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Evaluation of recovery after intravenous sedation

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ABSTRACT: The Intravenous Sedation (IVS) Guideline Working Group of the Japanese Dental Society of Anesthesiology (JDSA) formulated guidelines for intravenous conscious sedation in dentistry. These guidelines were then published on the website of the JDSA in October 2009. These guidelines were developed in accordance with the “MINDS Handbook for Clinical Practice Guideline Development 2007” published by the Medical Information Network Distribution Service (MINDS), and were listed on the MINDS Website in February 2011. One of the authors participated in the planning of these guidelines and was responsible for the section on recovery period. The revised version has been published on the website of the JDSA in May 2017. In this review, the following three issues are explained: 1) basic points of view with regard to the recovery process after IVS; 2) influence of aging on the physiological and pharmacological function and points of attention regarding IVS management in elderly patients; and, 3) comparison results of recovery criteria among IVS and/or general anesthesia guidelines of domestic and international academic societies.

Key Words: intravenous sedation (IVS), recovery criteria, home readiness, guideline, elderly patients

1. Evaluating items and recovery process

1) The items to be evaluated with regard to recovery after IVS

Items to be evaluated after anesthetic management and surgery are vital signs, cognitive and psychomotor functions, mobility and balance functions, postoperative nausea and vomiting (PONV), pain, and bleeding (Fig. 1). Nausea and vomiting are discharge prolonging factors in general anesthesia. However, they are not observed in IVS without the use of narcotics, as midazolam and propofol have prophylactic effects against them.3-4

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Evaluation of recovery after intravenous sedation

2) Where should one focus as the endpoint of recovery?

Korttila\(^5\) classified the recovery process after general anesthesia into three stages i.e., home readiness, street fitness, and complete recovery. This classification is equally applicable to recovery after IVS. Another classification includes three stages of early recovery, intermediate recovery, and late recovery\(^6\). In this classification, home readiness is regarded analogous to intermediate recovery (Fig. 2).

3) Permission for discharge: home readiness

The necessary condition for discharge is that the patient should be safe to undergo further recovery at his or her home with a responsible adult attendant. Table 1 shows the discharge criteria of our intravenous conscious sedation guidelines\(^7\). Vital signs usually recover to normal levels by the time the patient is moved to the recovery room under conscious sedation. Cognitive and psychomotor functions are essential for the evaluation of the recovery process in cases of general anesthesia and IVS. However, from the perspective of home readiness, only the recovery of orientation (that is, orientation to person, place, and time) is regarded as an essential condition\(^8\). Therefore, it would not be an exaggeration to say that a patient can only be permitted to be discharged when he or she is able to walk without a subjective and objective stagger.

4) More precise evaluation of recovery for safer discharge

More precise evaluation of recovery is preferable in the following cases 1) for walking on busy streets, 2) anxiety about the quality of the attendant, or 3) necessity of safety margin for discharge. There are two types of computerized precise posturoographies. One is conventional computerized static posturography (CSP) which examines swaying of gravity during standing with no perturbation stimuli\(^9\). The other is computerized dynamic posturography (CDP) which examines the dynamic postural adjustment function (A and B in Fig. 3\(^8,9\))\(^10\), and is more sensitive than CSP regarding the depressant effect of the equilibrium function of midazolam\(^8,11\). As a simple test for the recovery of dynamic balance function, the timed up and go test (TUG test, Fig. 4\(^12,13\)) is available. This simple test is confirmed to be highly correlated with the perturbation stimuli test\(^8,9\). In our previous study\(^9\), the recovery after IVS with midazolam for elderly volunteers was recorded in terms of the recovery time, which was 70 min, 80 min, and 80 min by the Digit Symbol Substitution Test (DSST) which is regarded as a reliable psychomotor test with paper and pencil\(^14\), perturbation stimuli test, and TUG test, respectively. Therefore, in many cases, when recovery of dynamic postural adjustment function is confirmed, high-level cognitive and psychomotor function seems to have recovered as well. Then, it is suggested that the simple dynamic balance function test can be a substitute for this confirmation in the clinical setting.
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2. Attention points to IVS for the elderly patients

1) Aging and the evaluation of body balance

There are no significant differences between the elderly subjects and the young adult subjects in terms of the baseline values of precise static balance function tests and simple up-right standing test with closed-eyes called Romberg's test. In contrast, the baseline values of precise dynamic balance function in elderly individuals are lower than those in young adults.

