Preoperative tests

Consultation on draft guideline - Stakeholder comments table
12/10/2015 - 23/11/2015

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Age Anaesthesia Association	Full	61	5.92	We, as an organisation, feel that the majority of anaesthetists would like to see a resting ECG in very elderly patients and all patients over 80 years ASA II or higher, even for a minor procedure. Whilst it may not alter management, it leads to heightened awareness of potential as yet undiscovered health problems and thus increased intraoperative vigilance. ECG abnormalities are common in this group, up to 80%, and whilst not directy prognostic of postoperative morbidity, the identifying them can lead to the patient appropriately being referred for further investigation after the procedure. Minor procedures are not the same as minor anaesthetics. This is a consensus viewpoint only, as evidence for, or against is poor. However, it is a cheap, non invasive intervention.	Thank you for your comment. We agree that there is limited evidence on this topic. The consensus of the GDG was that resting ECG for minor surgery (ASA grades 1 and 2) and intermediate surgery (ASA 1) would not alter perioperative management. Patients would be monitored intraoperatively which would pick up any issues and allow the patient to be referred on as appropriate. Preoperative ECG is therefore not considered to be necessary in these circumstances, however clinical judgement should be used which is reflected in the use of a 'do not routinely offer' recommendation.
Department of Health	General			Thank you for the opportunity to comment on the draft for the above clinical guideline. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you for your response.
Northampton General Hospital	Full	65-71		There is no mention of the use of the straightforward lab blood test for BNP [brain natriuretic peptide] measurement as an indicator of ventricular dysfunction, and its use in distinguishing between cardiac and respiratory causes of breathlessness. It is also useful in determining whether a heart murmur is clinically important, in addition to resting ECG. Our preop assessment service would routinely perform this test before requesting echocardiography, unless a pre-existing diagnosis of established heart failure has been made. This way we reduce inappropriate use of our echo service which has significantly more limited capacity than our laboratory. We believe that this is an	Thank you for your comment. B-type Natriuretic Peptide was not included in the scope of this guideline and the GDG was therefore not able to comment on the use of this test in the preoperative setting. We do however note that evidence in this area is evolving, although there are no prospective RCTs available yet. NICE have a robust process for reviewing published guidelines to determine if they need to be updated. This process will be followed for the Preoperative Tests guideline. More information can be found on the NICE website. This issue will be highlighted to

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				essential part of preoperative assessment of patients with possible ventricular disease, a practice supported by our cardiology team. [see research suggestion]	the NICE surveillance team and considered in future updates.
Northampton General Hospital	Full	95-96		We wholly support the avoidance of CXR unless specifically indicated, with one exception. In patients with suspected fractured neck of femur we routinely perform a simultaneous CXR and pelvic x-ray to minimise distress to a patient in pain which might be caused by performing a CXR later in the admission, and in the knowledge of the high incidence of occult cardiorespiratory disease in this specific group.	Thank you for your comment. This relates to emergency surgery and therefore the population you refer to is not covered by this guideline, although we accept that in certain populations the test may be clinically indicated.
Northampton General Hospital	Full	13	7	Should neurological comorbidities also be included	Thank you for your comment. Cardiovascular, respiratory, renal, diabetes and obesity were the comorbidities identified for inclusion during the scoping phase of the guideline. Neurological comorbidities were not identified as an area for inclusion by stakeholders. This may be because there is such heterogeneity within this group of disorders that overarching recommendations for preoperative testing in this subset of patients would not be useful.
Northampton General Hospital	Full	13	7	Is it possible for a person to have diabetes which requires treatment and also to be ASA2, given the known presence of occult complications which may exist but be currently asymptomatic	Thank you for your comment. The view of the GDG was that even if there is occult disease, this is unlikely to be severe enough to affect preoperative management. If it is severe enough it would be symptomatic and would be therefore reflected in an increased ASA grade.
Northampton General Hospital	Full	14	9	Should 'all' comorbidities read 'any' comorbidities	Thank you for your comment. This guideline covered the following specific comorbidities: cardiovascular, respiratory, renal, diabetes and obesity. The text 'all comorbidities' has now been deleted from the tables to avoid confusion.
Northampton	Full	15	8	The statement about monitoring anticoagulation at point	Thank you for your comment. The GDG agreed that

