EMERGENCY SURGERY

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In emergency surgery the principles of preoperative assessment should be the same as in elective surgery , except that the opportunity to optimise the condition of the patient is limited by time constraints. The urgency of surgery should be graded, e.g. by using the NCEPOD classification of intervention, and emergency theatre cases should be prioritised accordingly , i.e. immediate (within minutes), urgent (within hours), e xpedited (within days) or elective (timing to suit patient, hospital and sta ff). Medical assessment and treatments should be started even if there is no time to complete them before the start of a time-critical surgical procedure. Some risks may be reduced but some may persist; whenever possible, these need to be discussed with the patient during the consent process. Optimisation before urgent surgery can be more e ff ective in a critical care environment and patients may need to be admitted to critical care preoperatively . The likelihood of a high-risk emergency patient requiring postoperative critical care should be identified and discussed with the duty critical care physician. Summary box 21.3 Preoperative assessment for emergency surgery /uni25CF /uni25CF /uni25CF /uni25CF

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Start . Similar principles to that for elective surgery Constraints . Time, facilities available Consent . May not be possible in life-saving emergencies Organisational efforts . For example, local/national algorithms for the treatment of patients with multiple injuries

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