INTRODUCTION

Anxiety is an emotional state characterised by feelings of nervousness, worry, apprehension, and tension due to high activity of the autonomic nervous system. \[1,2\] Earlier studies have reported the prevalence of pre-operative anxiety ranging from 10% to 80%. \[3,4\] Pre-operative anxiety has both psychological and physiological effects by activation of the hypothalamic–pituitary–adrenal axis. \[5\] It can lead to deleterious effects on the haemodynamic parameters during the perioperative period; affect the overall anaesthesia management and surgical outcome by delayed awakening, post-operative pain, nausea–vomiting, delayed wound healing, and post-operative cardiac events. \[4-6\]
Pharmacological medications are used to reduce anxiety, but they may induce some adverse effects. In contrast to this, various non-pharmacological interventions like—reassurance, music therapy, breathing exercises, meditation, acupressure, pre-procedure education are used to allay pre-operative anxiety and they are inexpensive, easy to perform, do not require high level of technical skill or equipment and are without adverse effects.[7] Previous randomised controlled trials of pre-procedure education such as structured interview, multimedia, and question prompt tool were found to be more effective than conventional methods, but no study is available till date about the use of anaesthesia information sheet as a tool for pre-procedure counselling. No literature is available for the same in the Indian scenario. Hence, this study was designed to evaluate the effect of pre-operative counselling of patients using anaesthesia information sheet on anaesthesia-associated pre-operative anxiety as a primary objective. Secondary objectives were to assess pre-operative anxiety for surgery, correlation of demographic data with pre-operative anxiety and common causes of pre-operative anxiety.

**METHODS**

After obtaining institutional ethics committee approval (IEC/HMPCMCE/120/Faculty/19/215/20) and Clinical Trial Registry of India (CTRI/2021/04/032673) registration, this prospective randomised controlled study was conducted from April 2021 to December 2021. 110 patients of 18–70 years of age of either gender, American Society of Anesthesiologists (ASA) grade I–III, minimum education up to the fifth grade, able to understand either Gujarati, Hindi, or English languages, posted for elective surgery of 1–3 hours duration from General surgery, Gynaecology, and Orthopaedic departments were included in our study. Patients with a previous diagnosis of mental illness, cognitive dysfunction or on anti-anxiety medications were excluded from the study. The principles of the declaration of Helsinki were followed during the conduct of the study.

Assuming a moderate effect size of 0.6, a sample size of 50 per group was required, allowing for 5% type-I error to achieve 85% power. Considering 10% loss to follow up for various reasons, the sample size was increased to 55 per group. Standard formula viz. $n = \frac{2 \times (\alpha + Z\beta) \times \sigma^2}{\delta^2}$ was used to calculate the sample size and the calculations were performed in Microsoft Excel.

A total of 125 patients were assessed for eligibility and 110 patients were enrolled. After obtaining written informed consent, patients were randomly allocated to intervention or control groups by computer-generated random numbers using WINPEPI (WINdows Programs for EPIdemiologists).[8] The allocation was kept in an opaque-sealed envelope and the envelope was opened only after an eligible participant consented for the study.

An anaesthesia information sheet was prepared in English, Hindi, and Gujarati languages with communicative translation method. Internal and external peer review was done to ensure face validity of the prepared information sheet. The sheet had details about the meaning of anaesthesia, different types of anaesthesia, pros and cons of each method, the preparation of patient for anaesthesia and post-operative care [Annexure 1].

During pre-anaesthesia check-up, on the day prior to the surgery, pre-operative anxiety was assessed by the principal investigator who was involved in the study, using two questionnaires of visual analogue scale of anxiety (VAS-A): (1) VAS-A for anaesthesia and (2) VAS-A for surgery. VAS-A question was rated from 0 to 100, in which 0 means no anxiety and 100 means maximum anxiety. The patients were asked about the possible causes of their anxiety, previous history of surgery, any negative experiences with previous surgeries etc. Participants in Group-A were counselled by a third-year resident involved in the study, using an anaesthesia information sheet. Their queries were clarified during the counselling. Participants in Group-B were given information about anaesthesia by conventional verbal counselling with addressing of their queries by the same third-year resident. After an interval of 2h, anxiety for anaesthesia and surgery was reassessed by the principal investigator in both the groups using VAS-A scale. This investigator was blinded for the type of counselling method. If VAS-A was more than 40 in any group, patients were advised to take an anti-anxiety drug in the form of tablet alprazolam 0.5 mg on the night before surgery.