Moreover, the recovery time from IVS in elderly patients was prolonged as compared to that in young adults in the evaluation of the intentional dynamic balance function. These results imply that in the elderly, the dynamic postural adjustment function may be impaired, although their static balance function (upright posture with eyes closed) may not be markedly impaired. Therefore, we should consider that the elderly patient cannot always be adjudged safe based solely upon the results of Romberg's test which may be within the baseline value after IVS.

2) Pharmacological points of attention for IVS with midazolam

The simulated curves of blood concentration and the depth of sedation after the intravenous administration of an equivalent amount of a sedative in the young and the elderly patients are shown in Fig. 5 (A). Excessive sedation is likely to occur due to increase in the pharmacological effect in elderly patients. In addition, it may take a longer time for the elderly patients to recover and reach the level required for permission for discharge.
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Fig. 5 The predictable simulated curves of blood concentration and depth of sedation after the intravenous administration of bolus dosage of sedative in young adults and the elderly

A : Administration of an equivalent amount per kg
B : Administration of a smaller amount to the elderly
level (a), onset level of side effect ; level (b), lower limit of sedation effect ; level (c), attained level to recovery

due to delayed metabolism and excretion. However, if we performed adequate IVS management on the basis of pharmacokinetic and pharmacodynamic characteristics in the elderly patients (Table 2), effective and safe management can be performed, just as in young adults (B in Fig. 5)

3. Comparison of guidelines

Comparisons of recovery criteria among the revised intravenous conscious sedation guidelines of the JDSA, general anesthesia guidelines of medical societies of anesthesiology (Table 3), and IVS guidelines of international academic societies (Table 4) were made.

1) Indication of discharge criteria for safe discharge following ambulatory surgery

Only “motor function” is described as the evaluation item of mobility and balance function for discharge criteria in the Japanese Society of Anesthesiologists (JSA) guidelines. Use of a scoring system is considered to be of some help in the American Society of Anesthesiologists (ASA) guidelines. “Walking well without dizziness” is one of the evaluation items in revised post-anesthetic discharge scoring systems frequently used in the USA. This is almost equally true for the IVS guidelines in many countries. Only one research paper in English and papers of the JDSA have adopted Romberg’s test. “Ability to walk without dizziness” is the universal standard of evaluation of motor and balance function after general anesthesia and IVS.

2) Patient escort requirements

Out of all guidelines examined, eight required the presence of an attendant for the patient to be discharged. Two guidelines had no mention of an attendant. The JDSA guidelines prohibit the patient from leaving the hospital alone but make an exception. Recovery of psychomotor function in cases of propofol

Table. 3 Comparison of recovery criteria between the IVS guidelines of the JDSA and general anesthesia guidelines of medical societies of anesthesiology

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<tr>
<td>Postoperative assessment and monitoring of patient</td>
<td>SpO2 (Blood pressure and pulse rate are preferable)</td>
<td>Blood pressure, heart rate, SpO2, respiratory rate</td>
<td>Airways patenty, respiratory rate, oxygen saturation, pulse, blood pressure, mental status, temperature, pain, nausea and vomiting, hydration status, drainage, and bleeding should be routinely assessed during emergence and recovery.</td>
<td>Medical general anesthesia guidelines are stricter.</td>
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<tr>
<td>Discharge criteria</td>
<td>Refer to Table 1</td>
<td>Patients should be evaluated with certain criteria regarding the following 6 items: mental status, respiratory function, cardiovascular function, motor function, bleeding, and pain.</td>
<td>Patients should be observed until they are no longer at an increased risk for central nervous system or cardiovascular depression after discharge.</td>
<td>Make a little difference</td>
</tr>
<tr>
<td>Patient escort requirements</td>
<td>In principle, an essential factor (absolutely essential factor for diazepam and fluraxepam).</td>
<td>Essential factor. (Moreover, the attendant can take care of the patient in his or her home.)</td>
<td>Essential factor.</td>
<td>Make a little difference</td>
</tr>
<tr>
<td>Drinking clear fluids for discharge criteria</td>
<td>Not essential for discharge</td>
<td>Remains contentious[24]</td>
<td>Not essential for discharge</td>
<td>JSA guideline is stricter.</td>
</tr>
<tr>
<td>Uridnation for discharge criteria</td>
<td>Not essential for discharge</td>
<td>Remains contentious[24]</td>
<td>Not essential for discharge</td>
<td>JSA guideline is stricter.</td>
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<tr>
<td>Street fitness</td>
<td>Precautious to evaluate with simple dynamic balance test</td>
<td>Permission 24th after the operation[25]</td>
<td>Not described</td>
<td>JSA guideline is very strict.</td>
</tr>
<tr>
<td>Driving a car</td>
<td>Prohibited on the day of the procedure</td>
<td>Prohibited for up to 24 h[25]</td>
<td>Not described</td>
<td>JSA guideline is stricter.</td>
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IVS, Intravenous sedation ; JDSA, Japanese Dental Society of Anesthesiology ; JSA, Japanese Society of Anesthesiologists ; ASA, American Society of Anesthesiologists
was more rapid than that in cases of midazolam. The recovery time was 30 minutes after cessation of continuous infusion of propofol. Therefore, IVS management with propofol is suitable for patients who cannot find an attendant to accompany through the discharge from hospital by any possibility and can not live in hospital. In these cases, it seems innocuous for the patient to return home by taxi, one or two hours after sufficient clinical recovery.

