Preoperative Evaluation for Major Noncardiac Surgery

Focusing on Heart Failure

Adrian F. Hernandez, MD; L. Kristin Newby, MD, MHS; Christopher M. O'Connor, MD

The number of patients undergoing major noncardiac surgery has steadily increased over the last decade. Cardiovascular complications are important and often feared by patients, surgeons, and anesthesiologists. Although preoperative risk assessment has improved since Goldman and colleagues published their landmark article that introduced the Multifactorial Index of Cardiac Risk 25 years ago, it continues to require modification, especially with the increasing prevalence of heart failure and the increase in procedures performed in the elderly. This review will summarize preoperative assessment and perioperative management with an emphasis on heart failure.

Over the last 25 years, there has been steady improvement in the care of patients undergoing major noncardiac surgery. In the past, attention was focused on coronary artery disease (CAD) and the detection of ischemia. For the future, changes in the epidemiologic characteristics of patients undergoing surgery may require improved strategies and care, especially for those with heart failure (HF). This review will summarize preoperative risk evaluation and perioperative care focusing on HF.

EXPANDING SURGICAL VOLUME AND COSTLY COMPLICATIONS

The increasing volume of noncardiac surgical procedures and changes in the epidemiology of cardiovascular disease may collide to create an epidemic of postoperative complications despite improved care in both fields (Figure 1). In 2000, there were almost 40 million procedures performed in the United States, with over 10 million major noncardiac surgical procedures compared with only 519,000 cardiac surgical procedures.² The elderly pose a special problem since they are the largest population to undergo surgery, yet are at high risk for perioperative complications and major cardiac complications.³,⁴ Individuals 65 years and older account for over 10 million noncardiac procedures and at least 4 million major noncardiac surgical procedures each year, which has increased over the last decade.²

Based on information from the late 1980s, at least 1 million perioperative cardiac complications occur per year, with an estimated $20 billion in annual costs for in-hospital and long-term care.¹ Although studies show clinical pathways can reduce length of stay, there may be vulnerable groups, such as the older, poorer, or sicker populations, which may be more susceptible to adverse outcomes with subsequent costs occurring after the initial discharge.⁵-⁷ Currently, no accurate estimates are available owing to improvements in anesthesia techniques, β-blocker use, and risk assessment vs an increased prevalence of HF, an aging population, and more survivors of sudden death and myocardial infarction (MI) (Figure 2).

EVOLVING EPIDEMIOLOGY OF CARDILOGY

The incidence and prevalence of HF is soaring at a staggering rate. Based on the...
operative risk stratification and raise substantially the landscape of preoperative risk. With an aging population will change the epidemiology of cardiovascular disease along with chronic diseases such as atherosclerosis, hypertension, and diabetes. Recently, the Framingham Heart Study also showed an improvement in survival of patients diagnosed with HF, which, coupled with a rapidly growing elderly population, could also contribute to a higher long-term prevalence.11,12

These changes in the epidemiology of cardiovascular disease along with an aging population will change substantially the landscape of preoperative risk stratification and raise concerns whether our current strategies are adequate.

PREOPERATIVE RISK STRATIFICATION

Goldman and colleagues13 established a multivariable model of cardiac risk for noncardiac surgery, later named the original Cardiac Risk Index, which dramatically improved the prior American Society of Anesthesiologists (ASA) classification.14 There have been other models developed to assess risk for perioperative complications emphasizing different aspects. All use clinical assessment, medical history, and a few basic laboratory assessments and now serve as a routine component of preoperative screening.

Original Cardiac Risk Index

In their original study, Goldman and colleagues13 enrolled 1001 patients 40 years or older undergoing major noncardiac surgery. They derived a multivariable model using 9 clinical signs and standard laboratory measurements to generate a weighted cardiac index with 4 classifications predicting cardiac risk independent of surgery.13 This served as the basis for many years for most physicians assessing preoperative risk. However, limitations such as lack of model validation, unknown interobserver variability, and expectation bias due to event classification by investigators led to the development of other risk indices.

Modified Cardiac Risk Index

The next major development arose from a study of 455 consecutive patients referred to a general medical consultation service.15 Detsky and colleagues15 found an area under the receiver operator characteristic (ROC) curve of 0.69 for the original Cardiac Risk Index, which was lower than that in the original study by Goldman and colleagues.13 They simplified the point system, added angiography, and modified the criteria for HF, providing an improved c-index of 0.76. While the efforts of Detsky and colleagues15 were a substantial improvement, there were concerns of referral bias given that surgeons or anesthesiologists had to ask for a medical consultation. Overall, the main limitations were the single institution design, lack of end point adjudication, and the limits of generalizability of the risk index to “real-world” consultation.

