

GSJ: Volume 13, Issue 5, May 2025, Online: ISSN 2320-9186

www.globalscientificjournal.com

# Evaluation of anesthetiological care of surgical emergencies at the Sikasso Hospital

Minkoro TRAORE<sup>1</sup>, Amadou DEH<sup>1</sup>, Broulaye KAMISSOKO<sup>1</sup>, Kokoroba SIDIBE<sup>1</sup>, Mahamadou SANGARE<sup>1</sup>, Drissa BAMBA<sup>1</sup>.

Anesthesia-Resuscitation Service Hospital-Sikasso

**Corresponding Author :** Minkoro Traore, Master in Anesthesia-Resuscitation of the Sikasso Hospital, Mali

Email: minkoro11@gmail,com

Tel: 00223 76323744/ 66986703/ 66323744

Abstract

# Introduction

The purpose of this study was to assess the quality of anesthetiology management of SIKASSO hospital surgical emergencies. Methodology This was a prospective study on the quality assessment of anesthetic practices of surgical emergencies from September 1 to November 30, 2016. Our study focused on all patients with emergency anesthesia during our study period. All patients who have undergone an emergency anesthesia without distinction of age, ethnicity, religion in the emergency room; Was not included all the patients operated urgently outside the Emergency Reception Service, in gyneco-obstetrics. The data was collected on the investigation sheets and analyzed from the EPI Info 3.5 software. The entry was made from the Windows XP software.

# Results

over a period of 03 months We have completed our study of Sikasso's 197 patients on 2579 patients received in consultation or a frequency of 7.63%

# Conclusion

at the end of our study which lasted from September to November and which has Worn on the entire anesthetized population urgently in the general trauma, urology surgery, we were able to take stock of several elements related to our practice of anesthesia.One of the essential interests of this study has been the collection of incidents and accidents among the anesthetic population in the same structure, by the same practitioners over the same study period.

#### Key words: assessment, anesthetiological, surgical emergencies.

#### Introduction

Anesthesia is a medico-surgical act that requires a certain knowledge and respect for safety standards in order to perform a surgical act for the patient. The risk it comprises is all the more unacceptable as anesthesia is supposed not to provide direct profit to the patient's condition. However, to reduce this risk, each anesthetist-resuscitator doctor assesses it with regard to the benefits specified as part of a personalized medical approach. This implicit analysis leads to the choice of anesthetic technique adapted to each patient and the expected operative act. [38]. The formalization of the anesthetic process, intended to limit the variations of practices considered as sources of accident, supposes a coordination of technical and human resources, through an organization whose broad outline had been defined by the recommendations of the High Committee on Public Health, precursors of the Regulations in force. These recommendations include recommendations in other countries. However, their effectiveness has not been evaluated, although it is likely that these measures have helped to reduce anesthetic mortality and morbidity. This security logic does not reduce the frequency of complications of anesthesia at the level observed in the safest sociotechnical systems. The frequency of accidents in civil aviation or the electronuclear industry is of the order of 10-6, against 10-3 to 10-5 in anesthesia. [1] For several years, the profession has been committed to assessing the quality of work done daily by all re-emergent anesthety physicians. For this it is necessary to measure the activity, the prowess, but also the failures or failures to seek the likely causes and improve the quality of care in general and the practice of emergency anesthesia in particular. Hence the interest of this study entitled "Assessment of the anesthetiological care of the surgical emergencies at the Sikasso Hospital >>.

# **Materials and Method**

# of the Study Framework

Our study took place in the Emergency Reception Service and the Sikasso Hospital Operating Blocks located at Lafiabougou district not far from the police station of the 2nd arrondissement on the road to Missirikoro. Face of the village can appendix.

**Type of study** This was a prospective study on the assessment of the quality of anesthetic practices of surgical emergencies.

**Study period** Our study was spread over three (3) months of September in November 2016. Study population Our study focused on all patients who had emergency anesthesia during our study period and meeting the following

**criteria inclusion:** were included in our study: all patients who have undergone an emergency anesthesia without distinction of age, ethnicity, religion in the emergency room;

**Non-inclusion criteria:** All patients operated urgently outside the emergency reception service, in gyneco-obstetrics.

