SUBJECT: EGS/TRAUMA INTRAOPERATIVE CONSULTATION GUIDE **PAGE:** 1 of 6
UPDATED: 9/2019; 10/2022 **EFFECTIVE:** 10/6/2022

RECOMMENDATION(S): N. Bruce, MD **APPROVAL:** 10/6/2022
CONCURRENCE(S): Trauma/EGS Faculty

BACKGROUND:

It is commonplace that general surgery is consulted for intra-operative assistance during procedures conducted by other surgical services. The Acute Care Surgery team always has at least one surgeon in-house at all times and we will strive to accommodate all requests for intra-operative assistance. However, 24/7 availability is not always guaranteed due to a wide variety of high-acuity clinical responsibilities for the on-call surgeon. When possible, it is reasonable to ask that procedures with anticipated need for intra-operative assistance be performed during "regular" working hours (Monday – Friday, 0700 to 1700) because there are more surgeons in-house from the Acute Care Surgery team to distribute the burden.

PROTOCOL:

Pre-operative consultation:

This includes planned elective procedures (such as common procedures like VP shunt assistance or surgical feeding access for ENT head/neck resections) and inpatient consultations (such as emergent/urgent VP shunts, assistance with bowel evaluation or abdominal wall reconstruction). If given sufficient notice and delay would not cause patient harm, it is reasonable to ask that such procedures be performed during regular working hours.

- It is expected that a representative from the general surgery team (resident, APRN, or attending) see the consult, perform, and document a H and P.
    - Exceptions will be made for surgeries with less than 1 hour notice (i.e. a level 1 emergency).
    - This should include a thorough, documented surgical history and physical exam.
- A separate consent for anticipated general surgical portion of the procedure should be completed, if feasible.
- A separate brief op note and op note should be dictated for the general surgery portion of the procedure.
- The default attending assigned to this consult will be the EGS on-call attending.
    - In the event that they are unavailable, the responsibility will fall to the trauma attending, the SICU attending, and then the back-up attending (in that order).
- If the EGS attending anticipates not being available (for example, due to concurrent cases or scheduling conflict), it is expected that they will discuss this directly with the next attending in line, when feasible.
- It is expected that the EGS resident complement be informed of any planned intra-operative assistance consults by the EGS attending, and vice-versa.
- Like all consults for the EGS team, the resident complement is expected to actively take part in the pre-operative planning, the operation (as delegated by the chief resident on service), and the post-operative care for these patients.

Intra-operative consultation:
This includes consults for which the patient is already in the OR, or proceeding to the OR within the hour (as a level 1 emergency).

- A separate, pre-existing H and P from the EGS team is not needed and not feasible before proceeding.
    - However, a documented consult note should be filed by a member of the Acute Care Surgery team post-hoc, when possible.
- The default attending for all intra-operative consults is the EGS on-call attending.
    - In the event that they are unavailable, the duties will fall to the trauma attending, the SICU attending, and then the back-up attending.
    - On nights, the back-up attending will be called in if the primary attending is unavailable.
- It is expected that the EGS resident complement be informed of any intra-operative assistance consults by the EGS attending, and vice-versa.
- Like all consults for the EGS team, the resident complement is expected to actively take part in the operation (as delegated by the chief resident on service), and the post-operative care for these patients.