



Preoperative Position Clinic: Assessing Intraoperative Position before Anesthesia

Behzad Maghsoudi*

Department of Anesthesia and Intensive Care, Shiraz University of Medical Sciences, Shiraz, Iran

Editorial

Patients are placed in the anticipated positions to allowing for adequate exposure and access during surgery after induction of anesthesia or sedation in the operating room.

The basic surgical positions include: Supine, prone, lateral and lithotomy. In addition, in some patients multiple positions are used for example single position or dual position surgeries for lateral lumbar inter body fusions [1].

In some surgeries complications associated with surgical positioning are considered as a rare event for instance brachial plexus paralysis may occurred because placement of a port in the third intercostal space for upper mediastinal dissection require auxiliary expansion, the right arm elevated cranially and simultaneously turned outward in prone esophagectomy [2].

Every surgical position has general and specific position-related injury potential, either anatomically as in limbs, neurologic plexuses, head and neck, breast, testis and penis, arteries and veins; or physiologic as problems with respiration, circulation, neuro humoral stress, abdominal pressure, etc. Noticeably, most of these complications are preventable.

Muscle relaxants are used to relax muscles before the patients were placed in the appropriate position. Muscle relaxants are proper positioning help in surgeons' desirable position but careful rotation and also the ultimate position surveillance should be considered without jeopardizing the patients' organs.

During positioning the patient is unconscious and mostly relaxed; that could increase the potential risk of positioning.

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*Correspondence:

Behzad Maghsoudi, Department of Anesthesia and Intensive Care, Shiraz University of Medical Sciences, Shiraz, Iran,

E-mail: maghsodb@sums.ac.ir

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The most complications during positioning could be attributed to the above conditions. Complication occurs even after surgery: acute primary angle closure that developed in the fellow eye rapidly after facedown position after vitrectomy surgery [3].

Anesthesiologist is encountered positioning complications most of the time for example accidental extubation in the prone position [4].

What could we do to decrease the chance of reducing the surgical position complications?

When the patient is anesthetized it is very difficult or mostly impossible to evaluate extremities and organs that at risk of positioning complications. So the logical solution is to access the effects of positioning when the patient is awake.

Therefore I recommend establishing a preoperative position clinic. This clinic should work in close collaboration between surgeon, anesthesiologist, operating room staff and the patient.

The surgeon should suggest the desired position for the surgery in the admission sheet. The anesthesiologist should take a complete medical history and conduct the physical examination with considering the anticipate position. Lastly the patient should be asked to lie on according to the desirable position, the same as surgeon requested. Patient should report any complaints while lying on the bed in the preoperative position clinic and anesthesiologist and his colleagues should try to solve the problems and ease the discomfort and also call and aware the surgeon to suggest any modifications or solution.

It is possible to expect further decrease in complications associated with patient positioning during surgical procedure with corporation and appropriate risk management.

Therefore it seems wise to establish preoperative position clinic in all preoperative clinics step by step.

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