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General Hospital				of care is ambiguous given the widespread use of novel oral anticoagulants whose impact on coagulation cannot be assessed using POCT. I think we need to be clearer on what is meant as this is a particular area which causes disruption to the surgical pathway, but also puts patients at risk.	the wording of this recommendation is ambiguous and agreed to add further detail to clarify the recommendation and reflect the point made regarding direct oral anticoagulants. The recommendation has been amended as follows: **Consider haemostasis tests in people with chronic liver disease having intermediate or major/complex surgery.** • **If people taking anticoagulants need modification of their treatment regimen, make an individualised plan in line with local guidance.** • **If clotting status needs to be tested before surgery (depending on local guidance) use point of care testing.**[1] [1. Note that currently the effects of direct oral anticoagulants (DOACs) cannot be measured by routine testing.]
Northampton General Hospital	Full	22	24	Exclusion of patients having cardiovascular surgery is inconsistent with inclusion of patients having vascular surgery [of all kinds] referred to elsewhere in the document when assessing evidence and decision on the kind of AAA repair. Preop assessment of patients for vascular surgery is highly specialised. Is it included or excluded?	Thank you for your comment. When developing the scope cardiac surgery and surgery undertaken on blood vessels intimately connected to the heart (including the thoracic aorta) were excluded. However certain types of vascular surgery (including peripheral vascular and AAA surgery) were included. This was the case throughout the entire guideline. The GDG was unable to make any recommendations on CPET based on the available evidence, but acknowledge that there is ongoing

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					research in this field, and a reference to this is included with the Linking evidence to recommendations (LETR) section..
Northampton General Hospital	Full	175	26-28	I am not clear whether the patient groups listed on P175 should be subject to routine sickle testing or not.	Thank you for your comment. To clarify, the recommendation applies to all groups listed on page 175. Patients should not be routinely offered the sickle cell disease test. The rationale for this decision is set out in the Linking evidence to recommendations (LETR) section.
Northampton General Hospital	Full	176	9	Does recommendation 17 apply to 100% of patients? Are adult patients from African countries not to be considered for sickle testing [bearing in mind that they may well not have been born in UK and screened at birth]	Thank you for your comment. This recommendation does apply to all patient groups. The view of the GDG was that sickle disease will have become symptomatic by adult life and therefore would already be known, irrespective of testing. Screening from birth is an added safeguard. Clinicians would need to use their judgement to determine if the test was needed to guide management of the patient.
Northampton General Hospital	Full	176	9	What does the line at the bottom of the page 'anaesthesia is *good enough* mean? Is this referring to safety? Is it a useful comment. Is the concern about avoiding use of tourniquet in patients with sickle trait no longer regarded as having any supporting evidence?	Thank you for your comment. We have rephrased the Linking evidence to recommendations (LETR) section to state that intraoperative hypoxia is unlikely with modern anaesthesia, rather than modern anaesthesia is good enough. We did not specifically look for evidence on sickle cell disease and tourniquets. However the use of tourniquets, even in sickle cell disease, is only seen as a relative contraindication to tourniquets, so concern about tourniquets in patients with sickle cell trait is no longer relevant.
Northampton General Hospital	General	General		RESEARCH SUGGESTION: validity of using BNP to identify patients with significant ventricular dysfunction not otherwise identified and/or avoidance of unnecessary use of resting	Thank you for your comment. B-type Natriuretic Peptide was not included in the scope of this guideline as it is not currently used as a routine preoperative test.