Revised Cardiac Risk Index

In an effort to further improve available risk stratification tests, Lee and colleagues16 proposed an even easier risk stratification tool composed of 6 simple factors derived from the largest study cohort to date—4315 patients 50 years or older identified through the hospital’s Preadmission Test Center or in the hospital (Table 1 and Table 2). Through this mass screening process, approximately 80% of patients undergoing major noncardiac surgery were approached for enrollment into the study. Major cardiac complications were seen in 2% of patients in the derivation cohort and 2.5% in the validation cohort. Independent predictors of risk in this cohort were high-risk type of surgery (intraperitoneal, intrathoracic, or suprainguinal vascular), history of ischemic heart disease, history of HF, history of cerebrovascular disease, preoperative treatment with insulin, and preoperative serum creatinine level greater than 2.0 mg/dL (>176.8 µmol/L). The area under the ROC curve for this model was 0.806 in the validation cohort, compared with 0.582 for the Modified Cardiac Risk Index, 0.701 for the original Cardiac Risk Index, and 0.706 for ASA class.

Overall, this simplified approach effectively grouped patients into 3 groups. What to do for low-risk patients is straightforward, but those classified as intermediate or high risk still require clinical judgment for the best approach. The investigators used an improved study design by having study personnel who did not participate in subjects’ care perform daily medical review to collect data, and a reviewer blinded to preoperative clinical data classified all postoperative outcomes. Of note, possibly related to the smaller size of the validation cohort, was that insulin therapy and preoperative serum creatinine level did not prove to be as important in the validation
phase. Another limitation is that the model cannot take into account changes in a patient’s clinical status over time. For example, if a patient has decompensated HF today, the physician delays surgery for 1 month, and the patient clinically improves, the patient’s calculated risk remains the same, which may or may not reflect reality. The same applies to a patient with a recent acute coronary syndrome who has surgery delayed for months after coronary revascularization.

**HF AND NONCARDIAC SURGERY**

**Role of HF in Risk Indices**

In the original Cardiac Risk Index by Goldman and colleagues,\(^1\) clinical signs of HF including an S3 gallop or jugular venous distention (JVD) were the most significant predictors of postoperative life-threatening or fatal cardiac complications. In the final analysis, signs of HF carried the highest weight in the original Cardiac Risk Index. In addition, 36 of the 39 patients manifesting 1 or more life-threatening cardiac complications had pulmonary edema (Table 3).

Owing to the diverse group of clinicians evaluating numerous patients, in actual practice, the prior assessment for HF soon was recognized to be impractical. In the study by Detsky and colleagues,\(^15\) the interobserver agreement for S3 and JVD was poor (κ statistic, 0.42 and 0.50, respectively). Therefore, to make the diagnosis of HF more objective and reproducible preoperatively, Detsky and colleagues grouped HF into 2 categories as the presence of alveolar pulmonary edema within 1 week or ever. Although the definition was stricter, HF still had a major role in predicting events as well as being a major outcome. Of the 43 serious events, there were 10 new or worsened episodes of HF without alveolar pulmonary edema, and 5 episodes of alveolar pulmonary edema.\(^13\)

In the Revised Cardiac Risk Index study population, HF was both an important predictor and a key complication. The outcome required a formal reading of pulmonary edema on the chest radiograph by a radiologist with a plausible clinical setting. In the validation set, it provided the highest odds ratio (4.3) for major cardiac complications. In addition, it was an important outcome similar to MIs.\(^16\) Other models have shown HF as an important predictor of perioperative events and the degree of HF appears to correlate with complications.\(^17\)

**Diagnosis of HF in Risk Indices**

Despite use of the standard Framingham criteria for HF in a number of large epidemiological studies, investigators have not clearly applied these same standard definitions in preoperative risk studies.\(^18\)\(^19\) Table 4 summarizes the definitions of HF that have been used in the major preoperative risk studies.

