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Asa npo guidelines chart

Current zero per os (npo) standards promote pre-operative fasting as an approach to reduce the volume and acidity of the patient's gastric contents to reduce the risk of bloating and subsequent pulmonary aspiration. Pre-anesthesia fasting standards apply to any procedure in which soothing medications reduce the protective respiratory reflex that under normal conditions prevents aspiration. The scientific basis for fasting standards largely depends on theories of anatomy and physiology and rooted in the consensus of expert opinions with limited evidence to support improved clinical outcomes. Preoperative fasting standards are developed by anesthetic communities with almost all after a variant of the 2-4-6-8 rule. The American Society of Anesthesiologists (ASA) advises patients to fast from fatty foods or meat eight (8) hours before surgery, non-breast milk or light meal for six (6) hours before, breast milk for four (4) hours before, and clear liquids, including water, pulp-free juice, and tea or coffee without milk for two (2) hours before anaesthesia.¹ In Canada, the Canadian Anesthesiologists' Society guidelines are very similar to ASA guidelines, but the Canadian Pediatric Anesthesia Society fasting guidelines now encourage children to have clear fluids up to an hour before surgery.^{2,3} The European Society of Anaesthesiology (ESA) pre-operative fasting guideline prohibits solid food for six hours before elective surgery and encourages patients to drink clear fluids up to two hours for adults and one hour for children.⁴ The concern is that the standards may be too rigid and contribute to patient injury or poor anaesthesia outcomes. Recent research on preoperative fasting suggests that prolonged fluid fixing can lead to adverse results such as anxiety, dehydration and postoperative nausea and vomiting.⁵ Similarly, prolonged fasting has resulted in cases of hypoglycaemia and hypovolaemia, more frequently seen in children.^{2,5} To improve our understanding of preoperative fluid handling, it has been researched to understand whether current fasting standards are actually beneficial to protect patients from harmful clinical outcomes.⁶ Postoperative nausea and vomiting are a common complaint in patients who have received sedation/anesthesia, which has been attributed to patient dehydration due to prolonged preoperative fluid attachment. It has been reported that patients on average rapidly from fluids for seven hours before surgery despite instruction to maintain fluid intake under current guidelines up to two hours before.⁷ A recent study published in the European Journal of Anaesthesiology in 2018 by McCracken and Montgomery examined postoperative nausea and vomiting of approximately 2018. 10,487 patients, of whom 4,697 had no restrictions on preoperative intake of clear fluids prior to surgery at the Torbay Hospital Day Surgery Unit in the UK.⁸ The incidence of nausea within 24 hours was reduced from 270/5192 (5.2%) to 179/4724 (3.8%) in patients who could drink up to surgery.⁸ Similarly, patients with unlimited fluid intake were more likely to categorize their surgical experience as very good. Of the 10,487 patients in the study, there were no side effects of pulmonary aspiration of gastric contents. Therefore, McCracken and Montgomery suggest that unlimited consumption of clear liquids before anesthesia can help reduce the rate of postoperative nausea and vomiting.⁸ Du et al. investigated whether milk or other non-clear liquids require fasting of six hours as recommended in the current guidelines.⁹ In this prospective cross-sectional study, 8- to 14-year-olds fasted overnight and were randomised to drink equal volumes (296 ml) either apple juice, 2% milk or Ensure ready (high protein-ready liquid). Their research showed that clear liquids were cleared more completely by 90 minutes after ingestion. But at 3 to 3.5 hours after ingestion, both clear liquids and milk were essentially completely cleared. They concluded that differentiation between clear and non-clear liquids in current guidelines is not supported by the results.⁹ This suggests that current fasting guidelines are too rigid for non-human milk, and that four hours, instead of six hours, may be more appropriate. The key factor in gastric emptying can be the caloric content. Okabe and colleagues examined whether calorie content was either based on the composition of gastric emptying.¹⁰ Comparing equal amounts of non-human milk and pulp-free orange juice diluted with either gum syrup or water to match the number of calories, this study found that there were no significant differences in liquid gastric emptying time after drinking the same number of calories. They also discovered that the intake of beverages not exceeding 220 kcal in calories will be sufficiently cleared in less than two hours.¹⁰ Therefore, liquid gastric emptying can mainly depend on the total caloric content instead of the type of liquid, whether it is non-clear liquids such as milk or clear liquids such as apple juice. Therefore, npo rules for liquids should take into account corresponding calories instead of liquid type or volume. Beach and colleagues examined aspirational and lung-hazardous events in a prospective database of 139,142 paediatric patients receiving procedural sedation/anesthesia across 40 general and children's hospitals in the United States between September 2007 and November 2011.¹¹ Of the 139,142

