Position statement

Anaesthesia for Gastroenterological Procedures

Preamble

Anaesthesia for gastroenterological procedures incorporates techniques variously referred to as analgesia, sedation and general anaesthesia. There is a continuum from sedation through to general anaesthesia. The level of sedation may vary depending on the degree of procedural stimulation, the doses and timing of the drugs administered[1], and patient factors. There is a clear difference in terms of risk and need for skilled intervention between conscious (also called mild to moderate) sedation where the patient still responds purposefully to tactile and verbal stimuli, and deeper sedation/general anaesthesia.

The anaesthesia administered is determined by practitioner and patient preference and the nature of the planned procedure. For example, the performance of flexible sigmoidoscopy may be facilitated by analgesia alone, colonoscopy may be facilitated by 'sedation', but therapeutic upper gastroenterological procedures may require general anaesthesia. With advances in endoscopic equipment and techniques and the advent of endoscopic ultrasound there is an increasing range of interventional endoscopic procedures that are longer in duration, more complex and mostly require deep sedation or general anaesthesia.

In Australia, the majority of patients wish to be 'unaware'. This is commonly achieved by 'sedation' with a benzodiazepine/opioid/propofol drug sequence – a recent survey of Australian anaesthetists suggest propofol is nearly always part of the anaesthesia administered[2]. When propofol is used for anaesthesia for gastroenterological procedures, the ASA believes that general anaesthesia is a frequent end point[3].

The use of sedation for colonoscopy has been shown to improve visualisation for the proceduralist and increases the rates of successful completion/caecal intubation[4]. There is also some evidence that the use of propofol leads to increased patient satisfaction and faster recovery and discharge times[5].

The ASA believes that the successful completion of gastroenterological procedures is facilitated by the presence of an anaesthetist.

Principles

The ASA endorses the following principles for Anaesthesia for Gastroenterological Procedures:

1. Gastroenterological procedures may be successfully completed with a variety of anaesthetic techniques.
2. Two medical practitioners should be present if propofol, propofol analogues, or other general anaesthesia agents are used to facilitate the gastroenterological procedure.
3. The practitioner administering propofol or other agent (as detailed in [2] above) should be a credentialled medical practitioner with a scope of practice incorporating anaesthesia. As per ANZCA PS 9[6], as a minimum standard non-anaesthetist medical practitioner wishing to provide analgesia or 'sedation' should have received appropriate training, which includes airway and resuscitation skills.
4. An assistant must be exclusively available for the anaesthetist when deep sedation or general anaesthesia is planned, for patients in ASA classes 3, 4, and 5, and for those having complex procedures e.g. therapeutic upper gastroenterological procedures.
5. An assistant must otherwise be exclusively available for the anaesthetist if requested by the anaesthetist.
6. When propofol is used to facilitate the gastroenterological procedure, all ANZCA documents relating to the provision of general anaesthesia should be observed.

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References

1. Committee on Quality Management and Departmental Administration (2014), 'Continuum of depth of sedation: Definition of general anaesthesia and levels of sedation / analgesia', *American Society of Anesthesiologists*, accessed November 28th, 2015, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia
2. Leslie K, Allen ML, Hessian E, Lee AY-S (2016), 'Survey of anaesthetists' practice of sedation for gastrointestinal endoscopy', *Anaesth Intensive Care*, 44(4):491-497.
3. *ASA News* (2009), 'Gastroenterology sedation: what anaesthetists believe', published July 2009.
4. Radaelli F, Meucci G, Sgroi G, Minoli G (2008), 'Technical performance of colonoscopy: the key role of sedation/analgesia and other quality indicators', *Am J Gastroenterol*, 103(5):1122-1130.
5. Singh H, Polua W, Cheang M, Choptain N, Inegbu E, Baron K, Taback SP (2008), 'Propofol for sedation during colonoscopy', *Cochrane Database of Systematic Reviews* 2008 Issue 4 Art no: CD006268 (updated 2011), accessed August 26th, 2019, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006268.pub2/full
6. ANZCA PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures (2014), accessed August 26th, 2019 http://www.anzca.edu.au/resources/professional-documents

* ANZCA documents relating to the provision of general anaesthesia can be accessed at http://www.anzca.edu.au/resources/professional-documents

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