Descriptive statistics [mean (standard deviation), frequency (%)] was used to depict the profile of the participants. Effect of both modalities on VAS-A for anaesthesia and VAS-A for surgery was assessed using paired t test. The reduction in VAS-A for anaesthesia and surgery was contrasted across the groups using analysis of variance (ANOVA) on difference scores.
Variations in VAS-A for anaesthesia and surgery at baseline with various sociodemographic variables were assessed using ANOVA. A P value less than 0.05 was considered statistically significant. The analysis was performed in STATA (14.2) version.

**RESULTS**

110 patients, (51 General surgery, 25 Gynaecology, and 34 Orthopaedics patients) were recruited in two groups (n = 55 each). All studied patients were analysed and followed up [Figure 1].

Demographic profiles (age, gender, marital status, literacy) along with previous history of surgery, any negative experience during previous surgery, types of anaesthesia, duration of surgery and type of surgery were comparable in both the groups [Table 1].

The overall incidence of pre-operative anxiety in the study population was 36.6%. Intra-group comparison of intervention Group-A and control Group-B for pre- and post-counselling scores for anxiety about anaesthesia and surgery was statistically significant (P < 0.001) [Table 2]. The reduction in mean of VAS-A for anaesthesia in Group-A was 16.6 ± 6.9 as compared to Group-B was 4.4 ± 5.8 (P < 0.001). Reduction in mean of VAS-A for surgery in Group-A was 14.6 ± 7.8, while in Group-B was 4.8 ± 7.3 (P < 0.001) [Figure 2, Table 2].

Thematic analysis of the responses on the open-ended question “What are the things that you are afraid of?” The most common causes reported by patients were fear of intra-operative pain 87.3%, post-operative pain 41.8%, recovery issues 6.4%, and others 32.7%.

The female gender was significantly associated with higher pre-operative anxiety for anaesthesia (P < 0.001) and surgery (P = 0.01). Increasing ASA grade was associated with higher pre-operative anxiety for anaesthesia (P = 0.04) and surgery (P = 0.02) [Table 3]. About 21% of patients (n = 23) required anti-anxiety medications in the study population. Trends suggested lower need for anti-anxiety medications in intervention Group-A compared to control Group-B albeit the difference was not statistically significant [16.4% vs. 25.5%, P = 0.24]

**DISCUSSION**

Patient anxiety was reduced after pre-operative counselling using either conventional verbal counselling or the newer method-anaesthesia information sheet. However, the use of anaesthesia information sheet for pre-operative counselling showed a significant reduction in anxiety. The overall incidence of pre-operative anxiety in our study was 36.6%, which is comparable to previous studies. Bansal et al. [11] have highlighted in their narrative review that pre-operative anxiety is a neglected issue.

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**Conflict of interest**

The authors declare that there is no conflict of interest.

**References**

1. Kharod, et al.: Anaesthesia information sheet for pre-operative anxiety

**Tables**

Table 1: Demographic profiles

| Variable          | Group A (n = 55) | Group B (n = 55) |
|-------------------|-----------------|-----------------|
| Age (years)       | 50.2 ± 15.3     | 51.1 ± 14.8     |
| Gender (female)   | 32 (58.2%)      | 28 (50.9%)      |
| Marital status    |                 |                 |
| Literacy (%)      | 82 (149.6%)     | 85 (154.5%)     |
| Previous surgery  |                 |                 |
| ASA grade         |                 |                 |

Table 2: Anxiety scores

| Group          | Pre-counselling | Post-counselling | P-value |
|----------------|-----------------|-----------------|---------|
| Anaesthesia    |                 |                 |         |
| Group-A        | 20.0 ± 10.5     | 4.4 ± 6.9       | <0.001  |
| Group-B        | 24.4 ± 11.2     | 8.8 ± 7.3       |         |
| Surgery        |                 |                 |         |
| Group-A        | 22.0 ± 10.0     | 7.8 ± 7.0       | <0.001  |
| Group-B        | 26.6 ± 11.6     | 10.4 ± 8.8      |         |

**Figure 1:** Consolidated standards of reporting trials (CONSORT) flow diagram for the study participants

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and it must be assessed routinely during pre-operative anaesthesia check-up and counselling should be done by anaesthesiologist in patients with a high level of anxiety.

