Anaesthesia consent for children and young people living with obesity

PERIOPERATIVE RISK: Talking to children and families living with obesity

Meaningful discussions around perioperative risk seeking to gain informed consent must actively involve children and/or their caregivers in discussion. As far as possible, engage the child, seek their perspective/worries and plan discussions in advance of surgery. Consider the **B**enefits, **R**isks, **A**lternatives and doing **N**othing (BRAN approach)[1].

Inadvertent "fat shaming" does not support a compassionate approach. It may have long lasting negative psychological/physiological sequelae and promote future healthcare avoidance[2,3]. It also risks jeopardising the fragile relationship between the child, caregiver and anaesthetist.

- **Be mindful of your own preconceptions:** Despite best intentions, healthcare professionals demonstrate implicit bias around people living with obesity[3]. Avoid negative comments or assumptions about lifestyle/behaviours.
- **Use person-first language:** Put the person before the problem e.g. children and young people "living with obesity" rather than "obese child/young person"[4,5].
- **Use neutral terms:** "High BMI" and "increased/excess weight" are preferable to more stigmatising terms such as "obesity" and "morbidly obese" [4,5].
- **Listen to young people's concerns:** Invite their input and thoughts. Statements such as "other young people/families have said X" or "some children say Y" can help you show them that they are not alone[6].

Specific risks to discuss (and myths to dispel) when consenting children with a high BMI[7-10]

- **Airway management:** Airway obstruction under anaesthesia and difficult face mask ventilation are more common. Gas induction takes longer. IV induction is safest. Difficult intubation is NOT more common.
- **Respiratory complications:** Airway may be more irritable with more secretions and more prone to bronchospasm. Increased risk of postoperative chest infection and respiratory compromise.
- **Vascular access and regional blocks:** May be difficult, requiring multiple attempts and/or ultrasound guidance.
- **Positioning:** Children/young people may be asked to position themselves on a trolley/operating table. Going to sleep sitting up or in a ramped position may be beneficial. Pressure points should be protected.
- **Aspiration risk:** Whilst obesity may predispose to reflux disease, in isolation it is not an indication for RSI.
- **Day case surgery:** Dependent upon comorbidities, obesity alone is not necessarily a contra-indication. Where possible, day cases should be booked early in the day to allow sufficient time for recovery.
- **Analgesia:** Children with high BMI may experience more pain postoperatively[11]. Take time preoperatively to discuss analgesia options (in hospital and at home) and to establish realistic postoperative expectations.
- **Timings:** Anaesthetic induction and emergence may take longer.

Planning for the post-operative period

- **Sleep disordered breathing/OSA:** Increased risk of sensitivity to opiates and sedation with respiratory compromise. Consider and discuss opiate sparing/free techniques. Children with home CPAP machines should bring them to theatre for possible initiation in PACU or later.
- **Deep vein thrombosis/pulmonary embolism risk:** Young people >13 years with high BMI are at increased risk and may require thromboprophylaxis intra/postoperatively in hospital and/or on discharge[12].
- **Recovery:** May be prolonged with increased risk of overnight admission or a higher level of care e.g. HDU.

For guidance ONLY. Not a substitute for experienced clinical judgement. For use in conjunction with the Royal College of Anaesthetists "*Common events and risks for children and young people having an anaesthetic*" risk infographic[13].

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