

Manual M-2, Professional Services. Part XIV, Surgical Service

Chapter 1, Surgery (Paragraphs 1.01 through 1.03)

Revises Chapter 1 through Change 26 dated December 23, 1976

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PART XIV

M-2

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY MANUAL

PROFESSIONAL SERVICES



PART FOURTEEN

SURGICAL SERVICE

WASHINGTON 25, D. C.

NOVEMBER 20, 1955

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WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

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RESCISSIONS

This manual rescinds the following material.

1. COMPLETE RESCISSIONS

a. Manuals

M-2, part XIV, chapter 5, change 14, dated May 31, 1967.

b. Interim Issues

- II 10-177
- II 10-66-47
- II 10-77-42

c. Circulars

- 10-62-81
- 10-64-178
- 10-84-124
- 10-91-083

d. Regulations and Procedure

- 6210
- 6371
- 6808(A)

e. Technical Bulletins

- TB 10A-96
- TB 10A-106
- TB 10A-182
- TB 10A-309
- TB 10A-345

f. All-Station Letters and/or Other Communications

Date	Subject
March 8, 1949	Administering of Spinal Anesthetics by Nurse Anesthetists
September 18, 1951	Recovery Rooms
June 19, 1953	Administering Spinal Anesthetics; Use and Abuse of CO ₂

2. PARTIAL RESCISSIONS

a. Manuals

Pars. 111, 112, and 114, chart XXXII and figs. 81, 83, and 84, M10-6.

RESCISSIONS--Continued

b. Circulars

Par. 4, sec. II, t Cir. 291, 1946

c. Technical Bulletins

TB 10A-272 (insofar as consent for surgery is concerned)

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CHAPTER 1. SURGERY

1.01 STATEMENT OF POLICY

a. The Surgical Service in hospitals will be established to provide service in the diagnosis, care, and treatment of patients assigned to the Surgical Service.

b. The age at which a person, other than members of the Armed Forces receiving hospital treatment under official authorization, may give consent for surgery will be the same as the governing law of the State where the VA hospital is located. See subsequent paragraphs for exceptions to the need for consent for surgery from members of the Armed Forces.

1.02 REQUIREMENTS FOR SURGERY

a. The following requirements will be met:

(1) Whenever feasible, patients requiring surgery will be admitted to a surgical ward.

(2) Consent for surgery will be obtained as follows:

(a) Consent From Patient

1. Except as provided in subparagraphs (b) and (c) below, consent will be secured from an adult patient, or a minor member of the Armed Forces receiving hospital treatment upon official authorization, by signature on SF 522, Authorization for Administration of Anesthesia and For Performance of Operations and Other Procedures, before a surgical operation is performed upon him.

2. Spinal puncture will not be performed without consent of the patient. Such consent may be obtained orally. However, a progress note will be recorded in the clinical record on the date oral consent is given, signed by the physician who obtained permission. The provisions of subparagraphs (b) and (c) below will apply when a patient is a minor or is unable to give informed consent for performance of a spinal puncture.

(b) Consent From Patient's Guardian of Person or Next of Kin

1. Consent of the patient's guardian of person or next of kin will be secured on SF 522:

a. If the patient is unconscious or a minor (other than a minor member of the Armed Forces receiving hospital treatment upon official authorization), or

b. If the patient has been adjudged incompetent by a court, and/or, as a result of a psychiatric disorder, is unwilling or unable to sign the authorization, or is incapable of comprehending the significance of such action or of exercising appropriate judgment.

2. In the case of lobotomy, an explanation of the possible complications, as well as the possible benefits, will be given to the patient if [the patient] is empowered to give consent, otherwise to the guardian of person or next of kin.

3. When SF 522 is transmitted by mail to the guardian of person or next of kin, it will be forwarded with an individually typewritten letter signed by a physician.

4. The obtaining of *written* permission from a guardian of person or next of kin, on SF 522, for administration of anesthesia and performance of operations and other procedures, including consent for performance of spinal puncture, is optional. Verbal permission, granted by telephonic communication which has been properly recorded on a plastic disk or belt, is acceptable permission. It is necessary, however, that the telephonic permission be preceded with a proper introduction, e.g., "This is Paul Brown, Chief of Orthopedic Surgery at the VA Hospital, (location). Am I speaking to Cathy E. Black, the wife of Lee A. Black?"

2-29 After a proper basis for introduction is laid, verbal permission would be conveyed by telephonic communication and recorded. [On receipt of the telephonic recording, an SF 522 with cover letter will be mailed to the next of kin for signature.] The original transcribed copy of the telephonic permission will be filed in the patient's medical records folder. After transcription, the recording will be clearly labeled to include patient's name, identification number, date, and identity of hospital. [The recording will be retained until such time as a signed SF 522 can be obtained from the next of kin or guardian using the procedure outlined in subparagraph 3, above. On receipt of the signed SF 522 from the guardian or next of kin, the recording can be disposed of in accordance with Records Control Schedule 10-1. The transcribed copy will be attached to the signed SF 522 and filed in the medical record.]