There are various subjective and objective methods used to measure pre-operative anxiety. The objective methods can be more precise in measuring anxiety, but they require continuous monitoring, advanced equipment, skilled staff and are costlier. The subjective methods are easy to practise, do not require any specific instruments, do not require any technical skill and are not expensive. VAS is brief and simple to administer. It has a minimum respondent burden. These characteristics make it ideal for use in routine practice. VAS-A is a valid tool to measure anxiety.[12-15]

The most important finding of this study was a reduction in mean scores of VAS-A for anaesthesia and surgery which was significantly higher in the intervention group (Group-A) compared to control group (Group-B) ($P < 0.001$). In a prospective randomised

![Figure 2: Pre- and post-counselling anxiety scores for anaesthesia and surgery amongst cases (Group-A) and control (Group-B)](image)

### Table 1: Demographic profile of the study population

| Variable                  | Details of Variable | Case (Group-A) ($n=55$) | Control (Group-B) ($n=55$) | $P$  |
|---------------------------|---------------------|--------------------------|----------------------------|------|
| Age (years)               |                     | 46.18 (13.55)            | 46.2 (14.71)               | 0.99*|
| Gender                    | Male                | 56.4% (31)               | 50.9% (28)                 | 0.57**|
|                           | Female              | 43.6% (24)               | 49.1% (27)                 |      |
| Literacy                  | Primary             | 20% (11)                 | 7.3% (4)                   | 0.06**|
|                           | High school         | 43.6% (24)               | 63.6% (35)                 |      |
|                           | Graduate & above    | 36.4% (20)               | 29.1% (16)                 |      |
| Marital status            | Unmarried           | 7.3% (4)                 | 9.1% (5)                   | >0.995***|
|                           | Married             | 90.9% (50)               | 90.9% (50)                 |      |
|                           | Separated           | 1.8% (1)                 | -                          |      |
| Previous surgeries        | Yes                 | 36.4% (20)               | 47.3% (26)                 | 0.25**|
|                           | No                  | 63.6% (35)               | 52.7% (29)                 |      |
| Negative experience during previous surgeries | Yes | 5.5% (3) | 3.8% (2) | >0.995*** |
|                           | No                  | 94.5% (52)               | 96.4% (53)                 |      |
| ASA grade                 | ASA grade I         | 3.6% (2)                 | 3.7% (2)                   | >0.995***|
|                           | ASA grade II        | 56.4% (31)               | 61.8% (34)                 |      |
|                           | ASA grade III       | 40% (22)                 | 34.5% (19)                 |      |
| Type of anaesthesia       | Regional            | 70.9% (39)               | 70.9% (39)                 | >0.995***|
|                           | General             | 29.1% (16)               | 29.1% (16)                 |      |
| Type of surgery           | General surgery     | 43.6% (24)               | 49.1% (27)                 | 0.84**|
|                           | Gynaecology         | 27.3% (15)               | 23.6% (13)                 |      |
|                           | Orthopaedics        | 29.1% (16)               | 27.3% (15)                 |      |
| Duration of surgery in hours |                 | 1.91 (0.47)               | 1.88 (0.55)               | 0.76**|

ASA: American Society of Anesthesiologists; SD: Standard deviation. *Independent sample t-test **Chi square test. *** Fisher’s exact test. Data for Age and Duration of surgery in hours is presented as Mean (SD). Data for all other variables is presented as Percentage (number).
controlled observational study, Jadin et al.\cite{16} reported that VAS for pre-operative anxiety was found 1.2 points lower (out of 10) after structured interview as compared to standard interview in younger patients (<47 years). Jlala et al.\cite{17} in a randomised controlled study, compared counselling by multimedia method versus conventional method, using VAS and State Trait Anxiety Inventory (STAI) and reported a reduction in pre-operative anxiety. They did not aim to separate anxiety related to anaesthesia and surgery in their methodology as contrast to the current study wherein we measured both separately. Lim et al.\cite{18} used a question prompt list as a tool and STAI to measure anxiety in patients undergoing breast surgeries and reported a reduction in anxiety of the patients. Nevertheless, all the questions in the question prompt list were about surgery, whereas we used anaesthesia information sheet and evaluated anxiety for both anaesthesia and surgery. The findings of the current study were similar to previous studies\cite{16–18} and confirm that anaesthesia information sheet is one of the methods of counselling that helps in reducing anxiety more effectively than conventional verbal methods. 16.4% patients were advised anti-anxiety medication in Group-A compared to 25.5% in Group-B, thereby suggesting the lower need for antianxiety medication in Group-A.