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				echocardiograph/polysomnography/LFT's tc	
Northampton General Hospital	Short	General		Please cross reference my comments on the full guideline which are equally relevant to the short guideline	Thank you – this has been done.
Royal College of Anaesthetists / Preoperative Association	Full	General	General	We would like to see definitions of the grading of surgery – using terms such as Minor/Intermediate etc. is not clear. In particular, the ESC/ESA and ASA/ASC terms overlap.	Thank you for your comment. The surgery grades and illustrative examples of the types of surgery covered are set out in the glossary. In addition we have also repeated this is in section 3.3.1 for clarity. We have removed references to numbered surgery grades as we appreciate this can be confusing.
Royal College of Anaesthetists / Preoperative Association	Full	General	General	It would be useful to have guidance as to how long the results of a test are valid for in the absence of symptoms – especially ECG and Echocardiogram	Thank you for your comment. How long test results are valid for is variable, so it is not possible to be specific in this guideline.
Royal College of Anaesthetists / Preoperative Association	Full	General	General	We welcome the idea that staff will provide information to patients on the tests they are carrying out.	Thank you for your comment.
Royal College of Anaesthetists / Preoperative Association	Full	General	General	Throughout the guideline the authors seem to imply that for certain patients it is unnecessary to do tests because they are going home the same day. This is not a valid reason on which to base that decision.	Thank you for your comment. The GDG's decisions about the utility of testing were based primarily on the degree of comorbidities and the invasiveness of surgery. There is sometimes an argument for doing certain tests in order to have a baseline with which to compare following surgery, but the GDG felt that this was unnecessary where the likelihood of postoperative complications was very low. Patients discharged the same day have a reduced likelihood of post-operative complication. It should be noted that all recommendations that were **'do not offer'** have now been changed to **'do not routinely offer'** in order to acknowledge more clearly that there will be exceptions where the test

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					is clinically indicated. Clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient.
Royal College of Anaesthetists / Preoperative Association	Full	21	Table 1	The definitions of the ASA Grades that are used are not the same as the 'standard' ASA grading. Much of the guidance hinges around the ASA Grade used for a particular patient; **we recommend that the definition of the ASA Grades should follow the accepted definitions.**	Thank you for your comment. The definitions of the ASA grades were adapted from the ASA website and abbreviated. A reference has been provided in the full guideline.
Royal College of Anaesthetists / Preoperative Association	Full	50	4.10	We strongly support the recommendation that preoperative tests results undertaken in primary care are included when referring patients for surgery. We believe this will save money and inconvenience.	Thank you for your response.
Royal College of Anaesthetists / Preoperative Association	Full	61	Table 5.9	We disagree with the structure of this table and we disagree with the recommendation. The table creates new subgroupings of ASA3/4 but in practice these groups are difficult to distinguish. We do not support this distinction, and we strongly believe **the two groups should be combined.** RESTING ECG ***ASA1*** The table recommends that ASA1 (ie patients with no known comorbidities) should have a resting ECG before major surgery if they are over 65 years of age. We believe that this age limit is too high, because of the increasing risk of coronary artery disease, and we think that **a resting ECG should be considered flexibly in patients younger than this (down to the age of 50) in the light of local public health data.** We also think an	Thank you for your comments. Please see responses to each point below: **Combining subgroups of ASA3 and ASA4** The GDG recognise that there may be crossover within the comorbidities and have therefore amended the table and recommendations to combine the subgroups as suggested. The recommendations for ASA3 and ASA4 have changed in the process (outlined under heading 'ASA3 and ASA4 (all surgery types)' below. **ASA1** This recommendation is in line with the ESA guideline which uses age 65 as a lower limit. The Delphi results also supported this view. Clinical judgement should always be used to determine whether a test is necessary in someone below the age of 65; however the GDG acknowledged that variation in prevalence of cardiac problems may be

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				ECG should be considered in patients having surgery associated with significant blood loss. ***ASA2*** We concur with the Delphi group and the American, European and Canadian guidelines, recommending that an ECG is considered in these patients. ***ASA 3/4*** The table recommends that a resting ECG does not need to be carried out on ASA 3/4 patients having minor surgery. We do not agree with this, and **strongly recommend that a resting ECG is carried out an all ASA3/4 patients, irrespective of the magnitude (minor/intermediate/major) of the surgery.** We note that the Delphi group also felt that ASA 3/4 patients should all have a resting ECG, regardless of magnitude of surgery, and feel that this recommendation has to be changed. We do not believe that these changes will significantly delay surgery, and we do not feel that the ECG used in theatre (which is only a 3-5 lead) is an adequate substitute for a 12-lead.	a factor that should also be taken into account locally. A statement to this effect has been added to the Linking evidence to recommendations (LETR) section in the full guideline. Regarding ASA1 patients having surgery associated with significant blood loss, It should be noted that all recommendations that were **'do not offer'** have been changed to **'do not routinely offer'** in order to acknowledge more clearly that there will be exceptions where the test is clinically indicated. Clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. **ASA2** Thank you for your comment. **ASA3 and ASA4 (all surgery types)** In combining the ASA3 and ASA4 subgroups, the following changes were made to the recommendations. - Major surgery: Offer (this remains the same) - Intermediate surgery: Offer (this was previously consider, but has been upgraded to reflect the higher common denominator where the subgroups have been combined) - Minor surgery: Consider if no ECG results are available from the past 12 months (this was previously do not offer, but has been upgraded to recognise that there may be issues such as uncontrolled atrial fibrillation in some cases)

