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<th>Page</th>
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Appendix 1

Table 1-10. Recommended laboratory testing for patients having ambulatory surgery

<table>
<thead>
<tr>
<th>Age less than 50 years, Healthy</th>
<th>No tests unless specified by surgeon for specific surgical issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrocardiogram</td>
<td>• Age 50 or older</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Current or past significant cardiac disease</td>
</tr>
<tr>
<td></td>
<td>• Current or past circulatory disease</td>
</tr>
<tr>
<td></td>
<td>• Cardiothoracic procedure</td>
</tr>
<tr>
<td>Chest x-ray</td>
<td>• Major respiratory condition with change of symptoms or acute</td>
</tr>
<tr>
<td></td>
<td>• episode within past 6 months</td>
</tr>
<tr>
<td></td>
<td>• Cardiothoracic procedure</td>
</tr>
<tr>
<td>Serum Chemistries</td>
<td>• Renal disease</td>
</tr>
<tr>
<td></td>
<td>• Adrenal, thyroid, or other major metabolic disorders</td>
</tr>
<tr>
<td></td>
<td>• Diuretic therapy</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>• Genito-urological procedure</td>
</tr>
<tr>
<td>Complete blood count</td>
<td>• Hematological disorder</td>
</tr>
<tr>
<td></td>
<td>• Vascular procedure</td>
</tr>
<tr>
<td></td>
<td>• Chemotherapy</td>
</tr>
<tr>
<td>Coagulation studies</td>
<td>• Anticoagulation therapy</td>
</tr>
<tr>
<td></td>
<td>• Vascular procedure</td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td>• Patients for whom pregnancy might complicate the surgery or</td>
</tr>
<tr>
<td></td>
<td>• anesthesia</td>
</tr>
</tbody>
</table>

These tests may be required for administration of anesthesia and are not intended to limit those required by surgeons for issues specific to their surgical management.
### Table 3-3. Antibiotic regimens for infective endocarditis prophylaxis for high risk adult patients undergoing dental procedures

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agent</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Unable to take oral</td>
<td>Amoxicillin</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td></td>
<td>Ampicillin</td>
<td>2 g IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>Cefazolin or ceftriaxone</td>
<td>1 g IM or IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cephalexin*#</td>
<td>2 g</td>
</tr>
<tr>
<td>Penicillin or ampicillin allergic–oral route</td>
<td>OR</td>
<td>Clindamycin</td>
<td>600 mg</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>Azithromycin or clarithromycin</td>
<td>500 mg</td>
</tr>
<tr>
<td>Penicillin or ampicillin allergic and unable to take oral medication</td>
<td>OR</td>
<td>Cefazolin or ceftriaxone†</td>
<td>1 g IM or IV</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>Clindamycin</td>
<td>600 mg IM or IV</td>
</tr>
</tbody>
</table>

* Dental procedures involving manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa.

†Or other first- or second-generation oral cephalosporin in equivalent adult dosage.

‡Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin.

Appendix 3

Table 6-9. Summary of major changes in updated American Heart Association infective endocarditis (IE) guidelines

- Bacteremia resulting from daily activities is much more likely to cause infective endocarditis (IE) than bacteremia associated with a dental procedure.
- Only an extremely small number of cases of IE might be prevented by antibiotic prophylaxis even if prophylaxis is 100% effective.
- Antibiotic prophylaxis is not recommended based solely on an increased lifetime risk of acquisition of IE.
- Limit recommendations for IE prophylaxis only to those high risk cardiac conditions listed in Table 6-7.
- Antibiotic prophylaxis is no longer recommended for any other form of CHD, except for the high risk cardiac conditions listed in Table 6-7.
- Antibiotic prophylaxis is recommended for all dental procedures that involve manipulation of gingival tissues or periapical region of teeth or perforation of oral mucosa only for patients with underlying cardiac conditions associated with the highest risk of adverse outcome from IE (Table 6-8).
- Antibiotic prophylaxis is recommended for procedures on incision or biopsy of respiratory tract mucosa or for procedures on infected skin, skin structures, or musculoskeletal tissue only for high risk patients (Table 6.8).
- Antibiotic prophylaxis solely to prevent IE is not recommended for GU or GI tract procedures (Table 6-8). High risk patients with established GI or GU infection at the time of procedure may be prophylaxed with an anti-enterococcal agent.
- Guidelines reaffirm the procedures noted in the 1997 prophylaxis guidelines for which endocarditis prophylaxis is not recommended and extends this to other common procedures, including ear and body piercing, tattooing, and vaginal delivery and hysterectomy.