---

### Table 1. Revised Cardiac Risk Index\(^16\)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Definition</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>Any of History of MI, History of positive exercise test result, Current chest pain, Nitrate use, ECG with Q wave</td>
<td>1</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Any of History of HF, Pulmonary edema, PND, Bilateral rales, S3 gallop, CXR with pulmonary vascular redistribution</td>
<td>1</td>
</tr>
<tr>
<td>Type of surgery</td>
<td>High risk (intraperitoneal, intrathoracic, or suprainguinal vascular)</td>
<td>1</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>TIA or stroke</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Preoperative treatment with insulin</td>
<td>1</td>
</tr>
<tr>
<td>Renal function</td>
<td>Creatinine level &gt;2.0 mg/dL (&gt;177 µmol/L)</td>
<td>1</td>
</tr>
</tbody>
</table>

### Table 2. Major Cardiac Complication Rates Using the Revised Cardiac Risk Index\(^16\)

<table>
<thead>
<tr>
<th>Points</th>
<th>Rate (95% Confidence Interval), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.5 (0.2-1.1)</td>
</tr>
<tr>
<td>1</td>
<td>1.3 (0.7-2.1)</td>
</tr>
<tr>
<td>2</td>
<td>2.6 (1.5-5.6)</td>
</tr>
<tr>
<td>3</td>
<td>9.1 (5.5-13.8)</td>
</tr>
<tr>
<td>ROC</td>
<td>0.759</td>
</tr>
</tbody>
</table>

### Table 3. Event Comparison of Different Cardiac Risk Indices\(^*\)

<table>
<thead>
<tr>
<th>Event</th>
<th>Original(^13) (N = 1001)</th>
<th>Modified(^15) (N = 455)</th>
<th>Revised(^16) (N = 315)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of cardiac complications</td>
<td>39 (3.9)</td>
<td>47 (10.3)</td>
<td>92 (2.1)</td>
</tr>
<tr>
<td>Heart failure</td>
<td>36 (3.6)</td>
<td>16 (3.5)</td>
<td>42 (1.0)</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>18 (1.8)</td>
<td>14 (3.1)</td>
<td>46 (1.1)</td>
</tr>
<tr>
<td>Ventricular tachycardia/cardiac arrest</td>
<td>12 (1.2)</td>
<td>NA</td>
<td>16 (0.4)</td>
</tr>
<tr>
<td>Cardiac death</td>
<td>19 (1.9)</td>
<td>11 (2.4)</td>
<td>12 (0.3)</td>
</tr>
</tbody>
</table>

*Data are given as number (percentage).

Abbreviations: CXR, chest radiograph; ECG, electrocardiogram; HF, heart failure; MI, myocardial infarction; PND, paroxysmal nocturnal dyspnea; TIA, transient ischemic attack.
corporating the markers in routine
tion of HF and diagnosis of HF as a
prove both preoperative classifica-
peptide, it may be possible to im-
proval of commercial assays for B-
viewer classified events rather
most of the studies, a single re-
tually in the postoperative period,
diographs since it was not done rou-
primary provider to order chest ra-
all of the studies depended on the
importance of natriuretic peptides as
American Heart Association (ACC/
American College of Cardiology/
that are now recommended by the
have shifted from emphasizing physi-
Original13 Modified15 Revised16
Preoperative assessment of HF
has shifted from emphasizing physical
examination signs to simply hav-
ing a history of HF. In doing so,
problems of interobserver variabil-
ity and reproducibility in general
application were reduced. In the Re-
vised Cardiac Risk Index, the inves-
tigators defined HF by a combina-
tion of symptoms and signs that
incorporated some of the Framing-
ham criteria, but important ele-
ments were still missing such as or-
thropnea and dyspnea on exertion
that are now recommended by the
American College of Cardiology/
American Heart Association (ACC/
AHA) guidelines for the definition
of HF.10,18,20

The studies required a postop-
erative chest radiograph for confir-
mation of HF, which helped stan-
dardize the diagnosis.13,15,16 However,
all of the studies depended on the
primary provider to order chest ra-
idographs since it was not done rou-
tinely in the postoperative period,
causing end points to be missed. For
most of the studies, a single re-
viewer classified events rather than
a central events classification com-
mittee.13,15,17-21,22

Over the last several years, nu-
merous studies have highlighted the
importance of natriuretic peptides as
diagnostic and prognostic markers
in HF.23-26 With the recent ap-
proval of commercial assays for B-
type natriuretic peptide and N-
terminal pro-B-type natriuretic
peptide, it may be possible to im-
prove both preoperative classifica-
tion of HF and diagnosis of HF as a
postoperative complication by in-
corporating the markers in routine
assessment. Further studies will be
needed to assess the utility of such
a strategy.