The female gender was significantly associated with higher pre-operative anxiety for anaesthesia and surgery in this study. This finding corroborates with previous studies demonstrating higher pre-operative anxiety amongst females as compared to males.\cite{9,17,19} Unfamiliar environment, separation from family, fear of one’s life, length of hospital stay, post-operative pain were the points of concern for female patients.\cite{20} Female patients may need additional comprehensive and individualised pre-operative education to reduce anxiety in the pre-operative period.\cite{21} A systematic review and meta-analysis has shown satisfactory results with music therapy for female patients in the reduction of pre-operative anxiety.\cite{22} It was observed in this study that ASA physical status III patients had higher baseline pre-operative anxiety compared to ASA physical status I and II patients. This may be due to the fear that their comorbidities might increase the risk of surgery and anaesthesia. As per our knowledge, association of ASA physical status grading with pre-operative anxiety has not been studied in the past.

Other demographic variables were not found to be associated with pre-operative anxiety in the current study [Table 1]. Jafar et al.\cite{10} reported increasing level of pre-operative anxiety with increasing level of education, whereas, Lim et al.\cite{18} reported higher anxiety in patients with lower level of education. Mulugeta et al.\cite{3} reported significant association

### Table 3: Association of baseline pre-operative anxiety with demographic factors

| Variable                        | Details of Variable | VAS score of anxiety for anaesthesia | P     | VAS score of anxiety for surgery | P     |
|---------------------------------|---------------------|-------------------------------------|-------|---------------------------------|-------|
| Age                             |                     | 0.159                               | 0.182 |                                 |       |
| Gender                          | Male                | 36.6 (12.88)                        | <0.001| 39.9 (13.99)                    | 0.01  |
|                                 | Female              | 44.6 (12.40)                        |       |                                 |       |
| Literacy                        | primary             | 38.8 (11.21)                        | 0.20  | 44.3 (12.79)                    | 0.32  |
|                                 | High school         | 41.8 (11.96)                        |       | 44.6 (13.33)                    |       |
|                                 | Graduate and above  | 37.4 (12.38)                        |       | 40.3 (14.49)                    |       |
| Marital status                  | Unmarried           | 32.0 (10.47)                        | 0.10  | 35.2 (10.97)                    | 0.18  |
|                                 | Married             | 40.7 (12.04)                        |       | 43.9 (13.77)                    |       |
|                                 | Other               | 35                                  |       | 40                              |       |
| Previous surgeries              | Yes                 | 41.9 (12.31)                        | 0.16  | 44.9 (14.79)                    | 0.25  |
|                                 | No                  | 38.6 (11.81)                        |       | 41.9 (12.77)                    |       |
| Negative experience during surgeries | Yes | 40.0 (12.85)                        | 0.84  | 40.4 (22.77)                    | 0.71  |
|                                 | No                  | 39.9 (11.98)                        |       | 43.2 (13.34)                    |       |
| ASA grade                       | ASA grade I         | 31.2 (13.14)                        | 0.04  | 31.7 (14.10)                    | 0.02  |
|                                 | ASA grade II        | 38.3 (11.85)                        |       | 41.3 (12.63)                    |       |
|                                 | ASA grade III       | 43.3 (11.66)                        |       | 47.2 (14.22)                    |       |
| Type of anaesthesia             | Regional            | 38.6 (12.19)                        | 0.06  | 41.7 (13.56)                    | 0.09  |
|                                 | General             | 43.4 (13.56)                        |       | 46.6 (13.51)                    |       |
| Type of Surgery                 | General Surgery     | 39.96 (12.88)                       | 0.49  | 43.3 (14.58)                    | 0.34  |
|                                 | Gynaecology         | 42.29 (11.89)                       |       | 46.16 (13.98)                   |       |
|                                 | Orthopaedics        | 38.44 (11.02)                       |       | 40.88 (11.88)                   |       |

ASA: American Society of Anesthesiologists; VAS: Visual analogue scale; SD: Standard deviation. Data for all variables is presented as Mean (SD). Data for Age is presented as a number (Pearson’s correlation coefficient).
between pre-operative anxiety and gender, age, marital status, educational status, residence, family size, pre-operative information and previous surgical experiences on bivariate analysis. Jadin et al.\[16\] reported no association of pre-operative anxiety with previous experience of anaesthesia, whereas, Jafar et al.\[10\] reported association of pre-operative anxiety with lack of previous surgical experience. This suggests that the variance in pre-operative anxiety varies based on cultural and contextual differences.