3) Is drinking clear fluids an essential criterion for discharge?

Necessity of drinking clear fluid remains a contentious issue for discharge in the JSA guidelines, while it is not a requirement for discharge according to the JDSA and the ASA guidelines. A paper reported that only 14% of the elective drinkers vomited compared to 23% of the mandatory drinker group in the day surgery unit (P<0.001). It has also been reported that there was no significant difference in the frequencies of PONV following ambulatory surgery between the mandatory drinking and the nondrinking groups, either in the hospital or after discharge. Current mainstream belief is that drinking oral fluids is not a requirement for discharge from ambulatory surgical unit.

4) Is voiding an essential criterion for discharge?

Necessity of voiding remains contentious for discharge in the JSA guidelines, while voiding is not a requirement for discharge in the JDSA and the ASA guidelines. A paper reported that only 14% of the elective drinkers vomited compared to 23% of the mandatory drinker group in the day surgery unit (P<0.001). It has also been reported that there was no significant difference in the frequencies of PONV following ambulatory surgery between the mandatory drinking and the nondrinking groups, either in the hospital or after discharge. Current mainstream belief is that drinking oral fluids is not a requirement for discharge from ambulatory surgical unit.

5) Street fitness

Street fitness is a contentious matter. Various ideas have been proposed, that is, equal to home readiness, between home readiness and complete recovery, equal to complete recovery. The judgment of the JSA seems to be too severe. The contents of surgery may be added to the judgment.

6) Permitted time for driving a car

The revised intravenous conscious sedation guidelines of the JDSA and the Scottish Dental Clinical Effectiveness Programme (SDCEP) prohibit driving on the day of the procedure. In contrast, those of the JSA and the British Society of Gastroenterology prohibit driving for at least 24 h postoperatively. The American Society of Gastrointestinal Endoscopy also prohibits driving; however, the prohibition term is not described. There are no descriptions about driving postoperatively in the other guidelines. Recent anesthetics offer a fast road
to recovery and a high-evidence report confirms the relevance of early recovery of driving function after general anesthesia and sedation\(^4\), although many foreign reviews still recommend the prohibition of driving for more than 24 h after surgery under general anesthesia or sedation\(^41, 42\). There is no good evidence to suggest that driving should be prohibited for more than 24 h postoperatively\(^42\). Prohibition time is likely to shorten due to the accumulation of future evidences of early recovery\(^6\). The criterion of the JDSA guideline\(^2\) seems to be appropriate in the IVS management with propofol or midazolam, based on the present evidence.

**Conclusion**

1. The main items to be evaluated with regard to recovery after IVS:
   - Vital signs, cognitive and psychomotor function, mobility and balance function
2. Simplest and most important item to be evaluated for home readiness:
   - Ability of walking without a subjective and objective stagger
3. IVS management for elderly patients:
   - Special attention to dynamic balance function and dosage of sedative administrated
4. Comparison among guidelines about recovery criteria after IVS and general anesthesia
   1) IVS vs. general anesthesia
      - Little difference with regard to home readiness and instructions for the preoperative period at home
   2) Among IVS guidelines
      - Little difference except for prohibition duration for driving a car after IVS
        (from “not described” to “prohibited for up to 24 h”)

**References**