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					This guideline did not consider intraoperative 3-5 lead ECG so we are unable to comment on how it compares to 12-lead ECG.
Royal College of Anaesthetists / Preoperative Association	Full	70	6.6	ECHOCARDIOGRAPHY We agree with this recommendation, but would suggest that resting echocardiography could also be considered in patients with severe disease undergoing minor surgery, or in patients with a murmur and significant symptoms.	Thank you for your comment. The GDG agreed with the suggested change and have therefore amended the recommendation to remove any mention of complexity of surgery grade. This recommendation now applies across the board for all types of surgery (except for ASA1 which stays as do not routinely offer).
Royal College of Anaesthetists / Preoperative Association	Full	104	Table 9.8	OBSTRUCTIVE SLEEP APNOEA We would like to see more research on methods of increasing compliance with treatment of OSA.	Thank you for your comment. We agree that this is an important area, however compliance and treatment of OSA was not considered by this guideline.
Royal College of Anaesthetists / Preoperative Association	Full	104	Table 9.8	We would like to see better awareness amongst surgical staff and better assessments (eg using sleep study with pulse oximetry)	Thank you for your comment. The GDG agree this is an important area and identified the use of polysomnography as an area for future research. We have made the need for greater awareness through research clearer within the Linking evidence to recommendations (LETR) section.
Royal College of Anaesthetists / Preoperative Association	Full	116	Table 10.10	LUNG FUNCTION TESTS We think recommendation 8 would be better phrased as **Consider discussing the case with a senior anaesthetist…,** rather than the present wording of 'consider referring people…' since we feel this would be quicker.	Thank you for your comment. The GDG agreed with the suggested change and the recommendation has been revised to the following: **Consider seeking advice from a senior anaesthetist as soon as possible after assessment for people who:** • **are ASA grade 3 or 4 due to known or suspected respiratory disease <u>and</u>** • **are having intermediate or major or complex surgery.**
Royal College of	Full	140	Table	FULL BLOOD COUNT	Thank you for your comment. Orthopaedic

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Anaesthetists / Preoperative Association			11.10	We feel that **ASA2 patients with renal disease or diabetes and all ASA 3/4 patients should be offered Full Blood Count.** We also think that patients having certain orthopaedic procedures, where anaemia has been shown to affect outcome, should be offered this test. We also feel that Full Blood Count should be offered to patients having invasive surgery, liver disease, renal disease, bleeding disorders and at the extremes of age. Most anaesthetists would be unwilling to anaesthetise patients for elective surgery with an Hb less than 70g/dL.	procedures such as joint replacements are considered to be major surgery, and all patients undergoing this kind of surgery should be offered the full blood count test. The view of the GDG was that if a patient is significantly anaemic or suspected to be, they would be highly likely to be symptomatic and this would be reflected in an ASA grade of 3 or above. The test would therefore be considered or offered for these patients for intermediate or major/complex surgery respectively. The GDG felt that minor surgery would not entail major blood loss, so the presence of anaemia would not affect clinical management. However clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. This is reflected in the **'do not routinely offer'** recommendation which acknowledges more clearly that there will be exceptions where the test is clinically indicated.
Royal College of Anaesthetists / Preoperative Association	Full	152	Table 12.1	KIDNEY FUNCTION TESTS NICE Acute Kidney Injury Guidelines (CH169 – 1.1.1) state that acute kidney failure should be identified by comparing the creatinine against the baseline. We therefore think to comply with this then **Kidney Function Test should be offered to all patients before Major surgery.** Patients with renal disease often have chronic anaemia. We also think **ASA 2 patients having intermediate surgery and all ASA 3/4 patients should be offered Kidney function tests if they are taking diuretics or salbutamol** to detect hypokalaemia	Thank you for your comments. Please see responses to each point below: **All patients having major surgery** Most of the AKI risk factors listed in the AKI guideline would be reflected in an ASA grade of 3 or above, so these patients would be offered the test under this guideline. **Patients on certain drug therapy (ASA2 having intermediate surgery and all ASA3/ASA4 patients)** These populations are considered to be at risk of AKI, so would be covered by the current