Source: Antibiotics and your heart. American Dental Association Web site. Available at http://www.ada.org/public/topics/antibiotics.asp. © 2007 American Dental Association. All rights reserved.
## Appendix 4

Table 3-8. Identification and assessment of obstructive sleep apnea (OSA)

<table>
<thead>
<tr>
<th>Predisposing physical characteristics</th>
<th>Body mass index $&gt;$35 kg/m²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neck circumference $&gt;$17 inches (men), 16 inches (women)</td>
</tr>
<tr>
<td></td>
<td>Craniofacial abnormalities affecting the airway</td>
</tr>
<tr>
<td></td>
<td>Anatomical nasal obstruction</td>
</tr>
<tr>
<td></td>
<td>Tonsils nearly touching or touching in the midline</td>
</tr>
<tr>
<td>History of apparent airway obstruction during sleep (two or more)</td>
<td>Snoring (loud enough to be heard through closed door)</td>
</tr>
<tr>
<td></td>
<td>Frequent snoring</td>
</tr>
<tr>
<td></td>
<td>Observed pauses in breathing during sleep</td>
</tr>
<tr>
<td></td>
<td>Awakens from sleep with choking sensation</td>
</tr>
<tr>
<td></td>
<td>Frequent arousals from sleep</td>
</tr>
<tr>
<td>Somnolence (one or more)</td>
<td>Frequent somnolence or fatigue despite adequate “sleep”</td>
</tr>
<tr>
<td></td>
<td>Falls asleep easily in a nonstimulating environment despite adequate “sleep”</td>
</tr>
</tbody>
</table>

Positive findings in two categories = moderate OSA, three categories = severe OSA.
## Table 3-12. Consultation with internist or cardiologists with specific questions

<table>
<thead>
<tr>
<th>Medical issue</th>
<th>Specific question/request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active cardiac conditions (American Heart Association/American College of Cardiology guidelines)</td>
<td>Can treatment lower risk and allow ambulatory procedure?</td>
</tr>
<tr>
<td>Poor or unclear exercise tolerance with one or more clinical risk factors scheduled for greater than low risk surgery.</td>
<td>Need for noninvasive cardiac testing? Need for beta blockers to lower perioperative risk?</td>
</tr>
<tr>
<td>Atrial fibrillation or angina on anticoagulant therapy.</td>
<td>Timing of anticoagulant discontinuation? Need for low-molecular-weight heparin? Need for beta blockers?</td>
</tr>
<tr>
<td>Known coronary artery disease for intermediate surgical-risk procedure.</td>
<td>Cardiac status stable? Cardiac function adequate for ambulatory surgery?</td>
</tr>
<tr>
<td>Recent percutaneous balloon angioplasty or cardiac stent placement, particularly drug-eluting stents.</td>
<td>Type and function? How to convert to fixed mode? Plan for disabling, reenabling?</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>Can therapy be augmented? Begin or augment appropriate therapy.</td>
</tr>
<tr>
<td>Automatic implantable cardioverter defibrillator</td>
<td>Begin or augment appropriate therapy.</td>
</tr>
<tr>
<td>Active bronchospasm</td>
<td>Risk/benefit of discontinuation? Management strategy</td>
</tr>
<tr>
<td>Undiagnosed, undertreated significant hypertension.</td>
<td></td>
</tr>
<tr>
<td>Undiagnosed, undertreated significant diabetes.</td>
<td></td>
</tr>
<tr>
<td>Long-acting psychiatric medications</td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder (hemophilia, factor deficiency)</td>
<td>Management strategy</td>
</tr>
<tr>
<td>Symptomatic hemoglobinopathy</td>
<td>Management strategy</td>
</tr>
</tbody>
</table>
Appendix 6