The participants in the current study were asked about the possible causes for their anxiety. The most common causes were fear for intra-operative pain (87.3%), post-operative pain (41.8%), recovery issues (6.4%) and others (32.7%) like recurrence of disease, back pain after spinal anaesthesia, sore throat, etc. Mulugeta et al.\[3\] in their study reported fear of complications (52.4%), concern about family (50.4%), fear of post-operative pain (50.1%) and fear of death (48.2%) as the common causes of pre-operative anxiety. Thus, causes for pre-operative anxiety are subjective and can vary depending upon the demographic profile of the patients, their culture, and regional conditions. Also, non-pharmacological pre-operative anxiety interventions should be contextually adapted based on these factors, because anxiety before surgery is a vexatious feeling associated with fear and illness.\[4\] The anaesthesia information sheet was designed on the basis of perspectives about anaesthesia that were prevalent in the general population. It was translated into Hindi and Gujarati languages as per vernacular language of the local subjects. So, it was an economical, reproducible, convenient, and effective non-pharmacological tool designed for this study to reduce pre-operative anxiety. It included a brief introduction to anaesthesia relevant to the layperson about the anaesthesiologist, types of anaesthesia, pre-anesthetic check-up, consent, and intra-operative and post-operative management including pain control. The counselling process was not limited to the content of the sheet and patients were encouraged to seek clarifications.

This study has some limitations. Though several subjective and objective tools are available to measure the pre-operative anxiety, VAS-A was used. The results obtained by this study can show some subjective variations. Using multiple tools could have increased the accuracy of the results. Information related to anaesthesia was provided using an anaesthesia information sheet during pre-operative counselling, but similar information about surgery was not included as it was not a part of the study. Anxiety was assessed a day before surgery, before and after counselling using anaesthesia information sheet. Reassessing the patient in the pre-operative room, just before shifting the patient to the operation theatre would have given more information about the effectiveness of using anaesthesia information sheet. There was no pre-operative assessment by a psychiatrist to exclude the patients who had undiagnosed psychological and cognitive disorders coming to the hospital for the first time. It should be noted that pre-operative anxiety is a complex multifactorial phenomenon. Use of an information sheet during pre-operative counselling is just one method to reduce it. Determining various causes for pre-operative anxiety and developing multimodal strategies to reduce it should be tried with the intention of assessing synergistic interaction amongst different strategies. This can help to develop an institutional protocol to address the issue of pre-operative anxiety and management for the same.

**CONCLUSION**

Pre-operative counselling using anaesthesia information sheet is more effective in reducing pre-operative anxiety than conventional counselling in patients undergoing elective surgery. Females are more anxious than males and pre-operative anxiety increases with increase in ASA grading of the patients. The common factors leading to pre-operative anxiety amongst patients are fear of intra-operative and post-operative pain.

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**Conflicts of interest**

There are no conflicts of interest.

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ANNEXURE 1: ANAESTHESIA INFORMATION SHEET

Anaesthesia Information Sheet

- Anaesthesia is given to the patient before any surgical procedure, to stop the feeling of pain during and after any surgical procedure by blocking pain signals that reach the brain via nerves.
- Nowadays modern anaesthesia is very safe.
- Anaesthesia is given by a qualified Anaesthesiologist who will take care of patients during and after operation.
- Various types of anaesthesia are available. What type of anaesthesia is to be given to a patient is dependent upon surgical procedure, duration of the procedure, age of patient, general condition of the patient and need for post-operative pain relief.

TYPES OF ANAESTHESIA

1. General Anaesthesia

- In this, before starting the procedure, anaesthetic drugs are injected into a vein, inhalational anaesthetic drugs are given which make the patient unconscious.
- The patient doesn’t remember anything that happened during the procedure.
- Anaesthesiologist takes care of patient’s pulse rate, blood pressure and ventilation during general anaesthesia.
- After surgery, the anaesthesiologist will slowly bring back the patient’s consciousness.
- We give medication to prevent postoperative nausea, vomiting and pain.

