To Delay or Proceed: Impact of Recent Cocaine Use in Monitored Anesthetic Care for Endoscopy and Colonoscopy - Two Cases of Sick Patients and their Outcomes

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Traditionally, despite the absence of specific guidelines by the American Society for Anesthesiology or other such organizations, patients reporting recent cocaine use, or found to be cocaine-positive via pre-operative urine drug screen (UDS), have been considered as contraindications to immediate surgery, especially if non-emergent. Limited available literature on the effects of cocaine use often focuses on otherwise healthy patients presenting for emergent trauma cases. Information regarding cocaine use in sicker ASA 3 and 4 patients specifically is scarce, and less so in elective, low-risk procedures requiring only sedation, yet the same hesitation to go forward with anesthetics in this group here remains ubiquitous despite the lack of data.

Here we describe two cases in which chronic, intermittent cocaine users with significant co-morbidities required endoscopic or colonoscopy procedures that, while not emergent, were urgent in order to proceed with proper diagnoses and treatment. As well, both patients had complicated socio-economic backgrounds, and it was likely that if they did not undergo the procedure that day, they might not return until their conditions had progressed past the point of being feasibly able to treat. In at least one case, a colon cancer lesion was newly discovered as a result of not canceling the case. Both patients admitted to cocaine use within the last 24 hours prior to the anesthetic. In both cases, pre-operative UDS’s were not done since both patients already admitted to use. The procedures were completed under Monitored Anesthesia Care (MAC) sedation with propofol without complications, and they went home uneventfully.

Our institution has thus concluded that the benefit to proceeding with elective endoscopy or colonoscopy under MAC may outweigh the risks in carefully selected patients who have either tested positive for cocaine or admitted to use within the last 24 hours if they are otherwise hemodynamically stable at time of procedure, if they have provided informed consent, do not appear acutely intoxicated, and can be monitored post-operatively until they show a modified-Aldrete score of 10 and appear clinically appropriate for discharge by PACU staff. Further prospective outcome studies would prove useful in establishing more clear guidelines in this area.