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					recommendations which state the test should be offered or considered. Regarding patients who are ASA3/ASA4 having minor surgery, the GDG agreed to amend the recommendation for minor surgery from do not offer to consider, in order to reflect the risk of AKI (although it was felt the risk was low). In addition there is now also an overarching recommendation as follows: **Take into account any medicines people are taking when considering whether to offer any preoperative test.**
Royal College of Anaesthetists / Preoperative Association	Full	157	Table 13.4	HAEMOSTASIS TEST We recommend that haemostasis tests are offered to patients having major neuraxial blocks	Thank you for your comment. The recommendation states that haemostasis tests should not be routinely offered because the GDG felt that the likelihood of finding abnormal results before anaesthesia is not very high. We expect clinicians to take our guidance into account. But they should always base decisions on the person they are working with.
Royal College of Anaesthetists / Preoperative Association	Full	166	Table 14.1.9	HbA1C We strongly support the recommendation that diabetic patients should have their recent HbA1c test results included in their referral information. If it is not available then the GP should organise it at the time of referral.	Thank you for your response.
Royal College of Anaesthetists / Preoperative Association	Full	173	Table 14.2.8	HbA1C , UNDIAGNOSED DIABETES nAND URINALYSIS We also agree with the recommendation that patients not known to be diabetic should not be offered HbA1c before surgery. However we are concerned that there is no mechanism for recognising undiagnosed diabetes and that patients may present for surgery who do not know that they are diabetic.	Thank you for your comments. Please see responses to each point below: **HbA1c in undiagnosed patients** The view of the GDG and the consensus of the Delphi survey was that preoperative testing should not be used as an opportunity to screen for diabetes. However if diabetes is suspected, clinical

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				Because of the high incidence of diabetes in the surgical population, especially in the elderly, we recommend that the GDG consider which of the available tests – random blood sugar, urine dipstick or HbA1c – is used to detect asymptomatic diabetes.	judgement should be used to determine if the test is necessary. **Which test to use** Methods of screening for undiagnosed diabetes were not included within the scope of the guideline so we cannot comment on this issue.
Royal College of Anaesthetists / Preoperative Association	Full	176	Table 15.4	SICKLE TESTING Recommendation 18 would be better worded as Ask the person having surgery if they or any member of their family have sickle cell disease **or trait.** Patients who have never previously been tested and who have a family member who is affected should be offered a test.	Thank you for your comment. The view of the GDG was that sickle cell trait does not need to be referred to within the recommendations as it has no impact on perioperative clinical management of the patient. The consensus of the GDG was that there is no need to do the test to detect people with sickle cell disease (even if a family member has the disease) as this would usually already be known through the experience of symptoms by an adult patient. However clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. This is reflected in the **'do not routinely offer'** recommendation which acknowledges more clearly that there will be exceptions where sickle cell test is clinically indicated.
Royal College of Anaesthetists / Preoperative Association	Full	181	Reco mmen dation 20	Urine dipstick is widely used as screening test for asymptomatic diabetes (see our comment on Table 14.2.8). Whilst there are other tests available for this we acknowledge that urine testing is on widespread use and cannot be easily replaced.	Thank you for your comment. The view of the GDG is that preoperative testing should not be used as an opportunity to screen for diabetes. In addition the UK National Screening Committee does not recommend population screening for diabetes. Screening is also not mentioned in the 2015 Joint British Diabetes Societies' report on the

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					Management of adults with diabetes undergoing surgery and elective procedures: Improving standards report, so we believe this view is supported more widely.
Royal College of Anaesthetists / Preoperative Association	Full	183	Table 17.4	PREGNANCY TEST We welcome the introduction of flexibility for local processes, and the move away from mandatory testing. We feel that asking patients about their pregnancy status needs to be done with great sensitivity, especially in certain cultures and personal situations.	Thank you for your response.
Royal College of Nursing	General			This is to inform you that the RCN has no comments to submit to inform on the above draft guideline consultation at this time. Thank you for the opportunity.	Thank you for your response.
Royal College of Pathologists	General			I am just writing to inform you that the Royal College of Pathologists has no comments to make on this draft guideline.	Thank you for your response.
Royal College of Radiologists				Thank you for your inquiry. We were aware of the draft guideline on preoperative tests and sent the information to several stakeholders to ask for comments. The responses we received were neutral, either agreeing with the guideline or stating that they had no comments to make. For this reason the RCR did not complete the feedback form for NICE as there were no issues which needed to be raised.	
Royal College of Surgeons of England	Short	General	General	This guideline seems straight forward and unlikely to cause controversy	Thank you for your comment.
Royal College of Surgeons of England	Short	General	General	The wording 'not routinely' in the short version of the guideline should be replaced with wording explaining when the test should be given	Thank you for your comment. In general tests should not be performed unless there are circumstances when it is clinically appropriate to do