2. Spinal Anaesthesia

- This is the most common type of regional anaesthesia.
- Spinal anaesthesia is given for the surgeries in lower abdominal and lower limbs.
- In this, the anaesthetic drug is injected into the lower back, then it causes complete numbness from below the waist for a couple of hours.
- In this, the patient is awake and communicates if anything uncomfortable felt during the procedure.
- It helps in post procedure pain relief till the sensation returns back. Post operative nausea, vomiting is very rare.
3. Epidural Anaesthesia

- In this, a very small diameter flexible catheter is inserted into the back and repeated doses of anaesthetic drugs can be given and is useful for long duration surgery along with general anaesthesia or spinal anaesthesia.
- This technique helps in post-operative pain relief.
- This can also be used for pain relief during labour.

4. Nerve Block

- It is used to numb the specific part of the body by injecting anaesthetic drugs around the nerves causing temporary loss of movements and sensations of that part of the body.
- In this, the systemic side effects are less.

How do we prepare patients for anaesthesia?

- History and physical examination are taken by the anaesthesia doctor.
- All this will help in modifying the drugs and their doses
- Risk stratification is done.
- Patient needs to be kept nil by mouth
- An IV line is secured for providing drugs.

Written and informed consent will be taken from patients and relatives. All the procedures and steps to be done will be informed and explained to the patient.

Post Operative Care

- We give medications to prevent post-operative pain and post operative nausea and vomiting.
- Patients are shifted out of the operation theatre only when he/she is conscious and will be observed by the anaesthesiologist in the recovery room.
एनेस्थीसिया का मतलब चिकित्सा को रोकना है।
- किसी भी ऑपरेशन या नियम से पहले दर्द का एनेस्थीसिया दिया जाता है जिससे नसी से मात्रक तक पहुंचने वाले दर्द संकेत को रोक जाता है और उससे ऑपरेशन दौरान और बाद में दर्द को दर्द महसूस नहीं होगा।
- आजकल अपूर्वक एनेस्थीसिया बहुत ही सुरक्षित हो गया है।
- एनेस्थीसिया ही भाग्य एनेस्थीसियोलॉजी दृष्टिकोण दिया जाता है जो ऑपरेशन के दौरान और बाद दर्द की देखभाल करते।
- एनेस्थीसिया का प्रकार के होते हैं। दर्द को किस प्रकार का एनेस्थीसिया दिया जाता है, यह ऑपरेशन के प्रकार, ऑपरेशन के समय, दर्द की ऊर्ध्वता स्थिति और दर्द की परंपरा पर निर्भर करता है।

एनेस्थीसिया के प्रकार

1. जनरल एनेस्थीसिया
- इसमें ऑपरेशन शुरू करने से पहले एनेस्थीज़ा की दवाइयाँ नस या तो मात्रक से दर्द को ढी जाती है।
- इसके बाद दर्द को कुछ भी याद नहीं रहेता।
- एनेस्थीसियोलॉजी ऑपरेशन के दौरान दर्द की हिंदस्त की धुरकन, बद्द प्रश्न और संसूत का ख्याल रखेंगे।
- ऑपरेशन के दस्ताने एनेस्थीसियोलॉजी धीरे धीरे थर्दी की समान अवस्था में लाएँगे।
- ऑपरेशन के बाद दर्द का दर्द ना हो, उलटा ना हो और गले में खाल ना आए उसका अनाएस्थीसियोलॉजिस्ट ख्याल रखें।

2. भारतीय एनेस्थीसिया
- यह सबसे उपयुक्त उपयोग होते है रीजनल एनेस्थीसिया है।
- भारतीय एनेस्थीसिया नाभ के नीचे के चेक के हिस्से और पैरों के ऑपरेशन के लिए दिया जाता है।
- भारतीय एनेस्थीज़ा में पीओ के नीचे हिस्से में टाइप दी जाती है जिससे कमर के नीचे का भाग योद्दे घटे तक सूचना हो जाता है।
- दर्दी ऑपरेशन के दौरान पूरा समान अवस्था में होता है जिससे अगर उनको कोई तकलीफ हो तो डॉक्टर को बता सकते हैं।
- ऑपरेशन के बाद योद्दे घटे तक दर्द की दर्द में रहने मिलती है।
- भारतीय एनेस्थीज़ा दौरान कभी भी बद्द प्रश्न कम हो सकता है कभी भी कंपक्सी भी अति है जिसका अनाएस्थीसियोलॉजिस्ट ख्याल रखें।
- ऑपरेशन के बाद सर दर्द और कमर दर्द हो सकता है जिसका ख्याल रखा जाता है।