Echocardiography
Although echocardiography ap-
ppears to be very accessible and
potentially useful test for preoper-
ative evaluation, it has limited prog-
nostic value as a routine test. To help
determine the value of routine echo-
cardiography in preoperative screen-
ing, Halm et al27 evaluated 339 of 474
consecutive men in a Veterans Af-
fairs medical center with known or
suspected CAD. In this study, 8% of
patients had HF and 3% had ische-
ic events postoperatively. Al-
though an ejection fraction less than
40% and wall motion score were as-
associated with some outcomes, both
had poor predictor characteristics.

In a more recent study, Rohde and col-
leagues28 evaluated 570 patients en-
rolled in the Revised Cardiac Risk
Index cohort who under-
went trasthoracic echocardiogra-
phy at the discretion of their
physician within 3 months of sur-
ery. Overall, models including the
reported echocardiographic data pre-
dicted major cardiac complications
better than models with only clini-
cal variables (c-statistic, 0.73 vs 0.68;
P<.05). An abnormal echocardi-
ogram with any degree of systolic dys-
function, moderate to severe left ven-
tricle (LV) hypertrophy, moderate to
severe mitral regurgitation, or aor-
tic gradient of 20 mm Hg or greater
provided a sensitivity of 80%, speci-
ficity of 52%, positive predictive
value of 12%, and negative predict-
ive value of 97%. However, severe
LV dysfunction compared with mild
to moderate LV dysfunction did not
have as strong an association with
cardiogenic pulmonary edema and
MI. The heterogeneity of these find-
ings likely points out that HF and is-
chemic heart disease comprise a
combination of factors that change
every day, while we usually only
measure a few at 1 point in time.
Therefore, in the end, adding echo-
cardiography added little to risk
models.

Preoperative Stress Imaging
and HF
A number of studies have evalu-
ated stress imaging in preoperative
risk assessment; the largest experi-
nen with dipyridamole thallium-
201 imaging.29 Eagle and col-
leagues31 used a combination of
clinical and thallium data for pre-
operative assessment in patients with
vascular disease. The latest study
from his group used a model incor-
porating the clinical variables of ad-
vanced age (>70 years), angina, his-
tory of MI, diabetes mellitus, history
of HF, and prior coronary revascu-
larization.22 Importantly, even in that
study that emphasized ischemic
heart disease, HF was an important
predictor of the primary outcome
(nonfatal MI, fatal MI, or cardiac
death) in the training set and vali-
dation set with odds ratios of 2.7 and
3.2, respectively. Although thal-
lium scoring correlated with events,
the results showed that only the in-
termediate-risk group based on clini-
cal assessment benefited from fur-
ther testing to stratify patients into
low- and high-risk categories.

Table 4. Heart Failure (HF) Evaluation Definitions of the Different Cardiac Risk Indices

<table>
<thead>
<tr>
<th>Original13</th>
<th>Modified16</th>
<th>Revised16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative history</td>
<td>Not indicated</td>
<td>Respiratory distress relieved by diuretics</td>
</tr>
<tr>
<td>Preoperative physical signs</td>
<td>S3 gallop, JVD: elevation &gt;12 cm above the fourth intercostal space in midaxillary line</td>
<td>S3 gallop, JVD: &gt;3 cm vertical distance above the sternal angle with patient at 45° angle</td>
</tr>
<tr>
<td>Preoperative studies</td>
<td>CXR with pulmonary venous congestion</td>
<td>New or worsened HF, new respiratory distress, S3 gallop, JVD, and CXR with pulmonary edema or vascular redistribution</td>
</tr>
<tr>
<td>Postoperative diagnosis of HF</td>
<td>Pulmonary edema with classic CXR changes or respiratory distress and rales at least three fourths of the way up the lung fields that improved promptly with diuretic therapy</td>
<td>Pulmonary edema on CXR in a plausible clinical setting</td>
</tr>
</tbody>
</table>

Abbreviations: CXR, chest radiograph; JVD, jugular venous distention; PND, paroxysmal nocturnal dyspnea.
As observed by Eagle and colleagues, HF played a major role as a clinical predictor in other studies evaluating perfusion imaging. In a meta-analysis combining 5 studies using thallium imaging for preoperative risk assessment in 1188 patients, HF was the second most important predictor of cardiac events behind reversible thallium defect (odds ratio, 3.6; P<.001).  