5. There is no legal distinction between a verbal permission (granted by telephonic communication and properly recorded on a plastic disk or belt) and one received by telegram. Hence a station may, if existing circumstances warrant, send notice of intended administration of anesthesia and performance of operative procedure, including spinal puncture, by telegram and obtain consent by telegram communication from the patient's guardian or person or next of kin. Permission granted by telegram also requires a proper introduction. The text of the message will, therefore, contain a proper introduction covering identification of the patient and the person granting permission, and specifically state the type of operative procedure, anesthesia, etc., to be performed or administered. The Chief of Medical Administration will be responsible for checking the accuracy of the names, identification data, and the gross content of the message. If it is not complete, it must be held out for completion by exchange of supplemental messages with the person authorized to grant such permission. The original copy of the completed telegram granting permission will be filed in the patient's medical records folder.

6. In those instances where there is no guardian of person, and the patient's next of kin, after having been thoroughly informed that a surgical operation or other procedure is necessary for the preservation of the patient's health or life, refuses to consent for the patient, the Director or other person acting in that capacity will solicit the advice of the [District Counsel.]

(c) **Consent From Director or Chief of Staff.** The Director, if a physician, or the Chief of Staff, or other physician acting in that capacity, may sign SF 522 as the person authorized to consent for the patient and will enter an appropriate notation on the form when the patient is not empowered to give consent, provided that a surgical operation is necessary for the preservation of the patient's health or life, and

1. The patient has no guardian or known next of kin, or
2. Time does not permit obtaining consent from the patient's guardian or next of kin. The guardian or next of kin will be notified as soon as practicable of the reasons for furnishing the treatment without awaiting consent.

(d) **Disposition of SF 522.** SF 522, when signed by the patient or the person authorized to consent for [the patient,] will be filed in the patient medical records folder or outpatient treatment folder.

(3) Before surgery, the following forms, if appropriate, will be completed: SF's 508, 509, 510, 515, 516 and VA Form 10-2747. VA Form 10-2747 will be completed by 2 p.m. of day prior to operation.

(4) Before surgery and within a reasonable time, necessary hematological examinations will be made.

(5) On day of operation an examination will be made of the patient's heart and lungs with proper consultation, if indicated.

(6) The identity of the patient and the identity of the organ or side requiring operation will be established beyond doubt before proceeding with an operation.

(7) Immediately following the operation the surgeon will dictate his[/her] findings. [The surgeon] will be responsible for review and approval of his[/her] dictated findings.

(8) All specimens removed at operation will be properly identified and promptly forwarded to the laboratory for examination. The accompanying information will be recorded on SF 515.

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b. No visitors, whether physicians or lay persons, including relatives of patients who are to be operated upon, will be allowed entrance to the surgical suite or recovery room except with permission of the Chief, or Acting Chief, Surgical Service.

c. The Chief, Surgical Service, will have the responsibility for carrying out the recommended standards and regulations [set forth in applicable sections of Volume 2, "Gases," National Fire Codes, NFPA (National Fire Protection Association).]

d. Nurse anesthetists will not administer spinal, topical, or regional anesthetics, but they are not precluded from observing and caring for patients in whom a spinal or regional anesthetic has been induced by a physician.

e. Appropriate measures will be taken to prevent postoperative infections.

f. The operative findings and postoperative condition of patients on the seriously ill list will be reported to the Director, Professional Services.

g. (Deleted by change 4.)

h. The 24-hour period (from midnight to midnight) during which a surgical operation is completed will constitute the "day of operation." The succeeding 24-hour period, i.e., from midnight of the "day of operation" to the next midnight, will be the first day postoperative; the next midnight-to-midnight period, the second day postoperative, etc. The ending date of postoperative days will be determined by the Chief, Surgical Service, or his designee.

i. Nurse anesthetists may administer intravenous medication and blood during surgery or in the preoperative or postoperative period when such therapy is considered indicated by the physician in charge of the patient.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1123
Transmittal Sheet
March 27, 1998

~~NATIONAL ANESTHESIA SERVICE~~ ANESTHESIA SERVICE

- 1. REASON FOR ISSUE:** This handbook establishes the programmatic structure, policies and procedures that are to be used for the practice of anesthesia in the Veterans Health Administration (VHA).
- 2. SUMMARY OF CONTENTS/MAJOR CHANGES:** Policy has been revised to delineate more specificity for the policy and procedures for the anesthesiology services and sections in VHA facilities.
- 3. RELATED ISSUE:** None.
- 4. RESPONSIBLE OFFICE:** The Office of Patient Care Services (111L) is responsible for the contents of this VHA handbook.
- 5. RECISSIONS:** M-2; Part XIV, Paragraphs 1.02.1 – 1.02.3; Changes 17 and 20, are rescinded.
- 6. RECERTIFICATION:** This document is scheduled for recertification on or before the last day of March 2003.

S/Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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~~j. The administration of blood will at all times be safeguarded by a rigid observance of the procedure mandated in DM&S Manual M-2, Part I, "General," chapter 12.~~

1.02.1 TOPICAL ANESTHESIA FOR LARYNGOSCOPY, BRONCHOSCOPY, BRONCHOGRAPHY, BRONCHIAL ASPIRATION, AND GASTROSCOPY

a. **[Topical Anesthetic Agents.]** Drugs commonly used for topical anesthesia of the pharynx, larynx, and trachea are [(Pontocaine), tetracaine hydrochloride; (Xylocaine), lidocaine hydrochloride; (Cyclaine), hexylcaine] and cocaine hydrochloride. All are extremely potent agents and may produce [both typical and atypical untoward] reactions if used in excessive doses [(relative or absolute),] if administered too rapidly, or if used in hypersensitive, [allergic or intolerant] individuals.