Box 4-5. Anesthesia machine preparation for malignant hyperthermia-susceptible patients

- Flush anesthesia machine for 20 minutes with high-flow oxygen 10 L/minute
- Disable or remove vaporizers
- Change disposables; consider changing soda lime
- Adequate supply of dantrolene to treat a crisis
- Nontriggering anesthetic technique
- Observe for 2.5 hours before discharge: minimum of 60 minutes in phase I plus 90 minutes in phase II
- Acceptable for outpatient status if no sequelae after nontriggering anesthetic
### Table 5-6. Pediatric adjunct agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Muscle relaxants:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Succinylcholine</td>
<td>2 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>5–6 mg/kg</td>
<td>IM</td>
</tr>
<tr>
<td>Mivacurium (not currently</td>
<td>0.2 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td>available in the U.S.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atracurium</td>
<td>0.5 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td>Vecuronium</td>
<td>0.1 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td>Rocuronium</td>
<td>0.6–1 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td><strong>Opioids:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.5–2 μg/kg</td>
<td>IV</td>
</tr>
<tr>
<td>Morphine</td>
<td>0.05–0.1 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td><strong>Antiemetics:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>0.15 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>0.1 mg/kg (maximum 4 mg)</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>4 mg for children &gt;20 kg</td>
<td>ODT</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>0.15 mg/kg (maximum 4 mg)</td>
<td>IV</td>
</tr>
<tr>
<td>Promethazine</td>
<td>12.5–25 mg</td>
<td>Rectally</td>
</tr>
<tr>
<td>Prochlorperazine</td>
<td>2.5–5 mg</td>
<td>Rectally</td>
</tr>
</tbody>
</table>

Doses should be titrated starting with the lower recommended dose. IM, intramuscular; IV, intravenous; ODT, oral disintegrating tablet.
Appendix 8

Table 5-8. Pediatric analgesic drug dosage

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose</th>
<th>Duration of action (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Rectally</td>
<td>30–40 mg/kg*</td>
<td>4–6</td>
</tr>
<tr>
<td></td>
<td>PO</td>
<td>10–15 mg/kg</td>
<td>4–6</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>IV</td>
<td>0.5 mg/kg (maximum 30 mg)</td>
<td>6–8</td>
</tr>
<tr>
<td></td>
<td>PO</td>
<td>1 mg/kg (maximum 10 mg)</td>
<td>4–6</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>PO</td>
<td>5 mg/kg</td>
<td>6–8</td>
</tr>
<tr>
<td>Codeine</td>
<td>PO</td>
<td>0.5–1 mg/kg</td>
<td>4–6</td>
</tr>
<tr>
<td>Naproxen</td>
<td>PO</td>
<td>10 mg/kg</td>
<td>6–8</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>IV</td>
<td>1–2 μg/kg</td>
<td>0.5–1</td>
</tr>
<tr>
<td>Meperidine</td>
<td>IV/IM</td>
<td>0.5–1 mg/kg</td>
<td>2–4</td>
</tr>
<tr>
<td>Morphine</td>
<td>IV</td>
<td>0.05–0.1 mg/kg</td>
<td>2–4</td>
</tr>
</tbody>
</table>

Doses should be titrated starting with the lower recommended dose.

*Acetaminophen suppositories are available in sizes of 120, 325, and 650 mg. Usually, the calculated dose is rounded up or down to the nearest whole or half size suppository. IM, intramuscular; IV, intravenous; PO, per os.
### Table 5-10. Oral sedation techniques in children

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloral hydrate</td>
<td>25–50 mg/kg (for small infants up to 12 months)</td>
</tr>
<tr>
<td></td>
<td>25–75 mg/kg (for children older than 12 months)</td>
</tr>
<tr>
<td>Ketamine</td>
<td>5–10 mg/kg (above 1 year)</td>
</tr>
<tr>
<td>Midazolam</td>
<td>0.5–1.0 mg/kg orally</td>
</tr>
<tr>
<td></td>
<td>0.2–0.3 mg/kg intranasally (above 1 year)</td>
</tr>
<tr>
<td>Fentanyl (Oralet)</td>
<td>5–15 μg/kg transmucosally (for children weighing more than 15 kg)</td>
</tr>
</tbody>
</table>