# Method:

2.5 Measured Variables (see Shipping Sheet)

**2.6 Data Analysis and Processing** The data was collected on the fact sheets and analyzed from the EPINFO3.5 software.

The entry was made from the Windows XP software.

# Results

over a period of 03 months We have completed our study of Sikasso's 197 patients on 2579 patients received in consultation or a frequency of 7.63% Male sex was most represented with 142 cases either 72.08%. Youth is the most represented with 11 - 40 years or 58.37%. Students were the most represented with 31.97%. The majority of patients were evacuated or 65.41%. The majority of patients were operated for peritonitis, or 27.91%. AsA1U classified patients represent the majority of cases 72.08%. The majority of patients were supported in the 1st o'clock 52.28%. The majority of patients received a preoperative and postoperative

resuscitation or 71.57% and 80.71% respectively. The majority of patients were operated by AG more intubation or 49.23%. The majority of patients were intubated without incidents or 93.81%. The majority of patients did not have a cardiovascular incident, or 84.26%. The majority of patients did not have a respiratory incident 94.48%. The majority of patients were cramped in a calm state, 85.62%. The majority of patients were transferred to SSPI 75.12%. The majority of patients received postoperative antalgics, 86%. Deaths accounted for 2.53% of the cases supported.

#### Discussions

The male sex was the most represented with 142 cases 72.08% .tiogo.c. [59] had 56.5% of women in his series; Unlike Kante.m [38]; Diop. Mr. E [16] Gravot. B. [27] Venet.c [63]; and Diawara [15]} had 69%; 58%; 84%; and 52.2% of male patients operated in their series. This predominance of male sex in our series could be explained by the fact that obstetric surgery has not been considered in our study. The distribution of different age groups shows that most of the population was under 40 with a proportion of 58.37%. 73% of Kante.m patient [38] were under 40; 92.2% of Dicko patients. Mr. [16] were under 65 and Gravot. B [27] found 80.2% of patients under 65 years old. Digestive surgery accounts for 63.95% of interventions in our service. In a study conducted by Kante.m [38] Digestive surgery accounted for 79.4%; Diop. T. M [17] Obstetric surgery was most representative with 61.1% of interventions followed by digestive surgery with 26.6% of interventions. Diawara [15] found 29.6% and 26% respectively for general and urological surgeries. The types of anesthesia listed during our study were: general anesthesia plus orotchase incubation 56.85%; 31.97% rachianesthesia; sedation 11.16%. During our study 52.28% of patients were supported within 1 hours. This could be explained by the permanent presence of the anesthetist-resuscitator doctor, the anesthetist nurse and the surgical team. The majority of patients received a preoperative and postoperative resuscitation, is 71.57% and 0.71% respectively. This resuscitation is conducted by the doctor or anesthetist nurses. The majority of patients were intubated without incidents, or 93.81%. However, the most encountered incidents are the esophageal intubation; difficult intubation not planned and selective intubation with respectively 2.06%; 1,03%; 3.09% of cases. Diop. T. M [17] found in his study 0.6% difficult intubation. The most observed cardiovascular incidents are: hypotension 6.59%; bradycardie 2.53%; Hypertension 2.53%. In a study conducted by Kante.m [38] hypotension 6.1%; Bradycardie 4%; 2.8% high blood pressure; Diop. T. M [17]