- (1) Toxic effects of topical anesthetic agents are closely related to the amount (volume times concentration) of the anesthetic agent given, the rate of administration, and subsequent absorption.
- (2) Information on the toxicity and other characteristics of various topical anesthetic agents can be obtained from such sources as a drug compendium, standard medical textbooks of pharmacology, anesthesiology, the National Formulary, "New Drugs," and the package insert.
- (3) Typical untoward reactions to commonly used topical anesthetics are noted below. (For further information regarding atypical reactions see references in subpar. (2) above.)

NOTE 1: **[TETRACAINE.]** An untoward reaction to [tetracaine] is exhibited by pallor, slow or rapid pulse, muscular twitchings, and generalized convulsions [and/or other signs of CNS (central nervous system) stimulation or depression. With instances of over-dosage, hypersensitivity, allergy or other untoward reactions the following may occur: spasm of the thoracic cage and laryngeal musculature (preventing respiratory exchange), central respiratory failure, varying degrees of cardiac depression with or without abnormal rhythms, ventricular depression, tachycardia fibrillation, cardiac arrest, and peripheral vascular depression. Such patients rarely exhibit prodromal signs or symptoms of anxiety, excitement, and garrulousness unless there is a condition of marginal over-dosage or slow absorption. With massive over-dosage, extreme hypersensitivity or too rapid absorption, cardiovascular collapse may occur without any sign of central nervous system excitation. CNS depression is, however, usually present and is seen as unconsciousness, relaxation and cardiorespiratory depression.]

hy chg. 20
 NOTE 2: **[LIDOCAINE.]** An untoward reaction to [lidocaine] may ~~not~~ be signaled by cerebral excitation ^{but instead} [by] cerebral depression, denoted [by an initial appearance of drowsiness. During this depression phase, a] patient may remain unresponsive to questioning for one half to three quarters of an hour [or longer] without exhibiting wide variations of pulse, respiration and blood pressure. [Amnesia is often present. If convulsions occur, they may persist for some time since the drug is not hydrolyzed by the esterases in the plasma. With time and the subsequent mobilization, distribution and metabolism of the drug, the patient will return to normality without residual sequela.]

NOTE 3: **[HEXYLCAINE.]** An untoward reaction to [hexylcaine] occurs infrequently but follows a pattern similar to that [of tetracaine hydrochloride producing first cerebral and medullary stimulation] followed by depression and cardiovascular collapse.

NOTE 4: **[COCAINE.]** An untoward reaction to cocaine hydrochloride is [commonly] manifested by apprehension, anxiety, excitement, garrulousness, confusion, pallor, rapid thready pulse, shortness of breath, and convulsions with loss of consciousness. If [excessive quantities are] absorbed rapidly, collapse may occur without [any clinically noticeable] prodromal signs and symptoms. Death is usually due to cardiovascular failure probably engendered by direct action of the drug on the myocardium.

b. Choice [and Amount of Topical Anesthetic] Drug

- (1) Question each patient for a history of hypersensitivity, [allergic or untoward response to anesthetic] drugs. When patients give a history of

asthma, hay fever, or allergic reactions to food or drugs, USE ONLY THE MINIMAL EFFECTIVE CONCENTRATION AND DOSE OF THE SELECTED ANESTHETIC AGENT [IN AS SMALL INCREMENTS AS POSSIBLE OVER AS LONG A TIME AS FEASIBLE.] Patients considered poor physical risks tolerate topically applied anesthetic agents poorly and for them the total dose [also should be held at a minimum.] If a patient gives a history of untoward reaction to [an anesthetic] drug used on a previous occasion, it is recommended that another [type of] anesthetic agent [in a different chemical group or family] be selected for the procedure [being considered. This second topical anesthetic should be an entirely different chemical structure and classification in order to lessen the probability of a reaction.]

