3. ANESTHETIC MANAGEMENT OF AIDS PATIENTS

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All we know is still infinitely less than all that still remains unknown.
WILLIAM HARVEY, DE MOTU CORDES ET SANGUINIS, 1628

As the human immunodeficiency virus (HIV) epidemic continues to make inroads into the general public, anesthesiologists face an ever-increasing number of infected persons. Some have full-blown AIDS, some are known to be HIV-positive, but most by far are undiagnosed.

How can these unfortunates best be handled? What is the proper role of regional anesthesia in their care? Despite the enormous quantity of information concerning HIV and its associated diseases, remarkably little has been written on this topic.\(^1-^4\) Controlled studies concerning possible advantages of regional versus general anesthesia have not been done. Useful published guidelines based on either experience or thoughtful consideration are scarce. Basic information concerning the frequency of use of regional versus general anesthesia by practitioners is simply unavailable.

Would the availability of such information lead to better patient care? Doubtless it would. An interchange of information on this incompletely understood set of diseases could only serve to benefit the patients thus afflicted. This chapter may help to stimulate the process by which the anesthesia community learns to deal effectively with this group of patients and the diseases they face.

T. Janisse (ed.), Pain Management of AIDS Patients
OVERVIEW
The state of health of patients infected by HIV varies widely. At the one extreme, some of those suffering from full-blown AIDS are critically ill and subject to severe decompensation from even a mild anesthetic insult. At the other, many of those who, despite infection, still have a largely intact immune system are in robust good health without the least outward sign of disease.

The question exists whether some particular anesthetic might serve as a cofactor of AIDS. That is, whether that agent might cause a reactivation of latent HIV lodged within a T lymphocyte or other host cell. Cofactors do exist, but anesthetic agents are not thought to be included among their number. Medically, one can make a case that certain blocks might be ill-advised, if not actually harmful, but this is another matter and will be considered later. With these reservations, there may be no compelling medical reasons to treat the healthy, infected patient differently from the healthy, uninfected one. Furthermore, each day hundreds or thousands of persons who are infected with undetected HIV are routinely anesthetized, with no attention given to this underlying condition. No retrospective study has been done to suggest that their disease processes were affected by these anesthetics. Indeed, such a study would be difficult to do and difficult to interpret, particularly in light of the long incubation period of AIDS.

What this chapter addresses is largely sick patients with severe immunosuppression who need anesthesia for any condition, whether it be related to their underlying infection or not. Consideration is also given to those patients with early HIV infection in whom anesthetic management may differ based on their initial clinical presentation. For all patients the anesthesiologist needs to focus on preexisting conditions via a careful preanesthetic assessment. This approach, concentrating on a good history and physical examination, remains the most rational way to decide whether regional or general anesthesia is best for a particular patient.

Anesthetic care extends beyond the confines of the operative suite. Today, anesthesiologists are more involved with extended postoperative pain relief than they were formerly. Patients with AIDS often have a preexisting baseline of pain and may benefit especially from this newer service.

Regional analgesia for patients with AIDS who have a chronic pain syndrome will be addressed in chapter 6. The general principles discussed later concerning matters such as the control of infection apply as well for blocks performed for chronic pain as for surgical anesthesia.

The potential exists for the transmission of an HIV infection to a member of the hospital staff or to another patient. Transmission rarely happens, but when it does it is a catastrophe to those affected. Of particular importance, to help protect the staff and to ensure strict adherence to universal precautions, the anesthesiologist has a responsibility to educate other operating room and pain clinic personnel about the possible presentation of a person with HIV infection. Helpful guidelines will be presented to minimize the chances of inadvertent HIV transmission.