Hypotension accounted for 9.1%; The tensional peaks accounted for 7% of cases of anesthesia. The majority of patients did not have a cardiovascular incident or 84.26%. We observed that the majority of patients did not have a ventilation incident, or 94.48%. The incidents related to ventilation were the respiratory depression requiring treatment with a breakdown and bronchospasm accounted for 1.03% and 2.06% of patients operated under AG against 3% and 2.2% of patients in the study. Diop. T.M {17} and Kante.m. [38] Among the patients operated under AG with intubation the majority were extinguished in a calm state, 85.62% and 5.15% of patients had a wake up delay. These waking delays could be due to anesthetic drugs and the clinical state of patients. The majority of patients were transferred to SSPI 75.12% and hospitalization, or 14.7% of all patients operated. 8, 62% of patients were conducted in resuscitation, patients released after the operating room accounted for 1, 52%. This could be explained by a satisfactory state. The majority of patients received post-operative antalgics, or 90.86%. This high frequency could be explained by the fact that there is a protocol of systematic analgesia on awakening, it is done on demand mainly in ambulatory surgery. The pain was observed in 37 within 24 hours Post operative Diawara [15] found that 53.2% of patients had pain. The overall mortality rate was 2.53% in our series. Venet.c. [63] had a mortality rate of 2%; Diop.t.m [17] observed 3% mortality in its series. Our rate could be explained by the fact that patients are supported as soon as the anesthetist-resuscitator nurse under the responsibility of the anesthetistresuscitator physician and the other internal surgery.

#### Conclusion

at the end of our study that lasted from September to November and which focused on the entire anesthetized population in emergency in the general trauma, urology surgery services, we were able to take stock of several elements related to our practice. Anesthesia. One of the essential interests of this study has been the collection of incidents and accidents among the anesthetic population in the same structure, by the same practitioners over the same study period. The study focused on emergency patients, the conduct of anesthesia and its evolution in the 24 hours postoperatively. The male sex predominated with a rate of 72.08%. General anesthesia plus orotchaseal intubation has been most representative with 56.85%. Accidents and where cardiovascular incident prevailed in our study 15.73% and the anesthetic timing of accidents and incidents was the maintenance period. PER Anesthetic Mortality in the 24 hours postoperatively was 2.53%. The occurrence of incidents and anesthetic accidents can be prevented by a better assessment of patients preoperatively Available and adequate monitoring greater rigor in achieving anesthetic acts and a supervision and continuing training of staff anesthetist.

## REFERENCES

1. AUBAS S, PH biboulet, Daure J.P. Frequency and causes peroperative heart stops and waking rooms. About 102468 anesthesia. Masson, Paris. Ann FR Anesthréani1991; 10: 436-442.

2.Beecher H.K, TOOD D.P. A Study of the Deaths Associated with anesthesia and surgery. ANN SURG1954; 140: 2.

3.Buck N, Devlin H.B, Lunn J.N. Report on the Confidential Inquiry Into Perioperative Deaths. Nuffield Provincial Hospitals Trust, The Kings Fund Publishing House, London, 1987.

4.Brummer E.A. Monitoring Anesthesic Care: New Directions. Jama 1989; 261;1633. 5.Bodlander f.m.s. Deaths AssSociated with anesthesia.br J Anaesth 1975;47: 36.

6. Caplan R.A, Posner K.L, Ward R.J and ALL. Adverse Respiratory Events in Anesthesia: A Closed Claims Analysis. Anesthesiology 1990; 72: 828

7.Chopra V, Bovill JG, Spierdijk J, Koornneef F. Reported Significant Observations During Anaesthesia: A prospective Analysis Over A 18 -Months period.br J Anaesth, 1992; 68: 13-17.

8.Aplan R.A, Ward R.J, POSNER K, CHENEY F.W. UNEXPECTED CARDIAC ARREST DURING SPINING ANESTHESIA. At Closed Claims Analysis of Predisposing Factors. Anesthsiology1988; 68: 5

9.Cheny F.W, POSNER K.L, CAPLAN R.A. Adversse Respiratory Events Infreelessly Leading to Malpractice Suits, a closed claims Analysis.Anesthesiology 1991; 75: 932. 10.Cheny F.W, Posner R.A, Caplan R.A and ALL: Standard of Care Andanesthsia Liability. Jama 1989; 261: 1599.

11.Clifton B.S, Hotten W.Deaths Associated with Anaesthesia 1964; 19: 536.

