Anaesthesia Consent for the Patient with Obesity

SOBA UK

When talking to patients living with obesity about perioperative risk:

To achieve a meaningful discussion of risk and gain informed consent the patient must be an active participant in the conversation.

Inadvertent 'fat-shaming' is not only unkind, but also counterproductive to shared decision making, may cause psychological and/or physiological harm, and future healthcare avoidance.

- **Be Mindful of Your Own Preconceptions** – Despite best intentions, evidence suggests that healthcare professionals demonstrate implicit bias against people living with obesity. [1,2]
- **Use Person-First Language** – Put the person before the problem so you describe it as something they have, not as something they inherently are. For example, 'person living with obesity' rather than 'obese patient'.
- **Use Neutral Terms** – Use 'unhealthy weight' and 'BMI' in preference to more stigmatising terms such as 'fatness', 'obesity', 'excess fat' and 'morbidly obese' [4,5]. Remember to avoid using jargon and explain the potential benefits as well as the risks.

Specific risks to discuss (and myths to dispel) when consenting patients with a High BMI:

Airway Management

- **Shave their beard -** consider requesting patients in advance**.**
- **Sitting position -** explain that this is beneficial and that they will go to sleep like this.
- I**ntubation -** is not necessarily more difficult, however **desaturation** can be rapid & pre-oxygenation with a tight-fitting mask, or specific oxygen delivery technique (e.g. HFNO) is important. Discuss this with the patient prior to prepare them for techniques which can feel claustrophobic.
- **Recall -** remembering removal of the ETT during extubation should be explained.
- **Regurgitation & aspiration -** obesity increases incidence of risk factors (e.g. hiatus hernia). However, obesity alone does **not** increase this risk and RSI is **not** routinely indicated. [8]

Other Areas

- **Vascular access and Regional blocks** - explain these can be difficult, require multiple attempts & ultrasound guidance. May need to consent for CVC/PICC if IV access is likely to be very difficult.
- **Diabetes** – a reduction in calorie intake may occur in hospital, and dose adjustments or cessation may be required (e.g. for insulin, SGLT2 inhibitors). Ensure that the patient understands any changes made.
- **Accidental Awareness under GA** – there is an increased risk in patients with high BMI. [9]
- **Day Case Surgery** – obesity it not a definite contraindication. Ensure co-morbidities are optimised and appropriate expertise/equipment available. [11]

Planning the post operative period

- **Sleep disordered breathing (OSA/OHS)** – can increase sensitivity to sedation, with an increased risk of post-operative chest infection. Discuss non-opioid analgesic techniques as appropriate.[10] Good compliance with CPAP and symptom reduction can normalise OSA risk. Ask patients to bring their machine to theatres for possible use in recovery and later.
- **Recovery** – may be prolonged with greater risk of requiring overnight admission or higher level of care.
- **Deep vein thrombosis/pulmonary embolism** – increased risk. Discuss compression stockings (below-knee more likely to fit correctly), compression boots, early mobilisation and pharmacological agents (LMWH) which may need to continue following discharge.[10]

Further information for **patients**

SOBAUK

THE SOCIETY FOR OBESITY & BARIATRIC ANAESTHESIA

Further information for **clinicians**