

Summary of Anesthesia Issues for the Post-Polio Patient

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Polio results in widespread neural changes, not just destruction of the spinal cord anterior horn (motor nerve) cells, and these changes get worse as patients age. These anatomic changes affect many aspects of anesthesia care. No study of polio patients having anesthesia has been done. These recommendations are based on extensive review of the current literature and clinical experience with these patients. They may need to be adjusted for a particular patient.

1. Post-polio patients are nearly always very sensitive to sedative meds, and emergence can be prolonged. This is probably due to central neuronal changes, especially in the Reticular Activating System, from the original disease.
2. Non-depolarizing muscle relaxants cause a greater degree of block for a longer period of time in post-polio patients. The current recommendation is to start with half the usual dose of whatever you're using, adding more as needed. This is because the poliovirus actually lived at the neuromuscular junctions during the original disease, and there are extensive anatomic changes there, even in seemingly normal muscles, which make for greater sensitivity to relaxants. Also, many patients have a significant decrease in total muscle mass. Neuromuscular monitoring intraop helps prevent overdose of muscle relaxants. Overdose has been a frequent problem.
3. Succinylcholine often causes severe, generalized muscle pain postop. It's useful if this can be avoided, if possible.
4. Postop pain is often a significant issue. The anatomic changes from the original disease can affect pain pathways due to "spill-over" of the inflammatory response. Spinal cord "wind-up" of pain signals seems to occur. Proactive, multi-modal post-op pain control (local anesthesia at the incision plus PCA, etc.) helps.
5. The autonomic nervous system is often dysfunctional, again due to anatomic changes from the original disease (the inflammation and scarring in the anterior horn "spills over" to the intermediolateral column, where sympathetic nerves travel). This can cause gastro-esophageal reflux, tachyarrhythmias and, sometimes, difficulty maintaining BP when anesthetics are given.
6. Patients who use ventilators often have worsening of ventilatory function postop, and some patients who did not need ventilation have had to go onto a ventilator (including long-term use) postop. It's useful to get at least a VC preop, and full pulmonary function studies may be helpful. One group that should all have preop PFTs is those who were in iron lungs. The marker for real difficulty is thought to be a VC <1.0 liter. Such a patient needs good pulmonary preparation preop and a plan for postop ventilatory support. Another ventilation risk is obstructive sleep apnea in the postop period. Many post-polios are turning out to have significant sleep apnea due to new weakness in their upper airway muscles as they age.
COMMENT: Postop respiratory failure in these patients can be difficult to manage. The patient's pulmonary physician could help by doing a preop evaluation and being involved in postop ventilator management. This situation might call for the resources of an ICU in a major medical center.
7. Laryngeal and swallowing problems due to muscle weakness are being recognized more often. Many patients have at least one paralyzed cord, and several cases of bilateral cord paralysis have occurred postop, after intubation or upper extremity blocks. ENT evaluation of the upper airway in suspicious patients would be useful.
8. Positioning can be difficult due to body asymmetry. Affected limbs are osteopenic and can be easily fractured during positioning for surgery. There seems to be greater risk for peripheral nerve damage (includes brachial continued . . .

plexus) during long cases, probably because nerves are not normal and also because peripheral nerves may be unprotected by the usual muscle mass or tendons.

9. NEW IDEAS/THOUGHTS: Spinals: Recent studies demonstrating the presence of cytokines in the CNS of PPS patients lead me to be less enthusiastic about using spinal/epidural anesthesia. There is no data on this situation, and there are so many benefits to this regional anesthesia, and it might be suitable in some situations. Lidocaine would not be a suitable drug choice for PPS patients. It has been shown to cause nerve damage when used for a spinal. Regional anesthesia: Should the peripheral nerves of PPS patients be exposed to local anesthetics, especially for long periods postop? There is no data, but many PPS patients have atrophied peripheral nerves. Perhaps smaller doses of local anesthetics and avoiding continuous postop infusions would be safer. Above-the-clavicle blocks (supraclavicular and interscalene approaches): These have a high risk for diaphragmatic paralysis and should probably not be used in PPS patients, unless the patient can tolerate a 30% decrease in pulmonary function.

Summary:

PPS patients can have anesthesia and surgery safely, with careful preparation. Anesthesia and surgery is a process that involves anesthesia, surgery, and hospital care. For an optimal outcome, **ALL MUST BE AT HIGH LEVELS OF PERFORMANCE AND ACHIEVEMENT!** You, the patient, must work to be sure you get these. Remember, few surgeries are truly urgent and you usually have time to get data from the web, the state's hospital licensing department, the state's medical board, and other resources. You should also research the operation and its consequences to be sure you can deal with them. Don't rush into anything until you're satisfied you'll get the best. You deserve it

Updates From the September 20, 2014 conference "We're Still Here!" Living with the Late Effects of Polio," presented by the California North Coast Post-Polio Group. Included in Dr Calmes' talk was the following list of "Anesthesia Issues for Post-Polio Patients."

For more info: Review "Postpolio Syndrome and Anesthesia" by David A. Lambert, MD; Elenis Giannouli, MD; & Brian J. Schmidt, MD, The University of Manitoba, Winnipeg, Canada, in the September 2005 issue of Anesthesiology (Vol. 103, No. 3, pp 638-644). This article reviews polio, postpolio syndrome and anesthetic considerations for this patient population.