Risk Factors for Postoperative HF

With today’s current approach to preoperative care, it is unclear what the risk factors for postoperative HF are. In a 1990 study by Mangano and colleagues, a history of dysrhythmia, diabetes, duration of anesthesia, vascular surgery, and narcotic anesthesia were all associated with postoperative HF while postoperative ischemia was not. They speculated that vascular surgery placed patients at higher risk because of the length of the procedure and volume of intravenous fluids. In another study, Charlson and colleagues found that the risk for postoperative HF was limited to patients with preoperative symptomatic cardiac disease, especially in patients with diabetes. Another possible factor in postoperative HF may be the inability to administer some HF medications because of the inability to use an oral route postoperatively. Finally, it appears that surgery leads to activation of the renin-angiotensin system and postoperative elevations in cortisol as well as epinephrine levels.  

Timing of HF Perioperatively

Manifestations of perioperative HF usually develop during the day of surgery or the second to third postoperative day, although this is not well studied.  

Perioperative Care

The exact approach to patients with HF in the perioperative period is uncertain, but understanding the degree and cause may be helpful. The ACC/AHA guidelines state, “Every effort must be made to detect unsuspected HF by a careful history and physical examination.”  

The mainstay of perioperative care is to identify patients with intermediate to high risk features and either perform preoperative evaluation with noninvasive testing followed by revascularization or use perioperative β-blockers (Table 5). There are no randomized controlled trials indicating the effect of revascularization preoperatively, and previous observational studies provide a mixed picture. Until a large randomized trial is done, the benefit of revascularization remains to be definitively proven for prevention of perioperative cardiac events. Randomized controlled trials support β-blocker therapy perioperatively, but there have only been 30 patients with HF in these trials. The first major trial using atenolol in 200 patients with CAD or at risk for CAD showed a reduction in deaths and combined cardiovascular outcomes. However, the benefit was not apparent until after discharge and was largely seen during the first 6 to 8 months after surgery, although the protocol only stipulated therapy during hospitalization.

The Dutch Echocardiographic Cardiac Risk Evaluation Applying Stress Echocardiography (DECREASE) study also supports the merits of perioperative β-blocker therapy. Of the 846 patients screened with dobutamine echocardiography, 112 with positive test results were ultimately randomized to perioperative treatment with bisoprolol or standard care. The primary end point of death from cardiac causes or nonfatal MI was significantly different between the randomized groups; 2 patients (3.4%) in the bisoprolol group compared with 18 patients (34%) in the standard care group (P<.001) experienced the primary end point. Of note, 8 patients with extensive wall-motion abnormalities either at rest or during stress testing were excluded. If the Revised Clinical Risk Index is considered, dobutamine stress echocardiography only adds significant prognostic information for patients with 3 or more risk factors. Thus, in most patients who have fewer than 3 risk factors, use of perioperative β-blockade without having to undergo substantial testing appears reasonable. However, the study was limited in describing an approach for patients with HF since it only had 14 patients with HF and HF was not an outcome.

One issue that arises in surgical patients that may be particularly important for patients with HF is how to administer their medications appropriately if patients are not able to take anything orally. Clinicians use intravenous medications such as β-blockers in the perioperative period, but timing or duration is uncertain in patients with worsening HF, given the small number of patients in clinical trials. More-

Table 5. Tests and Strategies for Managing Patients With Heart Failure (HF) in the Perioperative Setting

<table>
<thead>
<tr>
<th>Test or Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perioperative β-Blockade</strong></td>
<td>Patients with HF should normally be taking β-blockers for long-term benefits. If not, try to start β-blocker therapy early enough to ensure it is well tolerated before surgery.</td>
</tr>
<tr>
<td><strong>Stress Testing</strong></td>
<td>It should be done in high-risk patients with ≥3 points on the Revised Cardiac Risk Index or in patients considered at intermediate risk who are unable to receive perioperative β-blockers or if testing would be done as normal clinical care for long-term goals.</td>
</tr>
<tr>
<td><strong>Degree of HF Compensation</strong></td>
<td>Currently, requires clinical judgment. No objective testing strategies have been evaluated in the perioperative setting.</td>
</tr>
<tr>
<td><strong>Echocardiography</strong></td>
<td>Routine use of echocardiography does not add information for risk stratification or potential changes in management. It should be reserved for evaluation of clinical changes as done for routine management of HF.</td>
</tr>
<tr>
<td><strong>Right Heart Catheterization and Monitoring</strong></td>
<td>Current evidence does not support its routine use. If needed, measurement of central venous pressure is adequate for perioperative management of volume status.</td>
</tr>
</tbody>
</table>
over, the pharmacodynamics of intravenous medications may not be as well appreciated by clinicians compared with the more routinely used oral agents.