Doses should be titrated starting with the lower recommended dose.
## Appendix 10

Table 5-1. Fasting recommendations

<table>
<thead>
<tr>
<th>Ingested material</th>
<th>Minimum fasting period (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear liquids (<em>water, fruit juices without pulp, carbonated beverages</em>)</td>
<td>2</td>
</tr>
<tr>
<td>Breast milk</td>
<td>4</td>
</tr>
<tr>
<td>Infant formula</td>
<td>6</td>
</tr>
<tr>
<td>Nonhuman milk</td>
<td>6</td>
</tr>
<tr>
<td>Light meal</td>
<td>6</td>
</tr>
<tr>
<td>Heavy (high fat) meal</td>
<td>8</td>
</tr>
</tbody>
</table>
# Appendix 11

Figure 6-4. American Society of Anesthesiologists difficult airway algorithm.

1. Assess the likelihood and clinical impact of basic management problems:
   - A. Difficult Ventilation
   - B. Difficult Intubation
   - C. Difficulty with Patient Cooperation of Consent
   - D. Difficult Tracheostomy

2. Actively pursue opportunities to deliver supplemental oxygen throughout the process of difficult airway management

3. Consider the relative merits and feasibility of basic management choices:
   - A. Awake Intubation
   - B. Non-Invasive Technique for Initial Approach to Intubation
   - C. Preservation of Spontaneous Ventilation

4. Develop primary and alternative strategies:

   **A. AWAKE INTUBATION**
   - Airway Approached by Non-Invasive Intubation
     - Invasive Airway Access\(^{(a)}\)
     - Succeed\(^{*}\)
     - FAIL
     - Cancel Case
     - Consider Feasibility of Other Options\(^{(a)}\)
   - Invasive Airway Access\(^{(a)}\)
   - Intubation Attempts After Induction of General Anesthesia

   **B. INTUBATION ATTEMPTS AFTER INDUCTION OF GENERAL ANESTHESIA**
   - Initial Intubation Attempts Successful\(^{*}\)
     - Initial Intubation Attempts UNSUCCESSFUL
     - FROM THIS POINT ONWARDS CONSIDER:
       1. Calling for Help
       2. Returning to Spontaneous Ventilation
       3. Awakening the Patient
   - Initial Intubation Attempts UNSUCCESSFUL
     - Emergency Non-Invasive Airway Ventilation\(^{(e)}\)
     - Successful Ventilation\(^{*}\)
     - FAIL
     - Emergency Invasive Airway Access\(^{(b)}\)
     - LMA ADEQUATE\(^{*}\)
     - LMA NOT ADEQUATE OR NOT FEASIBLE
     - EMERGENCY PATHWAY
     - Ventilation Not Adequate, Intubation Unsuccessful
     - Call for Help
     - Emergency Non-Invasive Airway Ventilation\(^{(e)}\)
     - Successful Ventilation\(^{*}\)
     - FAIL
     - Emergency Invasive Airway Access\(^{(b)}\)

5. **FACE MASK VENTILATION ADEQUATE**
   - NON-EMERGENCY PATHWAY
     - Ventilation Adequate, Intubation Unsuccessful
     - Alternative Approaches to Intubation\(^{(a)}\)
     - Successful Intubation\(^{*}\)
     - FAIL After Multiple Attempts
     - Invasive Airway Access\(^{(b)}\)
     - Consider Feasibility of Other Options\(^{(a)}\)
     - Ablation of Spontaneous Ventilation

6. **FACE MASK VENTILATION NOT ADEQUATE**
   - CONSIDER / ATTEMPT LMA
   - IF BOTH FACE MASK AND LMA VENTILATION BECOME INADEQUATE
     - Emergency Non-Invasive Airway Ventilation\(^{(e)}\)
     - Successful Ventilation\(^{*}\)
     - FAIL
     - Emergency Invasive Airway Access\(^{(b)}\)

* Confirm ventilation, tracheal intubation, or LMA placement with exhaled CO\(_2\).