- (2) [With topical anesthetic agents a definite latent period is required for the onset of anesthesia--sometimes as much as 5 to 10 to 15 minutes. One should wait until the prescribed amount of anesthetic has had enough time to become established before assuming that an insufficient quantity of drug has been used and administering an additional quantity of anesthetic agent.]
- (3) [The following dosages apply to an average sized youthful adult. In prescribing the amount of topical agent to be administered to the individual patient, appropriate adjustments must be considered for age, weight, disease states, drug sensitivities, prior and concomitant treatment with other drugs. The dose absorbed will be less than the quantity of drug contained in the volume of anesthetic agent measured out for each individual patient. It is recommended that topical anesthesia should be administered only by those who are knowledgeable and experienced in the techniques of administering anesthetic agents and the treatment of untoward reaction by means of the following appropriate procedures, drugs and ventilatory equipment which should be immediately available. In general select one of the four agents listed below, on the basis of familiarity with the specific agents:
 - (a) Tetracaine hydrochloride (Pontocaine) will be used in a concentration not exceeding 1.0 percent with the total amount employed not exceeding 50 milligrams (5.0 cc. of a solution containing Pontocaine in a 1.0 percent concentration, or an equivalent volume of a more dilute solution). In only those rare instances where both deeper penetration and more profound anesthesia are mandatory, the 2.0 percent solution may be necessary. It will then be utilized with due consideration for the resultant increase in tetracaine blood level concentration, and probability of reaction. Awareness of the total topical anesthetic dosage administration and absorption rates and blood level concentration is vital. The total dosage must always be considered in terms of (1) its rate of absorption, which is in turn dependent upon the anesthetic drug concentration in the applied solution (the more concentrated drug being absorbed at a faster rate), the surface area and vascularity of the body organ to which the drug is applied, (2) the resultant circulating blood level concentrations of the anesthetic drug, and (3) the concentration and effect of the drug at various effector sites within the heart and CNS, etc.
 - (b) Lidocaine (Xylocaine) hydrochloride may be used topically in concentrations not exceeding 4.0 percent with the total amount employed not exceeding 200 mg. (5.0 cc. of solution containing Xylocaine in 4.0 percent concentration or an equivalent larger volume containing Xylocaine in a lesser concentration).
 - (c) Hexylcaine (Cyclaine) may be used in a concentration not exceeding 5.0 percent with the total amount employed not exceeding 250 mg. (5.0 cc. of solution containing Cyclaine in 5.0 percent concentration

or an equivalent larger quantity containing Cyclaine in a lesser concentration).

- (d) Cocaine hydrochloride may be used in a concentration not exceeding 10.0 percent with the total amount employed not exceeding 200 mg. (2.0 cc. of solution containing Cocaine in 10.0 percent concentration or an equivalent larger volume of a lesser concentration). A 4.0 percent Cocaine solution is quite effective. The same factors that apply to other local anesthetics also apply to Cocaine as far as the brain and heart are concerned. Historically, Cocaine has been a dangerous drug and its use, as well as the use of all other topical anesthetic agents, should be limited to physicians familiar and experienced with its properties, actions, and management of its untoward effects.]

c. Preanesthetic Preparation and Preliminary Medication

- (1) The oral or rectal administration of a barbiturate either pentobarbital (Nembutal) or secobarbital (Seconal) 2 hours prior to establishment of topical anesthesia may be recommended. The barbiturate may be given intravenously at a reduced dose level in the event there will not be a lapse of 2 hours between the decision to undertake laryngoscopy, bronchoscopy, or esophagoscopy and the performance of any of these procedures. The dose of either barbiturate should be varied to meet varying conditions of age, weight, and degrees of debility. It is seldom that a dose larger than the recommended hypnotic dose is necessary. Barbiturates may be given if necessary for sedation. Since barbiturates only partially obtund reactions to topical anesthetic agents, the administration of a barbiturate should not be considered as a complete safeguard against an untoward reaction.
- (2) If a necessity for pain relief, sedation, or sleep still exists; the subcutaneous administration of morphine sulphate grains 1/6 (10.0 mg.) and atropine sulphate grains 1/150 (0.4 mg.), 1 hour prior to surgery to the average 150-pound adult may be indicated. Meperidine HCL (Demerol) 50 mg. may be substituted for morphine if it is considered necessary to avoid the nausea that morphine might produce in susceptible individuals.
- (3) Withhold food for 4 hours prior to induction of anesthesia; and food and fluids for 3 hours after instrumentation. Fluids, as well as food, should be withheld after instrumentation inasmuch as the paralysis of the laryngeal reflex might permit aspiration of fluids which the patient attempts to drink.]

d. Methods of Production of Topical Anesthesia--Anesthetic Administration--Observation of the Anesthetized Patient

- (1) Apply the selected anesthetic agent solution by means of a curved pharyngeal applicator equipped with a firmly fixed pledget of absorbent cotton. Pledgets should be moistened with the anesthetic solution and any excess solution from the pledget should be squeezed back into the container holding the original prescribed amount of solution.
- (2) The use of a single agent is recommended. In any sequential combination of different anesthetic agents, the additive effects must be considered. Mixtures of two or more agents in the same solution are not recommended.
- (3) The use of anesthetic solutions as gargles are fraught with extreme hazard because of the relative large quantities, and because of the fear of inadvertently swallowing of the drug with subsequent absorption. The use of a gargle technique is to be discouraged in general.

