| M5.3 | Metabolic and Bariatric Surgery in Hong Kong | 14:30 | Room 423 & 424 |
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## Gist of Anaesthetic Care for the Morbidly Obese

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The physiological and mechanical changes of obesity and treatment must be considered after a bariatric surgery is done for a morbidly obese patient. It is believed that the most common adverse intra-operative event in bariatric surgery is anaesthesia related (1%).

When do we need to do an awake intubation in obesity?
How to reliably assess the presence of obesity hypoventilation syndrome?
Do we need a post-operative intensive care support for bariatric patients and what are the selection criteria?
Can they be suitably extubated post-operatively?

Anaesthetists often encounter difficulty in airway management and ventilation in obese patients. They are also prone to develop early desaturation following apnoea, and the effect can persist long after extubation. Peri-operative sleep disordered breathing (SDB) also poses a significant impact on the overall outcome. The method of maximising oxygenation in these patients will be shared.

Post-operative pain and analgesia are other challenges. The impact of multimodal intra-operative analgesia will be highlighted. Together, their differences in side effect profiles and efficacy in the treatment of post-operative surgical pain in obesity patients will also be discussed.

Obesity is also associated with important systemic changes that can potentially affect the pharmacological profile of anaesthetic drugs. The majority of anaesthetic drugs are strongly lipophilic and unpredictable in dosage. Recent evidence in utilisation of various types of pharmacokinetic model to assist dosing will be reviewed.

Enhanced recovery after surgery (ERAS) methodology has demonstrated consistent benefits in patients undergoing colorectal, urological and thoracic surgeries. Principles of these protocols could be applied to bariatric surgery. The anaesthetic components in its pre-operative, intra-operative and post-operative phase will be reviewed.