a. Other options include (but are not limited to): surgery utilizing face mask or LMA anesthesia, local anesthesia infiltration or regional nerve blockade. Pursuit of these options usually implies that mask ventilation will not be problematic. Therefore, these options may be of limited value if this step in the algorithm has been reached via the Emergency Pathway.

b. Invasive airway access includes surgical or percutaneous tracheostomy of cricothyrotomy.

c. Alternative non-invasive approaches to difficult intubation include (but are not limited to): use of different laryngoscope blades, LMA as an intubation conduit (with or without fiberoptic guidance), fiberoptic intubation, intubating stylet or tube changer, light wand, retrograde intubation, and blind oral or nasal intubation.

d. Consider re-preparation of the patient for awake intubation or canceling surgery.

e. Options for emergency non-invasive airway ventilation include (but are not limited to): rigid bronchoscope, esophageal-tracheal combitube ventilation, or transtracheal jet ventilation.

## Table 7-3. Adult sedative and analgesic drug doses administered as boluses or infusion technique²¹–²⁴

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Bolus dosage</th>
<th>Infusion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam</td>
<td>25–50 μg/kg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1–2 mg (when used with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>propofol)</td>
<td></td>
</tr>
<tr>
<td>Propofol</td>
<td>0.25–1 mg/kg</td>
<td>10–75 μg/kg per minute</td>
</tr>
<tr>
<td>Methohexital</td>
<td>0.25–1 mg/kg</td>
<td>10–75 μg/kg per minute</td>
</tr>
<tr>
<td>Dexmedetomidine</td>
<td></td>
<td>0.2–0.7 μg/kg per hour</td>
</tr>
<tr>
<td>Ketamine</td>
<td>0.3–0.6 mg/kg</td>
<td>300–600 μg/kg per hour</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>25–50 μg</td>
<td>Not recommended</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>5–10 μg/kg</td>
<td>0.25–1 μg/kg per minute</td>
</tr>
<tr>
<td>Remifentanil</td>
<td>0.1–0.3 μg/kg</td>
<td>0.025–0.1 μg/kg per minute</td>
</tr>
</tbody>
</table>

Doses should be titrated starting with the lower recommended dose.
Appendix 13

Table 8-3. Onset time, duration of effect, and maximum recommended dose of local anesthetic agents used for peripheral nerve blocks

<table>
<thead>
<tr>
<th>Local Anesthetic Agent</th>
<th>Onset (minutes)</th>
<th>Duration (hours)</th>
<th>Maximum dose (mg/kg) of solution with epinephrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloroprocaine</td>
<td>10–20</td>
<td>1–2</td>
<td>14</td>
</tr>
<tr>
<td>Lidocaine</td>
<td>10–20</td>
<td>2–3</td>
<td>7</td>
</tr>
<tr>
<td>Mepivacaine</td>
<td>10–20</td>
<td>3–6</td>
<td>7</td>
</tr>
<tr>
<td>Bupivacaine</td>
<td>15–30</td>
<td>6–12</td>
<td>3</td>
</tr>
<tr>
<td>Ropivacaine</td>
<td>15–30</td>
<td>6–12</td>
<td>3.5</td>
</tr>
</tbody>
</table>
Appendix 14

Table 8-5. Dose of adjuvant in final solution according to site of administration

<table>
<thead>
<tr>
<th></th>
<th>Spinal</th>
<th>Epidural</th>
<th>Peripheral nerve block</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine</td>
<td>50–200 μg</td>
<td>2.5 μg/mL</td>
<td>2.5 μg/mL</td>
</tr>
<tr>
<td>Phenylephrine</td>
<td>1–5 mg</td>
<td>2.5 μg/mL</td>
<td></td>
</tr>
<tr>
<td>Bicarbonate</td>
<td></td>
<td>0.1 mEq/mL</td>
<td>0.1 mEq/mL</td>
</tr>
<tr>
<td>Clonidine</td>
<td>150 μg</td>
<td>450 μg</td>
<td>50–100 μg</td>
</tr>
</tbody>
</table>
Table 9-4. Perioperative analgesics in the ambulatory setting—adults