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					so – it is not possible to be more specific within this guideline. It should be noted that all recommendations that were **'do not offer'** have now been changed to **'do not routinely offer'** in order to acknowledge more clearly that there will be exceptions where the test is clinically indicated.
Royal College of Surgeons of England	Short	General	General	Most routine prep testing is now managed by nurses in the context of a pre-assessment clinic and the guideline would be more useful if was perhaps more specific.	Thank you for your comment. It is not possible to be more specific in the guideline as this depends on individual circumstances. Furthermore preoperative assessment clinics operate in different ways, so this also makes it difficult to be more specific.
Royal College of Surgeons of England	Short	General	General	Despite it not being a diagnostic test, Group and Save is carried out at the same point in time as all of these pre-operative tests. To ensure this is not forgotten might it be useful to include when/ not G&S should be done pre-surgery?	Thank you for your comment. Blood cross-matching was excluded from the scope so we cannot comment on this test.
Royal College of Surgeons of England	Short	General	General	There are many thousand of wasted group and save samples and specific advice on what operations require this and which do not would be useful in the reassessment clinic context as staff are likely to err on the side of caution which leads to unnecessary waste (this goes for other testing too).	Thank you for your comment. Blood cross-matching was excluded from the scope so we cannot comment on this test.
Royal College of Surgeons of England	Short	4	41	Given concerns about undiagnosed diabetes, especially in the over 45 age group, should screening for high risk groups be included?	Thank you for your comment. The view of the GDG is that preoperative testing should not be used as an opportunity to screen for diabetes. Screening is also not mentioned in the 2015 Joint British Diabetes Societies' report on the Management of adults with diabetes undergoing surgery and elective procedures: Improving standards report, so we believe this view is supported more widely.
Royal College of Surgeons of England	Short	7	Table 1	The guidance of 'consider' in giving an ECG to ASA ¾ with respiratory or obesity comorbidities, should be	Thank you for your comment. The GDG considered the ECG recommendations in light of consultation

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				qualified to include when this test should be given	comments and agreed some changes which included combining the comorbidities. Please note that because of this, the previous 'consider' recommendation for ASA3 and ASA4 (intermediate) surgery has now been upgraded to offer.
Royal Pharmaceutical Society	General			The Royal Pharmaceutical Society has endorsed the response of the UK Clinical Pharmacy Association (UKCPA).	Thank you for your response.
Society for Cardiothoracic Surgery in Great Britain and Ireland		General	General	I have read the Draft guideline on Preoperative tests Routine preoperative tests for elective surgery. This is an impressive well evidenced document. These guidelines refer mainly to non-cardiac surgery. The specialty of Cardiothoracic Surgery does include the subspecialty of Thoracic Surgery which falls into the category of non-cardiac surgery. I note also that there was a Consultant thoracic Surgeon [redacted] [redacted] on the Guideline development group. The guidelines are well evidenced should provide a good basis for the development of a substantive document that should guide preadmission practice and management of non-cardiac cardiothoracic patients.	
The Society and College of Radiographers	General			The Society and College of Radiographers have no comments to make. All seems OK from our perspective.	Thank you for your response.
UK Clinical Pharmacy Association (UKCPA)	Full	14	10	We are concerned that this implies that no consideration of drug therapy is made when determining whether a full blood count is required. Patients who are ASA2 with co-morbidities may include patients who are warfarinised etc. and there is no indication/exception mentioned in the guidance that drug therapy ought to be considered when deciding whether a full blood test is required.	Thank you for your comment. While several drugs may result in subtle changes to full blood count, detecting these changes is unlikely to alter outcome or clinical management. More significant changes are likely to result in symptoms which would be reflected in a patient's ASA grade and would independently prompt testing. However, clinical