- (4) Administration of the selected agent in solution by means of a spray IS DISCOURAGED; but if a spray is used the atomizer must be of a type specifically designed for topical anesthesia. Its reservoir of 10 cc. maximum capacity must be calibrated in milliliters (cc.) so that dosage may be easily approximated to within one-quarter of a cc. Droplets released upon compression of the bulb should not be smaller than 30 microns or larger than 100 microns. The volume of solution expelled should not exceed 1.0 cc. with each 25 manual compressions of the bulb. Record the amount used and the time utilized in administering the drug. Mechanical means to provide air pressure should be avoided because of the hazard of inadvertent over-dosage.
- (5) As a final maneuver, with the patient in the sitting or semireclining position, instill up to 2 cc., in appropriate increments, of the selected anesthetic solution into the trachea by means of a curved laryngeal canula attached to a syringe. Take into consideration previously administered amounts of topical anesthetic agent. In accomplishing this intratracheal instillation maneuver, the patient may be asked to hold his tongue in the extended position while the anesthesiologist or endoscopist visualizes the larynx with a laryngeal mirror and thus assures himself that the anesthetic solution ejected from the laryngeal syringe actually has entered the trachea. Following successful instillation, and after a pause while the fluid trickles down to the carina, the patient will cough. Failure to cough, or coughing without a preceding pause, should lead one to suspect that the fluid entered the esophagus. Warn the patient to expectorate any free fluid in the pharynx. The final maneuver of instilling anesthetic solution into the trachea should be omitted as a preliminary to esophagoscopy and gastroscopy. It is during this intratracheal administration that over-dosage frequently occurs. Careful attention to total quantities given, allowance of sufficient time for the anesthetic to take effect, and close attention to the patient's vital signs are necessary procedures to reduce the incidence of untoward reactions.
- (6) Whenever the room is partially darkened, the patient should be checked from time to time for character and rate of his pulse and respiration and circulation. Any changes of import or evidence of untoward reaction, warrant institution of immediate remedial treatment, with discontinuance of the endoscopic procedure.]

e. [Treatment of Untoward Reactions

(1) Drugs and Equipment

- (a) An anesthetic gas machine (or two cylinders of oxygen with functioning bag and mask attachment for intermittent positive pressure administration of oxygen) or an AMBU or similar type of equipment for providing adequate respiratory ventilation.
- (b) A pharyngeal airway of the Guedel type, or Safar's modification to facilitate mouth to mouth resuscitation or its equivalent.
- (c) A syringe of 20 cc. capacity containing thiopental (Pentothal) in solution of 2.5 percent concentration for controlling convulsions. If thiopental (Pentothal) is not available, an aqueous solution of secobarbital (Seconal) or pentobarbital (Nembutal) would be in good order. These latter two short-acting barbiturates have a latent period of several minutes. One should therefore fractionate the quantity of these barbiturates and should not exceed 100-125 mg. of barbiturates unless the convulsions persist. (Note: Anoxic episodes may also produce convulsions.) Oxygen via assisted or controlled respiration with or without a relaxant is preferred to the barbiturates since in most instances convulsions are of short duration. The convulsions

are usually followed by CNS depression which is deepened by barbiturates. Therefore, use only a minimal quantity of barbiturates, being aware of the delay in the onset of their action.

(d) An endotracheal tube (#7 for the average adult) equipped with a metal bite protector.

(e) A flashlight for observation of the patient in the darkened room and a laryngoscope for introduction of an endotracheal tube.

(f) Tracheostomy set, vasopressor, succinylcholine, aspiration catheters and aspiration equipment, blood pressure cuff and other emergency operating room setup as may be prescribed in the local hospital rules and procedures.

(g) A blood pressure cuff should be in place on the patient's arm in order to note the patient's blood pressure and pulse, prior to and during the instrumentation period.

(h) An arrangement for the intravenous administration of fluids is desirable especially in the poor risk patient or the patient receiving relatively large quantities of local anesthetic agent.

(i) A clock with a second hand or its equivalent ideally should be available.

(2) **Procedures.** Personnel applying anesthetic drugs topically should be prepared to treat the patient immediately.

(a) In the presence of untoward reaction exhibited by pallor, changes in CNS function, cyanosis, or thready pulse, instruct the patient to breathe deeply and/or administer oxygen preferably by either the assisted or controlled respiration technique. In addition, [elevate the legs 45 degrees but keep the body flat. This will increase the blood volume to the central circulation.] Intravenous fluids should be started, if not already running, at the first sign of an untoward reaction.

(b) In the presence of muscular twitchings, or any other changes in CNS function, discontinue the instrumentation immediately, establish and maintain an adequate airway and an adequate respiratory exchange. It may be necessary to insert [an] oral airway or [an S shaped] or similar mouth-to-mouth type [respiration device.] If twitchings continue, intravenously administer a short acting barbiturate in minimal concentrations (usually 2 or 3 cc. of 2.0 percent solution 40-50 mgm.).

(c) Where adequate knowledge of curare-type drugs is available, the Pentothal or other short acting barbiturates may be replaced by use of succinylcholine in minimum quantities necessary to control the convulsions. If succinylcholine is administered, **ADEQUATE RESPIRATORY EXCHANGE MUST BE MAINTAINED BY EITHER ASSISTED OR CONTROLLED RESPIRATORY TECHNIQUE.** Usually it will be necessary to provide immediate, adequate and continuous respiratory exchange by means of assisted, controlled, mouth-to-mouth or other artificial ventilation.

(d) In the presence of hypotension rapidly administer an adequate volume of fluids intravenously—normal saline, glucose in 5.0 percent concentration, plasma or blood, as indicated. Ephedrine or other positive inotropic vasopressors may be cautiously administered with intravenous fluids to treat the hypotension occurring with an untoward reaction to topical agents. Administration of an excessive amount of Epinephrine in the instance of an untoward reaction with Cocaine may produce ventricular fibrillation.

(e) Continue treatments with minimal amounts of barbiturate or succinylcholine and respiratory inhalational therapy as indicated until the anesthetic agent has been redistributed, untoward reaction ceases, sensorium becomes clear and respirations are adequate. Keep the patient under observation until [recovery] from the effects of the barbiturate and other drugs. Unconsciousness as a result of a local anesthetic reaching the brain may persist for several hours. During this time supportive therapy and constant observation must be continued until full consciousness returns.