3. पैड्स्टोरल एनेस्थीसिया
इसमें पीढ़ में बहुत ही छोटी जाली जाती है और उसमें से एनाथ्येज़ा की टक्कर दी जाती है।
- यह स्पाइनल या जेनरल अनाथैक्सके साथ दिया जाता है।
- इसका उपयोग प्रस्ताव का दंड कम करने में हो सकता है।

4. नवीन ब्लॉक
- इसका उपयोग शरीर के विशिष्ट भाग को सुधार करने के लिए किया जाता है।
- नसी के वाणी और एनाथेस्टिक दवाओं को टकराने के उस दिन या उसमें के हलस-प्लन और संवेदनाओं को कुछ समय के लिए बन्द किया जाता है।
- इसमें सबसे कम गेरलाभ है।

एनाथ्येसिया के लिए रोगियों को कैसे तैयार किया जाएगा?
- दंड की वीमारी का ड्रिलिंग और गैरशारीक जांच की जाती है और आयुश्चक जांच हो जो एनाथेस्ट्रीडिंग स्टाफ करवाए जाएगी।
- यह सब एनाथ्येसिया का प्रकार, दवाएं और मात्रा छूने में मदद करेगा।
- जोखिम वरीयवन किया जाता है।
- दंड ऑपरेशन से पहले कुछ घंटे तक खाना पीना नहीं दिया जाता।
- दंड की नस में एक जाली डाली जाएगी जिससे अनाथेसिया और दूसरी दवाई दी जाती है।

दंडी और रिश्वेदारों से लिखित और सूचित सहमानति की जाएगी।
- दंडी को सभी प्रक्रियाओं और घड़ी के बारे में समझाया जाएगा।

सन्दर्भ के बाद क्रमाल रखना
- ऑपरेशन के बाद दंडी और उनकी ना हो इसकी टक्कर दी जाती है।
- दंडी को ऑपरेशन चिकित्सक से बाहर तभी से जाया जाएगा जब तब उनके पूरी तरह से होस में आ जाएगा है, और एनाथेस्ट्रीडिंग स्टाफ रूपमें दंडी की देखरेख करेगे।
### Anaesthesia Information Sheet for Pre-operative Anxiety

**Kharod, et al.**

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- Anaesthesia information sheet for pre-operative anxiety
- Kharod, et al.

### Anaesthesia Information Sheet for Pre-operative Anxiety

| 1. General Anaesthesia |
|------------------------|
| - Operations should be performed under local anaesthesia or sedation. |
| - The patient is not aware of the operation or the surroundings. |
| - The patient is premedicated appropriately. |

| 2. Diagnostic Anaesthesia |
|--------------------------|
| - The patient is not aware of the procedure or the surroundings. |
| - The patient is premedicated appropriately. |

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- Spinal anaesthesia and epidural anaesthesia is the first choice.
- Spinal anaesthesia administered to the patient, provided the monitors are functioning.
- Spinal anaesthesia is administered to the patient, provided the monitors are functioning.
- Spinal anaesthesia is administered to the patient, provided the monitors are functioning.
- Spinal anaesthesia is administered to the patient, provided the monitors are functioning.
- Epidural anaesthesia and general anaesthesia are administered simultaneously.

3. Epidural Anaesthesia

- General anaesthesia and epidural anaesthesia are administered simultaneously.
- General anaesthesia and epidural anaesthesia are administered simultaneously.
- General anaesthesia and epidural anaesthesia are administered simultaneously.
- General anaesthesia and epidural anaesthesia are administered simultaneously.

4. Laryngeal Block

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- Patient anxiety in the absence of anaesthesia may lead to patient discomfort and may require additional sedation.
- Anxiety may be managed through preoperative preparation and communication with the patient.

**Anaesthesia Management:**

1. In the absence of anaesthesia, the patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

**Preoperative Preparation:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

**Postoperative Care:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

**Conclusion:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

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**Precautions:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

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**Postoperative Care:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

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**Conclusion:**

1. The patient may experience anxiety and discomfort.
2. The patient may require additional sedation.
3. The patient may need additional communication and reassurance.

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**References:**

1. Kharod, et al.: Anaesthesia information sheet for pre-operative anxiety.
2. Indian Journal of Anaesthesia | Volume 66 | Issue 8 | August 2022