

Title: Fasting Recommendations for Patients Receiving Moderate or Deep Sedation or Anesthesia

Policy: CP-60

Purpose: During a procedure under sedation or anesthesia, patients are at risk of aspiration; this can lead to serious negative consequences. This policy has been developed to standardize fasting recommendations.

Policy Statement: This policy has been developed to standardize the fasting recommendations for patients undergoing a surgical or invasive procedure performed under moderate or deep sedation, or with anesthesia. (Ref 1,2)

Instructions for elective surgery or procedures:

For elective surgery/ procedures with anesthesia and/or procedures under moderate or deep sedation, fasting rules have been adopted to maximize patient safety and patient and provider understanding i.e. keeping the rules simple and allowing for potential scheduling changes on the day of surgery or the procedure.

The following section outlines the recommended approach for patients undergoing a surgical or an invasive procedure:

On the day of an elective surgery or procedure

Liquids-

- No **alcohol after midnight** prior to the surgery or procedure.
- Patients **may** have clear liquids up to 2 hours prior to their **arrival time** to the hospital or procedure area. (Using the at arrival time allows for potential changes in scheduling once the patient arrives. For most elective cases this translates into clear liquids UNTIL 4 hours prior to the procedure or surgery time.)
- If the proceduralist, surgeon and /or anesthesiologist agree, the patient may have a sip of water with any preoperative oral medication prior to the surgery / procedure in the holding area or waiting room.
- **Clear liquids** include water (non-carbonated), fruit juices with no pulp such as apple juice, cranberry juice, white grape juice; black coffee or tea (no cream or milk, though sugar is acceptable); Kool Aid, Gatorade, Propel, Ice pops, Jello, fat free clear broths.
- Chewing gum, sucking hard candy on the morning of surgery may stimulate gastric secretions; it is unclear if this increases the risk of aspiration (ref 3). In the absence of clear evidence, hard candy should be considered a clear liquid

equivalent and maybe used up to 2 hours before the procedure. The evidence on the impact of pre-procedure gum is also limited. At a minimum, patients should be instructed to spit out any gum on arrival to the hospital.

Solids-

- Scheduled cases: All patients should follow the guidelines below regarding solid intake unless instructed otherwise by their surgeons and/or proceduralists
- Light Meal (6 hours before arrival)
- 1-2 eggs (cooked without oil), cereal with fat-free milk, piece of toast OR pita bread, plain white rice +/- clear broth, plain noodles +/- clear broth.
- All other foods & liquids (8 hours before arrival)
- All solids, all meat containing products, all fried foods, all dairy products, all types of cheeses, ice cream, all milk shakes, smoothies.
- Non-scheduled cases: Patients should be NPO for solids for at least 6 hours prior to non-scheduled cases.
- High risk conditions (including obesity, pregnancy, certain medical condition such as diabetes mellitus, chronic narcotic use or other conditions) can reduce gastric emptying and predispose patients to aspiration. In these patients the fasting period may need to be extended at the discretion of the provider(s).

Hypoglycemia management: If the patient has diabetes, and develops a low blood sugar, the patient should be instructed to take glucose gel (15 grams) or 4oz apple juice or five sugar packets. (for details on Hypoglycemia treatment please refer to Policy: [NPM 100-36 Hypoglycemia Management](#))

High carbohydrate clear liquids e.g. Gatorade or sports drinks may be recommended prior to surgery. Patients on an Enhanced Recovery After Surgery (ERAS) protocol may be instructed to ingest up to 400 cc of clear liquid up until 2 hours prior to surgical check in time. These patients will receive additional specific information regarding bowel preparation and fluid restrictions.

Oral contrast agents are generally considered to be the equivalent of a solid meal, evoking the **6 hour** fasting rule.

Oral bowel preparations are clear liquids and may be continued as directed up until 2 hours prior to the administration of sedation or anesthesia.

Patients receiving enteral nutrition through tube feedings.

1. For non-intubated patients,

- Tube feedings are considered solid food and should be held a minimum of 6 hours prior to the time the first sedative or anesthetic medication is administered.
- In general, for outpatient and SDA cases e.g. nursing home patients, tube feedings should be held after midnight on the day of surgery.
- For more information about types of tubes please refer to PPGD Policy: [900-1: "Use of Enteral Feeding Tubes and Tube Feeding Products."](#)

2. ICU patients receiving Enteral Nutrition:

- If the patient is intubated or has a cuffed tracheostomy, the tube feeds can continue up to or throughout the procedure (at the discretion of the anesthesiologist), unless the procedure involves the airway (e.g. tracheostomy), in which case it should be stopped at least 6 hours before elective surgery..
- However, if the patient is not intubated or will be undergoing an elective procedure involving the airway, the tube feeds must be stopped 6 hours in advance.
- For emergent cases in non-intubated patients, the tube feeds should be stopped, and the timing of the procedure will be determined after discussion between the proceduralist/ surgeon and the anesthesiologist.
- The location of the feeding tube is not relevant. There is no scientific evidence that a jejunostomy tube offers any less risk of aspiration than a gastric tube.

If the NPO conditions outlined above are not met and the procedure or surgery is non-emergent, and requires sedation or anesthesia, the procedure or surgery should be postponed until fasting recommendations are met or the procedure should be rescheduled to a different day.

Emergency procedures

It is recognized in certain circumstances a procedure or surgery is emergent or urgent. In these situations the risks associated with delaying the procedure or surgery may be greater than the risk of proceeding with a potentially full stomach.

If the patient has not met the required fasting recommendations outlined above, **and** the procedure cannot be delayed, it will be up to the physician provider(s) to decide if it is safe to proceed without sedation. If a general anesthetic with intubation or a neuraxial anesthetic is required, the decision to proceed will be made following a discussion between the surgeon/ proceduralist and the anesthesiologist. General

anesthesia with intubation does not guarantee that a patient with a full stomach will not aspirate, but it may reduce the risk.

For fasting recommendations for Emergency Department Procedures with Deep Sedation please refer to policy [CP-52 Deep Sedation](#).

Vice President Sponsor: Tony Weiss, MD, CMO

Approved By:

- | | |
|---|--------------------------------------|
| ☒ Medical Executive Committee: 6/16/21 | Daniel Talmor, MD
Chair |
| ☒ Operating Room Executive Committee: 4/8/2021 | Reuben J Azocar, MD
Chair |
| ☒ Interventional Procedures Committee: 5/17/2021 | Bettina Siewert, MD
Chair |

**Author: Richard J Pollard, MD, Anesthesia
Sal Obeidat, MD, Anesthesia**

Original Date Approved: 7/15/15

Revisions: 4/8/2021

Next Review Date: 6/24

References:

- Anesthesiology 2017;126 Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures: An Updated Report by the American Society of Anesthesiologists Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration
- Anesthesiology 2017;126:376-393 Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists: An Updated Report by the American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists
- Poulton TJ. Gum chewing during pre-anesthetic fasting. Pediatric Anesthesia. 2011;22(3):288–296.