(f) Should an untoward reaction progress to cardiac arrest, treat it by closed chest cardiac massage. If closed massage is not effective and it is deemed advisable, open massage should be used. This situation should be extremely rare.

(g) In some instances, narcotic antagonists may be useful to neutralize a previously administered narcotic. [The drug of choice is Naloxone. It has very few side effects or secondary depression effects. The dose for the average adult is 0.4 mgms. or 1 cc. injected intravenously or 0.8 mgms. or 2 ccs. injected intramuscularly.] Failure to obtain a response with [such a dose or with] similar agents is presumptive evidence that the depression is not due to a narcotic, and further administration of the antinarcotic should be discontinued.

(3) **Summary.** In summary, a thorough knowledge in the detection and management of reactions to local anesthetics is essential. Organizational procedures for immediately obtaining reasonable assistance and necessary equipment in the management of an untoward reaction should be known and understood prior to application of the anesthetic agent.

f. **Procedure if Initial Anesthesia Experience Contraindicates Instrumentation.** If the above method of anesthesia fails to provide adequate conditions to accomplish the intended instrumentation, discontinue any manipulation on that day. Where there is a history of reaction to or difficulty with topical anesthesia, adequate consultation and further evaluation with a competent anesthesiologist, chest physician, or allergist is indicated.

1.02.2 TOPICAL ANESTHESIA FOR URETHRA

a. Pontocaine hydrochloride used for topical anesthesia of the urethra has resulted in a number of reported untoward reactions.

b. The Council on Drugs of the American Medical Association calls attention to the fact that extreme caution is imperative when any local anesthetic is applied under conditions in which trauma to mucous membrane is likely to occur.

c. References in foreign literature to use of pontocaine hydrochloride urethrally indicate that it has been employed in a 0.1 or 0.2 percent solution. Solutions commercially available are in 1.0 and 2.0 percent concentration and, therefore, 10 times the strength of the suggested intraurethral dosages. It is evident that, if the weaker concentrations are employed, the risk which is always present in using any local anesthetic intraurethrally will be obviated or, at least, reduced. The Council on Drugs emphasizes that "one should use the smallest amount of the least toxic drug that will serve the purpose if reactions are to be avoided."

d. In addition to the strength of any injected solution, the rapidity of administration is another important factor. This factor is of special significance in urethral instillation since the total dose is usually injected at one time and retained. In the presence of trauma, rapid absorption can occur.

e. In view of the number of unfortunate reactions which have attended the administration of pontocaine hydrochloride urethrally, careful consideration will be given to all of the above factors in any instance in which it may be considered necessary to employ this drug.

July 29, 1970

M-2, Part XIV
Change 17

f. The following is quoted from New and Nonofficial Drugs, 1961, page 2, Local Anesthetics:

"Extreme caution also is imperative when any local anesthetic is applied under conditions in which trauma to mucous membrane is likely to occur. Hence, when local anesthetic drugs are being used, it is in the interest of safety to have instantly available (a) oxygen and the means of inflating the lungs with it or a means of artificial respiration intermittently and (b) a quick-acting barbituric acid compound prepared for intravenous administration."

g. It cannot be too strongly emphasized that in the use of any anesthetic, either within or outside the operating room, appropriate means should be immediately available to treat an untoward reaction.

1.02.3 POSTANESTHESIA FOLLOWUP AND RECORDING

a. Progress notes will include a postanesthesia followup, with findings recorded, signed by an anesthesiologist or registered nurse anesthetist.

b. The postanesthesia note will be made and timed to indicate that all effects of the anesthesia have worn off.

1.03 INSPECTION OF SURGICAL INSTRUMENTS

Inspection of surgical instruments for serviceability will be continuous. Broken or unserviceable surgical instruments will be returned to Supply Service for repair or replacement at suitable intervals.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1123
Transmittal Sheet
March 27, 1998

~~NATIONAL ANESTHESIA SERVICE~~ ANESTHESIA SERVICE

- 1. REASON FOR ISSUE:** This handbook establishes the programmatic structure, policies and procedures that are to be used for the practice of anesthesia in the Veterans Health Administration (VHA).
- 2. SUMMARY OF CONTENTS/MAJOR CHANGES:** Policy has been revised to delineate more specificity for the policy and procedures for the anesthesiology services and sections in VHA facilities.
- 3. RELATED ISSUE:** None.
- 4. RESPONSIBLE OFFICE:** The Office of Patient Care Services (111L) is responsible for the contents of this VHA handbook.
- 5. RECISSIONS:** M-2; Part XIV, Paragraphs 1.02.1 – 1.02.3; Changes 17 and 20, are rescinded.
- 6. RECERTIFICATION:** This document is scheduled for recertification on or before the last day of March 2003.

S/Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Distribution: **RPC: 1072**
FD

Printing Date: 3/98

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

10/22/82
M-2, Part XIV
Change 29

August 27, 1982

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: *The purpose of this change is to incorporate policies and procedures for informed consent into Part I, "General," Chapter 23, "Informed Consent."*

Page v: After paragraph 1.01, delete "1.02 Requirements for Surgery1-1".