<table>
<thead>
<tr>
<th>Analgesic</th>
<th>Dose</th>
<th>Duration of effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl</td>
<td>0.5–2 μg/kg</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Remifentanil</td>
<td>0.015–0.2 μg/kg/min</td>
<td>5 minutes after end infusion</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>10–15 mg/kg PO</td>
<td>4 hours</td>
</tr>
<tr>
<td></td>
<td>40 mg/kg PR</td>
<td></td>
</tr>
<tr>
<td>Propacetamol</td>
<td>20–30 mg/kg IV</td>
<td>4 hours</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>15–30 mg/IV</td>
<td>6–8 hours</td>
</tr>
<tr>
<td></td>
<td>30–60 mg/IM</td>
<td></td>
</tr>
<tr>
<td>Celecoxib</td>
<td>400 mg PO, then 200 mg PO</td>
<td>12 hours</td>
</tr>
</tbody>
</table>

Dose should be titrated starting with the lower recommended dose. IM, intramuscular; IV, intravenous; PO, per os; PR, per rectum.
### Appendix 16

**Table 9-5. Neuromuscular blocking agents and reversal agents in clinical practice**

<table>
<thead>
<tr>
<th>Agent</th>
<th>Intubation dose (2× ED95) mg/kg</th>
<th>Onset time (minutes)</th>
<th>Duration of action until train of four (TOF) &gt; 0.9 after intubation dose (minutes)</th>
<th>Common side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocuronium</td>
<td>0.6</td>
<td>1.5–2.5</td>
<td>55–80</td>
<td>Mild vagolytic</td>
</tr>
<tr>
<td>Vecuronium</td>
<td>0.1</td>
<td>2–3</td>
<td>50–80</td>
<td>None</td>
</tr>
<tr>
<td>Mivacurium*</td>
<td>0.15–0.2</td>
<td>2.5–4.5</td>
<td>25–40</td>
<td>Histamine</td>
</tr>
<tr>
<td>Atracurium</td>
<td>0.5</td>
<td>2–3</td>
<td>55–80</td>
<td>Histamine</td>
</tr>
<tr>
<td>Cisatracurium</td>
<td>0.1–0.2</td>
<td>3–6</td>
<td>60–90</td>
<td>None</td>
</tr>
<tr>
<td>Neostigmine</td>
<td>0.05–0.07μg/kg</td>
<td>2–5</td>
<td>60–90</td>
<td>Cholinergic</td>
</tr>
<tr>
<td>Edrophonium</td>
<td>0.5–1mg/kg</td>
<td>1–2</td>
<td>60–90</td>
<td>Cholinergic</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
<td>10μg/kg</td>
<td>1–2</td>
<td>30</td>
<td>Tachycardia</td>
</tr>
<tr>
<td>Sugammadex</td>
<td>2–4mg/kg</td>
<td>1.5–6.5</td>
<td>Unknown</td>
<td>No known side effects</td>
</tr>
</tbody>
</table>

*No longer available in the U.S.*
Appendix 17

Table 11-6. Office anesthesia checklist

<table>
<thead>
<tr>
<th>Facility design:</th>
<th>Date completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sufficient space</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recovery area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Meets building codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sufficient electrical outlets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Backup power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Visual access to patient at all times during surgery/proper lighting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment and supplies:</th>
<th>Date completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reliable O₂ source with backup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adequate source of suction and catheters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Self-inflating (Ambu) resuscitation bag capable of administering at least 90% O₂ with backup bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency cart/airway equipment/ACLS drugs for population(s) served (i.e., adult, pediatric)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communication device (telephone, intercom within reach)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scavenging system for waste gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood pressure, electrocardiogram, stethoscope, pulse oximeter, capnogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Functioning resuscitation equipment and defibrillator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Appropriate-sized airways, laryngoscope blade, masks/laryngeal mask airways</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dantrolene when using triggering agents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General preparedness:</th>
<th>Date completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Credentialed and licensed medical doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ACLS and/or pediatric ALS trained staff on premises until patient discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital transfer agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Quality assurance policies/initiatives and peer reviews</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ACLS, advanced cardiac life support; ALS, advanced life support.
Table 12-4. Postoperative antiemetic therapy—adults

