changed in the morning meeting and this update will be available to ward staff.

Thank you for your assistance.

References

1. Maltby JR, Sutherland AD, Sale JP & Shaffer EA. Preoperative oral fluids: Is a five-hour fast justified prior to elective surgery? *Anesth Analg*. 1986; 65:1112–1116.

2. Nygren J. The metabolic effects of fasting and surgery. *Best Pract Res Clin Anaesthesiol*. 2006; 20:429–438

3. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures: An Updated Report by the American Society of Anesthesiologists Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration. *Anesthesiology*. 2017; 126:376–393.