Pages 1-1 through 1-2a and 3: Delete paragraph 1.02.



DONALD L. CUSTIS, M.D.
Chief Medical Director

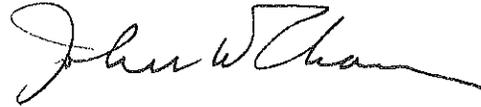
Distribution: RPC: 1038
FD

December 23, 1976

Part XIV, "Surgical Service," VA Department of Medicine and Surgery M-2, "Professional Services," is changed as indicated below:

The purpose of this change is to provide policy for the retention of telephonic recording media.

Pages 1-1 and 1-2: Remove these pages and substitute pages 1-1 and 1-2 attached.



JOHN D. CHASE, M.D.
Chief Medical Director

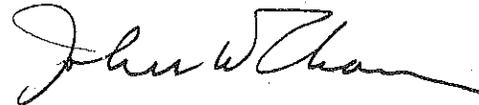
Distribution: RPC: 1038
FD

February 3, 1975

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

NOTE: The purpose of this change is to update instructions regarding topical anesthesia for laryngoscopy, bronchoscopy, bronchography, bronchial aspiration, and gastroscopy in keeping with latest developments.

- ✓ Page iii, paragraph 1c, line 3: Add change "15,".
- ✓ Page 3, paragraph 1.02.1a, NOTE 2
- ✓ Line 1: Delete "not" and insert "follow the prototype of tetracaine and".
- ✓ Line 2: Delete "but instead" and insert "or".
- ✓ Pages 4b.1 and 4b.2: Remove these pages and substitute pages 4b.1 and 4b.2 attached. (Par. 1.02.1e(2) (a), (b) and (g) changed.)
- ✓ RESCISSION: Change 15, M-2, part XIV.



JOHN D. CHASE, M.D.
Chief Medical Director

Distribution: RPC: 1038
FD

January 31, 1973

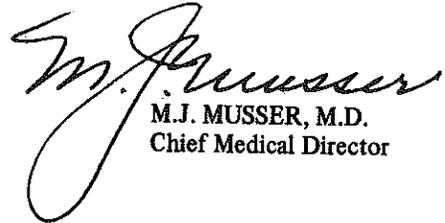
Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: The purpose of this change is to:

- a. Provide that the age at which a person may give consent for surgery agrees with State laws in which the hospital is located; except competent minor members of the Armed Forces receiving hospital treatment under official authorization may give consent.
- b. Update references to standards and regulations for fire protection.
- c. Provide that the consent of live organ donors be subject to the anatomical gift laws or other applicable laws of the State where the VA hospital is located.
- d. Provide that existing standard consent forms be used to give consent for anatomical gifts.
- e. Provide that the attending physician counsel donors and recipients of anatomical gifts as to the nature of, and risks involved in, transplantations and that he document the medical record accordingly.

✓ Pages 1 through 2a: Remove these pages and substitute pages 1-1 through 1-2a attached. (Par. 1.01 changed.)

✓ Pages 7-3 and 7-4: Remove these pages and substitute pages 7-3 through 7-4a attached. (Par. 7.03b (3), (4), and (5) changed.)


M.J. MUSSER, M.D.
Chief Medical Director

Distribution: RPC: 1038
FD

July 29, 1970

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

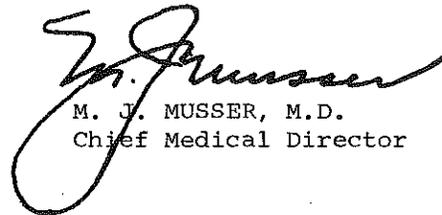
NOTE: The purpose of this change is to update instructions regarding topical anesthesia for laryngoscopy, bronchoscopy, bronchography, bronchial aspiration, and gastroscopy in keeping with latest developments.

Page iii, paragraph 1c: Add:

"Changes 1 through 3, 5 through 8 and 12, M-2, part XIV".

Pages 3 through 4b.1: Remove these pages and substitute pages 3 through 4b.3 attached. (Par. 102.1 changed.)

RESCISSIONS: Changes 1 through 3, 5 through 8 and 12, M-2, part XIV.



M. J. MUSSER, M.D.
Chief Medical Director

Distribution: RPC: 1038
FD

Revised by chg 20, 2/3/75

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-2, Part XIV
Change 15

June 23, 1967

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

NOTE: The purpose of this change is to establish a new policy providing for the acceptability of verbal permission (granted by telephonic communication and properly recorded on a plastic disk or belt) or telegram as consent for administration of anesthesia and performance of surgical operations and other procedures. Heretofore written permission was required from patient's guardian of person or next of kin whenever the patient was incapable or, as a result of a psychiatric disorder, unwilling to consent to a procedure.

chg 19 ✓ Pages 1 and 2: Remove these pages and substitute pages 1 through 2a attached. (Par. 1.02a(2) changed.)

H. M. Engle

H. M. ENGLE, M. D.
Chief Medical Director

Distribution: RPC: 1038
FD

✓ NOTE: Changes 1, 2, 3, 5, 7 and 8 have been completely absorbed and may be disposed of in accordance with DM&S Records Control Schedule 10-1.