pediatric patients, npo status was known for 107,947 patients, and 25,401 patients violated the npo as defined as no solid food for at least eight hours, no non-clear fluids for at least six hours, but having clear fluids within two hours of surgery. Of the patients surveyed, there were zero deaths, 10 aspirations and 75 major complications, defined as cardiac arrest or other required hospitalization. In non-npo patients, aspiration occurred in 8 of 82,546 (0.97 events per 10,000), while in patients who were not npo, aspiration occurred in 2 of 25,401 (0.79 events per 10,000) patients.¹¹ For perspective, with an incidence of aspiration close to 1 in 10,000, this low risk corresponds to the lifetime odds of drowning in a bathtub (1 in 8078).¹² This study concluded that npo status of liquids and solids is not independent predictors of aspiration and that other factors, as has ASA Physical status and age had a higher correlation to large negative results.¹¹ A study of a andersson retrospectively examined 10,015 paediatric patients at Uppsala University Hospital, Sweden, between 2008 and 2013 who received unlimited clear fluids until surgery.⁵ The study's goal was to determine the incidence of pulmonary aspiration associated with general anesthesia in elective procedures. They found the incidence of lung aspiration to be 3 out of 10,000 in paediatric patients with unlimited fluid intake prior to surgery.⁵ In the 3 cases of aspiration, patients did not require postoperative ventilator support or intensive care and symptoms reduced the day after surgery, without finishing with antibiotics.⁵ In Ontario, dental anesthesia is recognized. The Standard of Practice for Sedation/Anesthesia as created by the Royal College of Dental Surgeons of Ontario (RCDSO) adopted its preoperative fasting standards from the ASA. It represents an opinion or dogma of an expert community to balance patient status optimization, minimize patient problems, and maximize patient safety. However, prolonged fasting can cause dehydration, postoperative nausea and vomiting and contribute to a poor patient experience.⁶ Clinicians must follow the RCDSO standard, or face consequences from the supervisory body. Until standards evolve, this is a medicolegal requirement. Within this framework, clinicians should ensure that patients receive enough clear fluids for two hours before the sedation/anesthesia surgery for the best balance between providing positive results and minimizing risk. Oral Health welcomes this original article. References: ASA. Guidelines for practice for preoperative fasting and the use of pharmacological agents to reduce the risk of lung aspiration: Application to healthy patients undergoing elective procedures: An updated report from the American Society of Anesthesiologists Task Force on Preoperative Fasting and the use of pharmacological agents to reduce the risk of pulmonary aspiration. *Anesthesiology* 126, 376-393, doi:10.1097/aln.0000000000001452 (2017). Rosen, D., Gamble, J. & Matava, C. Canadian Pediatric Anesthesia Society statement on clear fluid fasting for optional pediatric anesthesia. *Canadian Journal of Anesthesia = Journal canadien d'anesthésie* 66, 991-992, doi:10.1007/s12630-019-01382-z (2019). 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Major side effects and relationships with Nil per Os Status in pediatric sedation/anesthesia outside the operating room: A report from the Pediatric Sedation Research Consortium. *Anesthesiology* 124, 80-88, doi:10.1097/aln.0000000000000933 (2016). Council, N. S. Odds to Die Due to Injury, United States, 2017 & https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/=> (2017). About author Cameron Goertzen is a current University of Toronto dental anesthesia resident and a University of Toronto DDS graduate. Cameron has a diverse background in research and has published articles on breast and mouth cancer. In his spare time, Cameron likes to play hockey, cooking/baking and hiking. Cameron is from Niagara-On-the-Lake and with his wife, Erin Goertzen, a first-year pediatric dental resident also at the University of Toronto, hopes to practice together after his studies. Jooyoung Ji practices in Ottawa, Ontario. Ontario. & https://>

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