SUMMAR' AND CONCLUSION

Pre-operative preparation is an important part in the anaesthetic management of surgical patients, not only so that the anaesthetist may study the patient's physical problems, but also he may give him psychological support for his forth-coming operation. Anaesthetist should offer skill in dealing with the patient's physical disability and understanding **his emotional reaction to** his disability, this **is the** way that fear and anxiety can be allayed.

Pre-operative assessment should detect diseases that may influence subsequent anaesthetic and post-operative management. Complete pre-operative examination should be performed by the anaesthetist, special examinations and laboratory studies should be carried out when necessary. This will help the anaesthetist to plan the proposed anaesthetic management and to estimate the operative risk. Anaesthetist should choose anaesthetic agents and techniques that lie within his limits of confidence, meet the patient's needs and satisfy surgical demands.

Occasionaly an operation must be postponed such as when the patient contracts a respiratory infection or digitalization is inadequate. Standard practice may have

be abandoned in an emergency. Operation may be necessary even though a full stomach or an exceptionally law hematocrite reading will otherwise dictate delay. Special care and preparation are required for certain diseased patients e.g. those with liver, chest or heart disease.

Premedication emerged in the beginning of this century by using drugs such as morphine, atropine and hyoscine before chloroform and then before ether anaesthesia. The aim of premedication was to reduce the dose of anaesthetics and to overcome their side-effects as vagal stimulation and increased secretions. The use of anticholinergic premedicant is now criticized by many anaesthetists because the degree of vagal blockade produced by these drugs is uncertain. Modern anaesthetic agents and techniques, with the exception of ether, do not cause any great problem with secretions. The chief goal of premedication that remains is the relief of anxiety. Many drugs have been used for this purpose, such as opiates, barbiturates, phenothiazine derivatives, butyrophenones and benzodiazepines. It is important to emphasize that these drugs are an aid, not a substitute for sympathy and reassurance.

Premedication may be ordered with great care in special circumstances e.g. the very old, the very young, the shocked and the dehydrated patients. Patients with full stomach may be premeditated with drugs that enhance gastric emptying as metoclopramide, or durgs that neutralize acid contents of the stomach as antacids or cimetidine. Alcoholics, drug-addicts, and candidates for out-patient surgery need special care in premedication.