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Perioperative stroke evaluation and treatment

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Abstract

One of the most harmful complications of patients undergoing non-cardiac, non-neurological interventions is perioperative stroke. This scientific statement reviews established risk factors for perioperative vascular accidents, perioperative and intraoperative strategies to mitigate the risk of stroke, suggestions for postoperative follow-up, and treatment approaches to minimize permanent neurologic damage in patients who experience a perioperative stroke. Perioperative stroke risk assessment should be done in all patients who are visited before surgery, in terms of the main risk factors, emphasizing the general cardiovascular risk, the time of surgery from the previous stroke, as well as the type of surgery that is planned. If the patient has a history of previous stroke, the postponement of elective surgery should be discussed for at least 6 months, preferably 9 months after the previous vascular accident. In these cases, other alternatives should be considered, such as non-surgical treatment, for patients with a high risk of stroke. In the intraoperative phase, an average arterial pressure 70 mm Hg should be maintained, especially in patients with medium and high risk for perioperative stroke. In all centers where surgery is performed, algorithms should be drawn up for the evaluation and treatment of perioperative stroke patients, followed by the stroke team, with adequate protocols for early treatment or immediate transfer of the patient to a specialized center. The return of blood flow to the damaged brain tissue is deeply important. Perioperative stroke patients should be evaluated for mechanical embolectomy and intravenous thrombolysis because these approaches are safer in selected patients. Mechanical thrombectomy is preferable to intravenous thrombolysis in large vessel occlusions. Preliminary imaging examinations, such as computerized angiography, should be applied to patients with severe stroke symptoms (NIHSS score >6 or with cortical deficits) in order to determine the full criteria for mechanical thrombectomy. The risk of hemorrhage in the operative wound must be taken into consideration according to the type of thrombolytic therapy.

Biography

I am a medical doctor, neurologist from Albania. I have graduated on 1992 from the Faculty of Medicine, University of Tirana, Albania. In 2002 I commenced the four year residency in infectious diseases and work at the neurological department of Regional Hospital of Shkodra. Currently I am doing Phd in neurology at University of Medicine, in Tirana – Albania. References 1. McTaggart RA, Ansari SA, Goyal M, et al. Initial hospital management of patients with emergent large vessel occlusion (ELVO): report of the standards and guidelines committee of the Society of NeuroInterventional Surgery. J Neurointerv Surg. 2015; 2. McTaggart RA, Yaghi S, Baird G, Haas RA, Jayaraman MV. Decreasing procedure times with a standardized approach to ELVO cases. JNIS. 2017; 3. Badhiwala JH, Nassiri F, Alhazzani W, et al. Endovascular thrombectomy for acuteischemic stroke: A meta-analysis. JAMA 2015; 4. Mozaffarian D, Benjamin EJ, Go AS, et al. Executive summary: heart disease and stroke statistics—2015 update: a report from the American Heart Association. Circulation 2015; 5. Centers for Disease Control and Prevention (CDC). Leading causes of death.