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serotonin (5HT₃) antagonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4–8 mg IV</td>
<td>Headache, dizziness</td>
</tr>
<tr>
<td>Dolasetron (Anzemet)</td>
<td>12.5–25 mg IV</td>
<td></td>
</tr>
<tr>
<td>Granisetron (Kytril)</td>
<td>0.35–1.0 mg IV</td>
<td></td>
</tr>
<tr>
<td><strong>Butyrophenones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Droperidol</td>
<td>0.625–1.25 mg IV</td>
<td>Extrapyramidal effects, dysphoria, drowsiness, dizziness</td>
</tr>
<tr>
<td><strong>Neurokinin (NK-1) antagonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aprepitant (Emend)</td>
<td>40 mg PO</td>
<td>Headache, constipation, pruritis</td>
</tr>
<tr>
<td><strong>Steroids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>4–10 mg IV</td>
<td>Rare with single dose</td>
</tr>
<tr>
<td><strong>Phenothiazines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prochlorperazine (Compazine)</td>
<td>5–10 mg IV, IM, PO</td>
<td>Sedation, drowsiness, hypotension</td>
</tr>
<tr>
<td></td>
<td>25 mg PR suppository</td>
<td></td>
</tr>
<tr>
<td><strong>Antihistamines (H-1) antagonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promethazine (Phenergan)</td>
<td>6.25–12.5 mg IV</td>
<td>Sedation</td>
</tr>
<tr>
<td></td>
<td>12.5–50 mg PR suppository</td>
<td></td>
</tr>
<tr>
<td>Hydroxyzine (Vistaril)</td>
<td>12.5–25 mg IV, IM</td>
<td></td>
</tr>
<tr>
<td><strong>Benzamides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethobenzamide (Tigan)</td>
<td>100–200 mg IV, IM</td>
<td>Extrapyramidal effects, dysphoria, drowsiness, anxiety, dizziness</td>
</tr>
<tr>
<td></td>
<td>200 mg PR suppository</td>
<td></td>
</tr>
<tr>
<td><strong>Anticholinergics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scopolamine patch (Transderm Scop)</td>
<td>1.5 mg transdermal</td>
<td>Dry mouth, blurred visions, hallucinations</td>
</tr>
</tbody>
</table>

IM, intramuscular; IV, intravenous; PO, per os; PR, per rectum.
Appendix 19

Figure 12-2. Algorithm for prophylactic antiemetic treatment.
### Table 12-5. Treatment modalities for postoperative hypertension

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose range</th>
<th>Half-life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beta blockers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propranolol (Inderal)</td>
<td>0.5–1.0 mg IV</td>
<td>2–4 hours</td>
</tr>
<tr>
<td>Labetalol (mixed alpha and beta) (Trandate, Normodyne)</td>
<td>5–10 mg bolus IV</td>
<td>4–6 hours</td>
</tr>
<tr>
<td>Esmolol (beta 1-selective) (Brevibloc)</td>
<td>0.25–0.5 mg/kg bolus IV</td>
<td>9 minutes</td>
</tr>
<tr>
<td>Metoprolol (beta 1-selective) (Lopressor)</td>
<td>5–25 mg IV increments</td>
<td>2.5–4.5 hours</td>
</tr>
<tr>
<td><strong>Vasodilators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydralazine (Apresoline)</td>
<td>2.5–5.0 mg IV increments</td>
<td>4–6 hours</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td>50–100 μg IV bolus</td>
<td>4–6 hours</td>
</tr>
<tr>
<td></td>
<td>0.1 μg/kg per minute</td>
<td></td>
</tr>
<tr>
<td><strong>Calcium channel blockers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicardipene (Cardene)</td>
<td>2.5 mg IV</td>
<td>6 hours</td>
</tr>
<tr>
<td><strong>ACE Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enalapril (Vasotec)</td>
<td>2.5 mg IV</td>
<td>4–6 hours</td>
</tr>
</tbody>
</table>

IV, intravenous.
AAAASF. See American Association for Accreditation of Ambulatory Surgery Facilities
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