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-2, Part XIV
Change 13

July 23, 1965

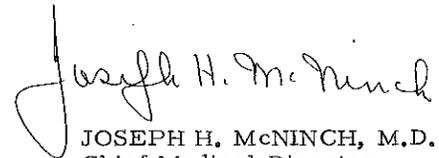
Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: Chapter 5 is revised to provide a uniform means for summarizing specific activities relating to surgery and anesthesiology in order to serve the professional needs of Central Office.

✓ Pages iii through v: Remove these pages and substitute pages iii through vi attached. (Contents pages brought up to date.)

chg 15 ✓ Page 1, paragraph 1.02a(2)(a) (annotation made by change 2): Delete "paragraph 1.05b" and insert "paragraph 2.08e(2)".

✓ Pages 7 through 15: Remove these pages and substitute pages 7 through 10 attached. (Ch. 5 revised; figs. 1 and 4 deleted.)


JOSEPH H. McNINCH, M.D.
Chief Medical Director

Distribution: Same as M-2, part XIV
FD DVB Publications Code 1038

August 20, 1964

Resc by change 24

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: This change adds a new paragraph 1.02.3, "Postanesthesia Followup and Recording," and incorporates the provisions of DM&S Circular 10-64-178.

- chg 10* ✓ Page iii, paragraph 1g: Add "Cir. 10-64-178".
- chg 12* ✓ Page iv: Under paragraph 1.02.2 insert the following:
"1.02.3 Postanesthesia Followup and Recording - - - - - 4b.1"
- chg 17* ✓ Page 4b.1: Remove this page and substitute page 4b.1 attached. (Par. 1.02.3 added.)
- ✓ Page 17: Remove this page and substitute page 17 attached. (Par. 6.01c changed.)

Joseph H. McNinch
JOSEPH H. McNINCH, M. D.
Chief Medical Director

Distribution: Same as M-2, Part XIV
FD

rescinded by Change 17

29 July 1970

*M2-14, ch
17 Resc
Cancelled*

Department of Medicine and Surgery
Veterans Administration
Washington 25, D.C.

M-2, Part XIV
Change 6

August 21, 1961

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: This change adds a new paragraph 1.02.2, "Topical Anesthesia for Urethra."

chq. 12 --- Page iv: Under "1.02.1" add:

"1.02.2 Topical Anesthesia for Urethra- - - 4b".

chq. 14 --- Pages 4a and 4b: Remove these pages and substitute pages 4a through 4b.1 attached.
(Par. 1.02.2 added.)

Wm. Middleton
WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Distribution:

Same as M-2, Part XIV

*Rec'd by
change 17*

November 14, 1958

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: This change adds a new paragraph 1.02.1, "Topical Anesthesia for Laryngoscopy, Bronchoscopy, Bronchography, Bronchial Aspiration, and Gastroscopy."

chg. 12 → Page iv: Under chapter 1, between lines 2 and 3, paragraphs 1.02 and 1.03, insert a new paragraph as follows:

✓ "1.02.1 Topical Anesthesia for Laryngoscopy, Bronchoscopy, Bronchography, Bronchial Aspiration, and Gastroscopy - - - - - 3".

chg. 15 → Page 2, paragraph 1.02: Delete subparagraph g.

Pages 3 and 4: Remove these pages and substitute pages 3 through 4c attached. (Par. 1.02j changed as directed by change 3; par. 1.02.1 added.)



WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Distribution:

Same as M-2, Part XIV.

Department of Medicine and Surgery
Veterans Administration
Washington 25, D. C.

M-2, Part XIV
Change 3

May 5, 1958

absorbed

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

ch 4

Page 3, paragraph 1.02j, lines 2 and 3: Delete "part VI, 'Pathology and Allied Sciences Service', DM&S Manual M-2." and insert "DM&S Manual M-2, Part I, 'General,' chapter 12."

Wm. Middleton

WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Distribution:

Same as M-2, Part XIV

rescinded change 17

Department of Medicine and Surgery
Veterans Administration
Washington 25, D. C.

M-2, Part XIV
Change 2

April 25, 1956

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

chg 15 Page 1, paragraph 1.02 a (2) (a), lines 7 and 8: Delete "For purposes of consent, spinal puncture will be considered as a surgical operation." and insert "For consent for performance of spinal puncture, see paragraph 1.05b, part X, DM&S Manual M-2." (Spinal puncture no longer considered surgical operation for purposes of consent.)

chg 10 Page 5, paragraph 3.02 a, line 5: Delete, "such as dermatology, gynecology, urology, and the like,".



WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Distribution:

Same as M-2, Part XIV

*absorbed by
chg. 13*

rescinded change 17

Department of Medicine and Surgery
Veterans Administration
Washington 25, D. C.

M-2, Part XIV
Change 1

January 17, 1956

Part XIV, "Surgical Service," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: The following change is made to eliminate the necessity of the 48-hour requirement of preoperative and laboratory workup.

ch. 15 — Page 2, paragraph 1.02a (4): Delete this subparagraph and insert the following:

"(4) Before surgery and within a reasonable time, necessary hematological examinations will be made."

Wm. Middleton
WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Distribution:

Same as M-2, Part XIV

checked by ch. 15

RESERVED CHANGE 17

1-23-56