A Note on Anesthesia for Mohs Nasal Defects

Jayne E. Coleman, MD¹ James F. Thornton, MD, FACS²

¹ Department of Anesthesiology, University of Texas Southwestern Medical Center, Dallas, Texas

² Department of Plastic Surgery, University of Texas Southwestern Medical Center, Dallas, Texas

Address for correspondence Jayne E. Coleman, MD, Department of Anesthesiology, UT Southwestern, 5323 Harry Hines Blvd., Dallas, TX 75390-8553 (e-mail: Jayne.coleman@utsouthwestern.edu).

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Abstract

Keywords

- ▶ nasal Mohs surgery repair
- ▶ general anesthesia
- ▶ MAC anesthesia

Patients needing surgical repair after nasal Mohs surgery require immediate prescreening by an anesthesiology provider to determine if the patient is a candidate for the appropriate anesthetic or is to be delayed for more medical evaluation. These patients may need anesthesia anywhere on the spectrum from local anesthesia only to general endotracheal anesthesia, and this may affect where and when the plastic surgeon can proceed.

Patients present for anesthesia and subsequent reconstruction, typically, the day of their Mohs surgery, usually without any prior medical workup. Often, patients are added on to the surgical schedule late in the day after the dermatologist has done the procedure and decided that the patient would be better served by closure in an operating room by a plastic surgeon. Anesthesiology providers then must quickly determine if the patient is an appropriate candidate for anesthesia; what type of anesthesia, such as general endotracheal anesthesia (GETA), monitored anesthesia care, or local anesthesia with sedation; the type of operative facility (outpatient vs. hospital); and of course if the patient has had anything to eat or drink (NPO).

The preoperative assessment of the Mohs patient includes NPO status, baseline cardiac rhythm, use of anticoagulants, time of last β blocker dose, room-air O₂ saturation, and body mass index (BMI). If the patient has a BMI greater than 40 and will require GETA, he is best served in a hospital setting because of the risk of exacerbation of sleep apnea after the use of intravenous (IV) narcotics. Patients who will be receiving anesthesia only by IV, must be able to lay flat sedated without the use of supplement oxygen. All patients are consented for general anesthesia, even if not intubated, as propofol is used and loss of consciousness is anticipated.

Patients requiring skin grafts to the nose, bilobed flaps, nasolabial flaps, and complex or simple closures typically receive IV general anesthesia, unless the surgeon or patient prefers GETA. Intravenous antibiotics and IV midazolam are given en route to the operating room. Once in the surgical

suite, monitors and oxygen by nasal cannula are placed. When the surgeon is ready to inject local anesthesia, enough propofol is given to induce brief unconsciousness. By keeping the patient comfortable during injection of local into the nose, blood pressure and heart rate will remain controlled, helping ensure less bleeding at the surgical site during the procedure. After the patient's breathing is deemed adequate, the oxygen is removed, always prior the surgical prep. Oxygen cannot remain on the face, as the open delivery of oxygen on the face is an unacceptable risk for surgical fires from the electric cautery that will be used.¹ Eyes are lubricated and covered during the procedure. If the patient is stable on room air and uncomfortable during the procedure, or because of the surgeon's preference, additional sedation may be administered during the repair procedure.

Patients having midline forehead flaps and other complicated procedures are put under GETA. This begins with IV antibiotics and IV midazolam en route to the operating room. After monitors and preoxygenation, the patient is induced with IV narcotic, induction agent and paralytic. Intubation follows with an oral Ring-Adair-Elwyn (RAE) endotracheal tube to keep the tube out of the surgeons' way. Lubricant is placed in the eyes prior to the prep and the surgeon covers the eyes in a sterile fashion during the procedure. These patients are extubated under deep anesthesia to decrease the risk of coughing and bleeding from the flap.

Recovery of Mohs nasal defect patients depends on the type of anesthesia administered. Patients receiving only local and IV sedation are usually awake and pain free on arrival in

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the postanesthesia care unit (PACU) and are discharged in 30 minutes with a prescription for oral narcotics and a follow-up plan with the surgeon. Patients extubated deep from general anesthesia arrive in the PACU with an oral airway and oxygen by face tent. A face mask is not used as it will sit on the surgical site. A frontal headache is expected in the forehead flap patient. The nose is usually pain free. These patients often need IV narcotics in the recovery area. Additionally, IV acetaminophen is used if the patient is deemed responsible not to take over the 3 g a day limit of acetaminophen after discharge, as recommended by the U.S. Food and Drug Administration. The patient and family members are coun-

seled on the amount of acetaminophen in home-discharge pain medicines. Forehead flap patients are also counseled to expect oozing from the surgical site on the first day, but to contact the surgeon if bleeding does not subside. No oral narcotics are given in recovery to protect the NPO patient from nausea on the car ride home. General anesthesia patients are discharged from PACU to home with a responsible adult after approximately 1 hour.

References

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