12.Chen M.M, Duncan P.G, Pope W.D.P and ALL. The Canadian Fourcenter Study of AnaestHesicoutcomes: II.CanOutcames Be used to Assess The Quality of Anaesthesia Care? Can J Anaesth 1992; 39: 5, pp 430-9.of general anesthesia.ii. Results.Anesthesiology 1990; 72: 262-268.

13. Cohen M.M, Duncan P.G, Poped.P, Wolkenstein C. A Survey of 112 000 aesthetic aat One Teaching Hospital (1975-83). Can Anaesth Soc J1986; 33: 22.

Annex

# I- Distribution of patients by sex



#### Graphic I: distribution of patients by sex

# **II- Distribution of patients according to age groups**

Table I: Distribution of patients by age group

Age	Frequency	Percentage
0 -10 years	16	8,12
11-20 years	29	14,72

21-30 years	45	22,84
31-40 years	41	20,81
41-50 years	23	11,67
51-60 years	16	8,12
61-70 years	15	7,61
71-and more	12	6,09
Total	197	100

# **III-** Distribution of patients by profession

# Table II: Distribution of patients by occupation

Profession		Parcantaga
11010551011		rereentage
Functions	23	11,67
Student	63	31,97
Farmer	33	16,75
Merchant	27	13,70
Breeder	19	9,64
Military	11	5.58
Others	21	10,65
TOTAL	197	100

# IV- Distribution of patients according to the mode of admission



## Graph II: Distribution of patients by mode of admission

# V- Distribution of patients according to the reason for admission

Table III:	Distribution	of	patients b	y	reason	of	admission
			APR 100				-

CLINICAL DIAGNOSIS	Frequency	Percentage
Intestinal obstruction	27	13,70
Appendicitis	21	10,65
Peritonitis	55	27,91
Strangled hernia	23	11,67
Abdominal trauma	11	5,58
open fracture of the leg and/or thigh	33	16,75
Crushed limbs/amputation	13	6,59
Foreign body	2	1,01

Intussusception	5	2,53
Burn dressing	4	2,03
Others*	7	3,55
TOTAL	197	100

# VI-Distribution of patients according to the ASA of patients

ASA class	Frequency	Percentage
ASA1U	142	72,08
ASA2U	35	17,76
ASA3U	11	5,58
ASA4U	7	3,55
ASA5U	2	1,01
ASA6U	0	0
TOTAL	197	100

# Table IV: Distribution of patients according to the ASA of patients

VII-Distribution of patients according to the time taken to receive care

TIME TO ANESTHESIOLOGY COVERAGE	Frequency	Percentage
< 1H	3	1,52
1H	103	52,28
2H	93	47,20
3Н	9	4,56
> <b>3</b> H	7	3,55
TOTAL	197	100

Table V: Distribution of patients according to the time taken to receive treatment

VIII-Distribution of patients according to the time of preoperative or postoperative resuscitation.

Table VI: Distribution of patients according to the time of preoperative or postoperative resuscitation.

Resuscitation	Frequency	Percentage
Preoperative	141/197	71,57
Postoperative	159/197	80,71

IX-Distribution of patients according to the type of anaesthesia received.

Type of anesthesia	Frequency	Percentage
Ag sedation without intubation	17	8,62
Ag plus intubation	97	49,23
Spinal anesthesia	61	30,96
Epidural anesthesia	7	3,55
Plexiglass block	15	7,61
Total	197	100

# Table VII: Distribution of patients according to the type of anaesthesia received.

# **X-Distribution of Intubation Incidents**

#### **Table VIII: Distribution of Intubation-Related Incidents**

Intubation-related incidents	Frequency	Percentage
Extubation accidentelle	0	0
Intubation œsophagienne	2	2,06
Intubation difficile non prevue	1	1,03
Traumatisme dentaire	0	0
Intubation impossible	0	0
Intubation sélective	3	3,09
Nécessité d'une ré intubation	0	0

Œdème de la glotte	0	0
Obstruction des voies aériennes ou de la sonde	0	0
Nécessité d'intubation après pose d'un masque laryngé	0	0
NEANT	91	93,81
TOTAL AG+IOT	97	100

