



nil-per-os (NPO): Can We Address It? With A Loco-Regional-National Database

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My opinion

Although the term "Say No To NPO!" has been registered as a trademark by BevMD LLC, California, United States,[1] the American Society of Anesthesiologists (ASA) should envision progressing towards it while balancing the dynamically evolving pros-cons evidence for preoperative hydration-nutrition status with pulmonary aspiration-complication risks. Currently, the issues may neither be (a) Why did *nil-per-os* (NPO) in relation to anesthesia-sedation-medication come into existence? nor be (b) Why did NPO in relation to surgery-procedure itself relegate into the background? nor be (c) What is the statistical evidence for the calculated projections of lost lives (mortality) or damaged lives (morbidity) in the likelihood of perianesthesia NPO being discarded? Per my limited understanding after reading the most recent medical literature,[2] the current issue, that creates debates around the question of NPO and thereafter hassles due to the absence of NPO during perianesthesia surgical care, may be the obscurities persisting in the ASA practice guidelines,[3] in regards to but not limited to, (a) potential consideration of creamer/milk in the coffee/tea as clear liquid when in < 1:5 ratio,[4] (b) potential avenue to recognize and resolve the chewing gums and candies becoming a cause of procedural delays/cancelations,[4] (c) potential for continuation of preoperative enteral feeds in patients whose airways are already protected with tracheal tubes preoperatively,[5] (d) potential redundancy during elective minor procedures under regional-only anesthesia or local-only anesthesia with or without minimal-to-moderate anxiolysis-sedation when regional-only anesthesia or local-only anesthesia with or without minimal-to-moderate anxiolysis-sedation may be done on non-empty stomachs in the case of emergencies like labor epidurals, cesarean sections and cardiac catheterizations/interventions,[6-7] (e) absent guidance in regards to oral contrast agents consumed prior to radiological procedures under anesthesia care and oral bowel cleansing solutions consumed prior to endoscopic procedures under anesthesia care,[8-9] and (f) disclaimer that sometimes the procedure in itself may be warranting

NPO rather than just its anesthesia care warranting NPO.Â Â Â Â Â

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The existential question is: Just like any other perianesthesia risk, who is taking this risk in regards to the consequences of absence or presence of NPO? Firstly, it is the patients who weigh in benefits vs. risks to their health and lives based on the medical evidence and information provided to them. Secondly, it is the payers who will most likely prefer to only pay for the uncomplicated low-risk essential procedures among the population insured by them. Finally, even though the perianesthesia NPO status may be guided through anesthesia literature despite the limited availability of very good quality evidence therein, both anesthesia providers and proceduralists collectively decide to continue/delay/cancel the procedures based on the calculated-risks' burden that they want to carry onto their conscience which constantly seeks assurance of patient safety even when trying to restrict perianesthesia medicolegal liability to the unexpected unpredicted poor outcomes only. One potential solution could be development of loco-regional-national database wherein local NPO-consequences' data guides the patients' decisions when they are consenting for the procedures while locally collected and regionally-nationally connected NPO-consequences' data can guide the regional-national organizations to update the guidelines for perianesthesia standards of care for the sake of medical practitioners, healthcare payers and medicolegal professionals. As inspired by Multicenter Perioperative Outcomes Group (MPOG),[10] the compulsory local database can anonymously retrieve data that may not be limited only to default collection of all patients' age, sex, pre-morbid risk of gastro-paresis, the procedure performed, presence of tracheal tube (presence of protective airway device), hours since solids and liquids consumption, elective or emergent procedure, the ASA continuum of depth of sedation used for the procedure,[11] and complications encountered like vomiting under anxiolysis/sedation/anesthesia, perianesthesia aspiration confirmed radiologically or endoscopically, and death due to aspiration so as to decipher the number needed to harm (NNH) for each complication as corresponding to non-adherence of regularly

updated NPO practice guidelines.

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Summarily, the idea is to request the ASA to explore further into the evolving evidence and provide guidance to practicing anesthesiologists like myself so that above-mentioned obscurities can be resolved to some extent by the time of next updates by the ASA until some new obscurities present to our constantly evolving perioperative medicine warranting the corresponding adjustments by the clinical researchers to investigate further and accordingly the ASA to guide more. Essentially, although intentional fasting may have some benefits when mostly-healthy population are seeking solace in achieving personal goals through fasting,[12] enforced perianesthesia fasting may NOT achieve similar benefits when mostly-sick patients are seeking medical help to restore normalcy to their health.

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