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				Without such consideration patients receiving certain drug therapy that may alter fbcs will not be identified and adequate pre-operative measures cannot be taken.	judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. Therefore we have now included the following additional recommendation: **Take into account any medicines people are taking when considering whether to offer any preoperative test.**
UK Clinical Pharmacy Association (UKCPA)	Full	15	1	As above; it is imperative that a patient's current drug therapy and its potential for alteration of renal function is a part of the consideration as to whether kidney function tests are required. We are concerned that assessing a patient, isolated from their drug therapy may result in necessary changes to therapy (e.g. for patient safety/optimising drug therapy) being missed and subsequently hindering the surgical outcomes and subsequent recovery.	Thank you for your comment. Patients taking certain drugs (for example lithium) would be undergoing monitoring. Information about altered renal function would therefore be known and should be available, so additional testing would not be required. Furthermore the guideline recommends that results from tests undertaken in primary care should be included within the referral information. In the case of minor surgery, homeostasis would not be altered to such a degree that subtle abnormalities alter the outcome or clinical management. However, clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. Therefore we have now included the following additional recommendation: **Take into account any medicines people are taking when considering whether to offer any preoperative test.**
UK Clinical Pharmacy	Full	15	8	The term 'monitor them at point of care' needs clarifying. Does this mean at pre-assessment or on admission?	Thank you for your comment. The GDG agreed that the wording of this recommendation is ambiguous

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Association (UKCPA)				Patients taking anticoagulants will require input to their care prior to their admission to ensure patients are admitted with an INR safe for surgery and appropriately anticoagulated (by low molecular weight heparins etc.) whilst not taking their regular anticoagulation medicines. Without such input surgeries may be cancelled, patients admitted for longer than necessary prior to surgery. This is a national issue demonstrating input at pre-assessment is needed.	and agreed to add further detail to clarify the recommendation. The recommendation has therefore been amended to the following: **Consider haemostasis tests in people with chronic liver disease having intermediate or major/complex surgery.** • **If people taking anticoagulants need modification of their treatment regimen, make an individualised plan in line with local guidance.** • **If clotting status needs to be tested before surgery (depending on local guidance) use point of care testing.[2]** **[2. Note that currently the effects of direct oral anticoagulants (DOACs) cannot be measured by routine testing.]**
UK Clinical Pharmacy Association (UKCPA)	Full	27	section 12	We feel an outcome not included is - a change in drug therapy	Thank you for your comment. Change in management was specified in some protocols where the GDG prioritised it. Change in drug therapy would be included as a subset within this.
UK Clinical Pharmacy Association (UKCPA)	Full	28	Chapter 14.1 intervention	An important outcome of such testing is the optimisation of a patients drug therapy resulting in improved surgical outcomes.	Thank you for your comment. Change in management was specified in some protocols where the GDG prioritised it. Change in drug therapy would be included as a subset within this.
UK Clinical Pharmacy Association	Full	120	18	As above	Thank you for your comment. As per the response to comment 21, change in management was specified in some protocols where the GDG

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(UKCPA)					prioritised it. Change in drug therapy would be included as a subset within this.
UK Clinical Pharmacy Association (UKCPA)	General	General	General comment	Existing good practice is the consideration of a patient's drug therapy when deciding if certain tests are needed, especially in relation to full blood count, clotting screens and kidney function tests. This does not seem to be the case throughout the guideline rather implying a decision 'to test' is being made on the ASA in isolation of other factors. This is something that needs to be made clear to readers and to encourage them to consider patients drug therapy as an important aspect of a patients needs at pre-assessment. Many of the studies included demonstrate that certain drug therapy will alter test results and needs to be considered. To overcome this the UKCPA are developing guidelines on the perioperative management of medicines, perhaps this could be something to which professionals could be signposted.	Thank you for your comment. A patient's drug therapy is reflected to a degree by their ASA grade, which is a key consideration when determining whether a test is necessary. However, clinical judgement should be used in all cases to consider individual circumstances and make decisions that are appropriate to the individual patient. Therefore we have now included the following additional recommendation: **Take into account any medicines people are taking when considering whether to offer any preoperative test.** Thank you for the notification of the development of your guideline. However, we are only able to signpost to other NICE guidance.

Registered stakeholders