

## Surgery and Diabetes

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## 5 Abstract

As incidence of diabetes is increasing, it become a routine to encounter diabetics in every surgical field. Whether it is cataract surgery, laparoscopic cholecystectomy, hysterectomy or cancer surgeries, screening for diabetes is a norm. Diabetes affects pathogenesis of many conditions requiring surgeries like diabetic foot, pyelonephritis and renal abscess, coronary bypass surgeries. Raised blood glucose also affects the course of operation and post-operative course. It affects the healing, infection and other complications. So it is desirable to well maintain the glucose level, so that neither person get ill effect like ketoacidosis or hyperosmolar coma, renal failure, infections nor he get hypoglycemia which adversely affects the life style of the recovering patients. (2, 3)

1. INTRODUCTION

18 s incidence of diabetes is increasing, it become a routine to encounter diabetics in every surgical field. Whether  
19 it is cataract surgery, laparoscopic cholecystectomy, hysterectomy or cancer surgeries, screening for diabetes is  
20 a norm. Diabetes affects pathogenesis of many conditions requiring surgeries like diabetic foot, pyelonephritis  
21 and renal abscess, coronary bypass surgeries. Raised blood glucose also affects the course of operation and post-  
22 operative course. It affects the healing, infection and other complications. So it is desirable to well maintain the  
23 glucose level, so that neither person get ill effect like ketoacidosis or hyperosmolar coma, renal failure, infections  
24 nor he get hypoglycemia which adversely affects the life style of the recovering patients. (2.3) II.

## 25 2 Managing Blood Glucose during

26 Perioperative Period a) Screening for diabetes in PAC (Pre anesthetic checkup) It is recommended for all patients  
27 above 35 year of age and one below this age with a risk factor (Obesity, hypertension, family history, h/o GDM,  
28 HIV, Physical inactivity).(1) So practically most adult patients requiring surgical intervention undergo blood  
29 glucose estimation. This screening many times make the diagnosis of diabetes for the first time.

If patient is found to have impaired blood glucose, then he can be directed to life style modifications, oral hypoglycemic agents and any further investigation required.

32 Those who are already diagnose with diabetes, it will be required to do fasting, post prandial blood glucose  
33 with HbA1c. (4) These test reflects the control and any untoward effect of glucose will be minimized if it remains  
34 in the range. The desired premeal blood glucose is 90-130 mg % and post meal is 140-180 mg%.

### 35 3 b) Perioperative control of Glucose

Now it is recommended not to stop oral hypoglycemic agents till day before surgery as we used to do previously except for SGLT 2 inhibitors. ( ??) If blood glucose is fairly controlled then we can continue with these medicines, otherwise it is prudent to switch to insulin. Use of Insulin has few merits and demerits as explained in the box 1. Most hospitals have their own insulin regimen for control of blood glucose in perioperative period depending upon the practices and insulin sensitivity of the individuals. ( ??)

41 **4 BOX 1: Merits and Demerits of Insulin use in perioperative  
42 period c) Effect of anesthesia on diabetes**

43 Now with introduction of newer techniques and novel agents for induction and maintenance of desired level of  
44 anaesthesia, it is very easy to control blood glucose. Local, regional, spinal and epidural anaesthesia lessened the  
45 systemic complications.

46 Author: e-mail: choudhary.drrajkamal@gmail.com General anaesthesia, long surgeries and labile diabetes  
47 increases the chance of glucose imbalance. These can be better tackled by Insulin infusion and hourly blood  
48 glucose monitoring.

49 Insulin use during surgery should be intravenous only because subcutaneous absorption become erratic due to  
50 various reasons like hypotension, 1. Eating pattern is not smooth 2. Drugs (fluids, medications and blood  
51 products) changes the level of glucose 3. Patient's daily activity is compromised, so it also influence the  
52 consumption of glucose. 4. Surgery related effects (pain/immobilization/ anxiety) can affect glucose levels.

53 anaesthesia drug effect, and various Intravenous infusion of crystalloids and blood products. During operation  
54 / surgery random plasma glucose should be maintained between 140-180 mg %.

55 **5 d) Post-operative period and Glucose control**

56 In post-operative period, we should give insulin because of its merits discussed earlier. In post op period once the  
57 patient extubated, start taking oral diet, we can switch to subcutaneous insulin or re-introduce oral hypoglycemic  
58 agents gradually. OHA which are known to cause hypoglycemia like sulphonylureas to be avoided early in the  
59 course. It is always better to start multiple subcutaneous insulin injection which is most physiologic and avoid  
60 chances of hypoglycemia. (7) Doses can be titrated according to meal, other drugs / fluids influencing blood  
61 glucose. Basal insulin is useful to control fasting level. Its steady action decreases the chances of hyperglycemic  
62 complications too. Points to be addressed in post-operative period is mentioned in box 2.

63 **6 BOX 2:**

64 Points to be addressed in post-operative periods III.

65 **7 Conclusion**

66 There is no one regimen which can address all patients in all kind of surgeries. So individual patient to be  
67 managed with unique approach depending upon the type of surgery, he is undergoing upon. Few basics to be  
68 understand in such clinical scenarios as described in box 3.

1. Emergency surgeries not to be postponed for deranged blood glucose.
2. Cancer surgeries are also semi urgent condition, individual risk benefit ratio to be considered before postponing a surgery just because of increased blood glucose.
3. For day care surgeries, no need to stop OHA, and start insulin- we can very well continue OHA, till a day before surgery and reintroduce all one by one as patient oral intake and activity increases.
4. Persons undergoing major surgeries can be switch to insulin (preferably Multi subcutaneous insulin injection (MSII)).
5. Even persons on GLP-1 analogue, DPP 4 inhibitors/ SGLT 2 inhibitors or premixed insulin should switch to MSII.
6. During operation, keep patient on Intravenous insulin with hourly glucose monitoring. Target is (140-180 mg %)
7. During post-operative period, gradual recovery demands gradual upgrading of insulin dose and reintroduction of OHA (if needed).

Figure 1:



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