General surgery consult guide

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| onthephones

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The Unwell Surgical Patient

- Vital signs are vitally important:
    - Is the patient well or unwell?
    - This information will help triage the urgency of the review.
    - But remember that patients with normal vital signs can also be very unwell, especially if they are young with lots of physiological reserve, or elderly with masking drugs such as beta-blockers. Trust your 'end-of-bed-ogram'.
- ISBAR is vitally important:
    - **Identify** three things; who you are, who the senior is (avoid the embarrassment of a long conversation with the wrong person in the middle of the night), and who the patient is.
    - **State** your request. 'I think the patient may need surgery' 'I need some advice' 'I am worried because...'
    - Give a brief **Background.** What they presented with, the history, relevant examination and investigation findings and what interventions they've had. Try to keep this to a few sentences. If the senior needs to fill in the gaps they will ask.
    - Summarise your **Assessment**. This is your chance to advocate again for the patient. "Overall I think the patient is in septic shock." "This is a significant change from their usual." "The patient almost fulfils criteria for a Code."
    - Restate your **Request**.

The Less Urgent Situation - What history should you JMOs know?

- History of presenting illness – the patient is trying to tell you the diagnosis! Listen.
- Past Medical History – think about organ system and anaesthetic/perioperative risk:
    - In particular, cardiorespiratory, renal and diabetes.
    - Any factors to suggest a ceiling of care should be established?
- Medications:
    - Anticoagulation and antiplatelet agents – which ones, and for what indication? Are they reversible?
    - Immunosuppression
- Previous surgery – especially abdominal surgery or gynaecological procedures.
- Social history – often overlooked, but often will change management.
- The last time the patient ate and drank.

What examinations should JMOs perform?

- Is the patient well or unwell? How unwell? Mild, moderate, severe?
- What are the vital signs?
- Abdominal examination:
    - Go back to Browse – inspection, palpation, percussion and auscultation.
    - Often missed – hernial orifices, flanks, genitalia.
    - DRE and PV for all patients unless there is a good reason not to.
    - Wounds – clean, dry and intact vs infected/cellulitic/dehisced.
    - Assessment of stoma (if applicable) – active/not active, consistency, passing gas.
    - All foreign bodies –drains, tubes, packs, ports, setons…

What investigations should JMOs arrange?

- Consider VBG, FBC, EUC, CMP, LFTs, CRP +/- lipase. Remember Choosing Wisely but also keep in mind that you may not have the chance to ‘add’ if the result is needed to inform management.
- If they are unwell and you expect they need urgent surgery – G+H and coags.
- Everyone should get urinalysis, and a beta-HCG in women of childbearing age.
- Consider a CXR – air under diaphragm, respiratory pathology mimic.
- Almost everyone should get an ECG.
- Special considerations:
    - Ultrasound abdomen/pelvis – great for hepatobiliary +- pelvic pathology/appendicitis.

- CT abdomen/pelvis – best discussed with a senior prior to ordering. There are often indications for certain types of scans. I.e. when to give IV/oral contrast, phases of scanning, i.e. portal venous vs arterial vs delayed phase.

When it is time to communicate...

- Use **ISBAR!** We like it...

What additional information would impress you?

- The organisation and synthesis of information is most impressive. This usually means that you are saying less, not more.
- Including the suspected diagnosis in the **Statement** of ISBAR. "I am worried about ischaemic gut in this patient" "I think this patient has a small bowel obstruction."
- Previous scans/operations/scopes – including where/how to access the images.
- If you don't know, you don't know – the senior would much rather that than a guess.

What are the common mistakes or omissions made by JMOs?

- Offering too much information. Keep the information to that which is relevant to the problem.
- Being non-specific about "abdominal pain". Use SOCRATES to take the history and then summarise the key features in your **Background**. E.g. "The patient has severe constant right upper quadrant pain radiating into the back and associated with nausea."
- Not engaging in meaningful thought about the cause of abdominal pain:
    - Loin to groin pain may be renal colic. Consider targeted investigation.
    - Lower abdominal pain in women – think about gynecological cause.
    - Epigastric pain – need to rule out chest pathology with CXR, ECG and troponin.
- Forgetting that diagnosis and management happen simultaneously in surgery. Start the resuscitation and ABC management. Commence analgesia, antiemetics, and IV fluids. Consider antibiotics, especially if the patient is already septic. Arrange for NGT and IDC if required.

Helpful Resources

UpToDate and ETG guidelines for antibiotics
CCrISP textbook

Tags: #Abdominal examination,#Abdominal surgery,#anticoagulation,#Choosing Wisely,#consult guide,#generalsurgery,#Immunosuppression,#ISBAR,#junior doctors,#referral,#requesting a consult,#SOCRATES