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POSTOPERATIVE COGNITIVE DECLINE IN THE ELDERLY

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After attending the presentation, the participants will be able to discuss the incidence and clinical features of postoperative delirium (PD) and postoperative cognitive dysfunction (POCD). Recognize ongoing controversies surrounding the time course, the severity, and even the clinical relevance of POCD. Identify subgroups of patients who are at higher risk for PD and POCD and assess the preventive strategies to reduce incidence of these complications. The brain is vulnerable during the perioperative period. Neurobehavioral disturbances are common complications of surgery, manifesting in three distinct forms: emergence delirium, postoperative delirium, and POCD. The relationship between these conditions has yet to be fully elucidated. Although not limited to geriatric patients, the incidence and impact of both are more profound in geriatric population. Delirium has been shown to be associated with longer and more costly hospital course and higher likelihood of death within 6 months or postoperative institutionalization. POCD is a condition characterized by deterioration of cognitive performance after surgery presenting as impaired memory and/or concentration. Perioperative physiological derangements (e.g. hypotension), anesthetics, duration of surgery, respiratory complications have been suggested as possible causes, but only age and limited education has proven to be consistent risk factors in most studies. Current research suggests that patients with preoperative cognitive impairment are at higher risk for POCD because of their already compromised status and their potential vulnerability to worsen into dementia due to a less cognitive reserve. In this presentation, we review the definitions, etiology, prevention and treatment of both disorders in patients undergoing major non-cardiac surgery.

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POSTOPERATIVE CARE OF A PATIENT WITH ACUTE BILATERAL VOCAL CORD PARALYSIS

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Recurrent laryngeal nerve (RLN) paralysis is an uncommon complication of regional blockade of the brachial plexus at the level of the interscalenes. Ipsilateral placement of a peripheral nerve catheter (PNC) in patients with a history of unilateral vocal cord (VC) paralysis is not contraindicated; however, contralateral placement of PNC should be avoided as bilateral VC paralysis may occur. Postoperative management of a patient with bilateral VC paralysis includes multidisciplinary monitoring of the airway and removal of the PNC. A 79 year old female with a past medical history of hypothyroidism and arthritis presented to the surgical intensive care unit (SICU) with respiratory distress, stridor, and impending respiratory failure requiring reintubation after receiving a right interscalene PNC for shoulder arthroplasty. While in the SICU, a previously unknown history of left VC paralysis after total thyroidectomy was elicited from the patient's family (this was previously treated with cord medialization). The PNC was removed, and patient remained intubated until effects of long acting local anesthetic were diminished. Patient was taken to the operating room for direct laryngoscopy and found to have unilateral chronic left VC paralysis with resolution of temporary right VC paralysis, presumably from interscalene PNC. In patients with a known history of unilateral VC paralysis, regional blockade to the contralateral interscalene is contraindicated. While rare, RLN paralysis as sequelae of an interscalene PNC can cause temporary or permanent ipsilateral VC paralysis. Healthcare providers caring for patients with bilateral VC paralysis should consider historical injuries as well as regional techniques that may have contributed to the acute condition. In this case, temporary RLN paralysis was alleviated with removal of the interscalene PNC and supportive care was provided until ENT was able to directly visualize an improvement in vocal cord motion and extubation was tolerated.

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