**Intraoperative Monitoring**

For patients with HF, some investigators recommend right heart catheterization (RHC) in the perioperative period depending on the clinical situation. Intraoperative hemodynamic changes are associated with increased complication rates, so logically most would assume invasive monitoring would reduce perioperative complications.

In an observational cohort study of 4059 patients who underwent major noncardiac surgery (excluding abdominal aortic aneurysm repair), the value of RHC was underwhelming. Over 200 patients had an RHC, with an overall 3-fold increase in the incidence of major postoperative cardiac events and an adjusted odds ratio of 2.0 for postoperative cardiac events. In evaluating ischemic outcomes alone, TEE was not predictive beyond routine clinical data.

**LIMITATIONS OF PREVIOUS STUDIES**

Preoperative evaluation has progressed substantially, but several limitations could be addressed in the future. Most of the prior studies were done in a single center, and only recently have studies incorporated multiple centers. However, these ongoing studies may be limited owing to the unique population within the Veterans Affairs system or because of the difficulty in generalizing from academic centers to community practice. Future studies must also address prior study limitations such as end point adjudication with a multiple reviewer system and standardized evaluation of HF outcomes. Finally, assessing early events after discharge and readmissions that may be related to perioperative cardiovascular events should be captured.

**FUTURE DIRECTIONS**

Now it is time to turn to evaluation of other medications and other preoperative risk stratification strategies, especially in patients with HF. Physicians do not routinely follow evidenced-based guidelines for risk stratification and testing strategies, while at the same time their estimates of cardiac risk compared with validated indices are poor. Thus, the future will require a diverse group of clinicians to efficiently and accurately evaluate a large number of patients possibly at higher risk.

Medications, such as statins, which were shown in a recent case-control study and another observational study to lower risk of perioperative cardiac complications, should be validated prospectively. In patients with HF or at risk for HF when undergoing noncardiac surgery, studies should evaluate the role of digoxin and angiotensin-converting enzyme inhibitors as well as other new therapies.

Measurement of multiple biomarkers such as natriuretic peptides or C-reactive peptide may provide a simple and efficient method of risk stratification compared with undergoing expensive noninvasive studies or even cardiac catheterization. In patients with NYHA class III-IV HF, the role of RHC or other noninvasive tests such as bioimpedance before surgery may be useful in addition to new therapies that may be available without as many adverse effects as currently used inotropic agents.

Finally, because of the pressure to reduce length of stay and prevent readmission, studies should evaluate new strategies, such as measurements of B-type natriuretic peptide levels, to aid decision making for discharge of patients with HF. Thus, there are many potential areas of investigation needed to reduce the morbidity or mortality of patients with HF undergoing major noncardiac surgery.

**CONCLUSIONS**

Patients with HF have as significant a risk of perioperative complications as patients with ischemic heart disease, and they should be evaluated thoroughly to ensure that they are well compensated prior to undergoing surgery and that standard perioperative β-blockade is used. Excessive testing with echocardiography or RHC does not necessarily assist in determining safety for surgery. Stress testing for high-risk patients may help in deciding proper therapies or revascularization strategies, while those at intermediate risk may only need β-blocker therapy. In most well-planned elective surgical procedures, the issues of stability while receiving β-blockers should already be settled. Postoperative monitoring for decompensation, appropriate medication use, and early fol-
low-up by a primary care provider should help further reduce perioperative complications.

There remain a number of unresolved issues, and perioperative care may need to be improved in patients with complex cardiovascular disease such as HF. Last minute cardiac consultations are already a part of daily care in the preoperative setting. Therefore, pathways for risk assessment and intervention should be simplified. Prior studies have emphasized ischemic heart disease, but with emerging techniques such as the measurement of biomarkers, more accurate determination of HF in the measurement of biomarkers, more accurate determination of HF in the preoperative setting may lead to further refinements in prognosis or diagnosis in patients undergoing noncardiac surgery.

Accepted for publication October 10, 2003.

Dr Hernandez is supported in part by an American College Cardiology Foundation/Merck grant.

Correspondence: Christopher M. O’Connor, MD, DUMC Box 3336, Duke University Medical Center, Durham, NC 27710 (oconn002@mc.duke.edu).

REFERENCES

39. Hassan SA, Hlatky MA, Boothroyd DB, et al. Out comes of noncardiac surgery after coronary bypass surgery or coronary angioplasty in the By-