



New Jersey Dental Society of Anesthesiology
October 7th, 2026

Management of the Obese Patient

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Learning Objectives

- Define obesity
- Discuss obesity prevalence
- Discuss physiologic changes in the obese patient
- Discuss anesthetic considerations when treating an obese patient
- Discuss strategies to manage an obese patient safely



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What Is Obesity?

- World Health Organization (WHO): "Overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health"



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What Is The Prevalence? (WHO)

According to the **World Health Organization (WHO)** 2022 statistics

- 1 in 8 people in the world are living with obesity
- 2.5 billion adults (43%) were overweight and 890 million (16%) were obese
- In children/adolescents (age 5-19) 390 million were overweight and 160 million were obese
- Worldwide obesity has more than doubled since 1990 (7% to 16%) and quadrupled in adolescents (2% to 8%)

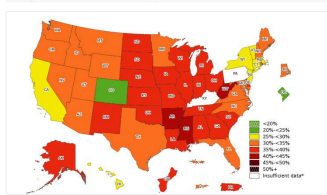
<https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>



4

What Is The Prevalence? (CDC)

Map: Overall Obesity



In 2023, more than 1 in 5 adults in all U.S. states and territories had obesity.

<https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-map.html>



5

What Is The Prevalence? (CDC)

Map: Non-Hispanic White Adults



Sixteen geographic areas had an obesity prevalence of 35% or higher for non-Hispanic White adults.

Map: Overall Obesity



In 2023, more than 1 in 5 adults in all U.S. states and territories had obesity.

<https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-map.html>



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What Is The Prevalence? (CDC)

Map: Non-Hispanic Asian Adults



Map: Hispanic Adults



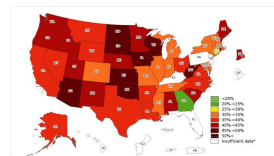
Map: New York: geographic area and statistical obesity prevalence maps: 10%



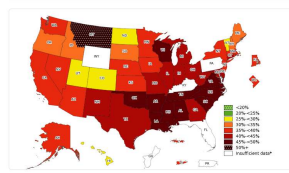
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What Is The Prevalence? (CDC)

Map: Non-Hispanic American Indian or Alaska Native Adults



Map: Non-Hispanic Black Adults



Map: New York: geographic area and statistical obesity prevalence maps: 10%



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What is the Prevalence? (CDC)

Figure 1. Prevalence of obesity in adults age 20 and older, by sex and age: United States, August 2021–August 2023

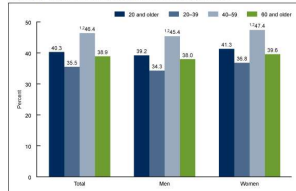
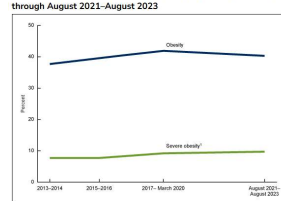


Figure 4. Trends in age-adjusted obesity and severe obesity prevalence in adults age 20 and older: United States, 2013–2014 through August 2021–August 2023



https://www.cdc.gov/obesity/data/adults/obesity.html

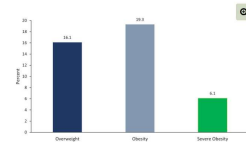


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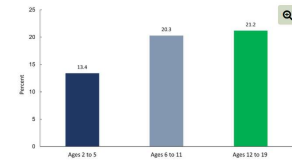
What is the Prevalence? (NIH)

Youth

Prevalence of overweight, obesity, and severe obesity among children and adolescents ages 2 to 19 years: United States, 2017–2018 NHANES data³



Prevalence of obesity among children and adolescents ages 2 to 19 years: United States, 2017–2018 NHANES data³



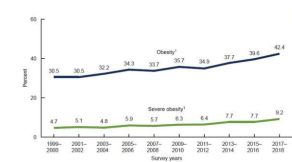
<https://www.cdc.gov/health-information/nhanes/statistics/overweight-obesity>



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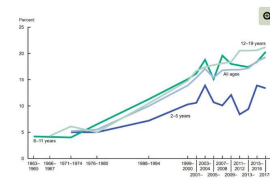
What Is the Prevalence? (NIH)

Trends in age-adjusted (1) (PDF, 47.3 KB) ² obesity and severe obesity prevalence among adults ages 20 and over: United States, 1999–2000 through 2017–2018³



Youth

Trends in obesity among children and adolescents ages 2–19 years, by age: United States, 1993–1995 through 2017–2018³



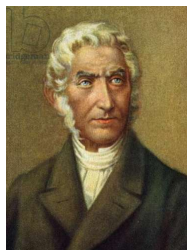
<https://www.cdc.gov/health-information/nhanes/statistics/overweight-obesity>



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Adolphe Quetelet

- Belgian Astronomer and Mathematician
- Proposed the Quetelet Index (later became BMI) in the 1830s
- Based off white European Male



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What is Body Mass Index (BMI)

- Body Mass Index utilizes height and weight to estimate a person's body fat percentage

BMI FORMULA

METRIC UNITS

$$\text{BMI} = \frac{\text{weight [kg]}}{\text{height}^2 [\text{m}^2]}$$

IMPERIAL UNITS

$$\text{BMI} = \frac{\text{weight [lb]}}{\text{height}^2 [\text{in}^2]} \times 703$$



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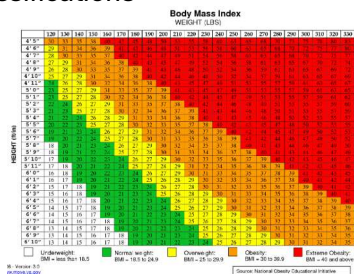
BMI Classifications

WHO CLASSIFICATION OF WEIGHT STATUS	
WEIGHT STATUS	BODY MASS INDEX (BMI), kg/m ²
Underweight	<18.5
Normal range	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥ 30
Obese class I	30.0 – 34.9
Obese class II	35.0 – 39.9
Obese class III	≥ 40



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BMI Classifications



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BMI Classifications Pediatric (Ages 5-19)

Status	Description
Normal weight	BMI >5 th percentile and <85 th percentile
Overweight	BMI ≥85 th percentile and <95 th percentile
Class I obesity	BMI ≥95 th percentile
Class II obesity	BMI ≥120% of the 95 th percentile, or BMI ≥ 35 and <40
Class III obesity	BMI ≥140% of the 95 th percentile or BMI ≥ 40



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BMI Classifications Pediatric (Under 5 years old)

Children under 5 years of age

- **Overweight:** Weight-for-height greater than 2 standard deviations above WHO Child Growth Standards median
- **Obesity:** Weight-for-height greater than 3 standard deviations above the WHO Child Growth Standards median.



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ASA Classifications Based on BMI

ASA 1: BMI under 30

ASA 2: BMI 30-40

ASA 3: BMI >40



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Can BMI Be Inaccurate?

BMI is based on White European males

- **Short Individuals:** BMI tends to overestimate people shorter than 5 feet tall
- **Tall Individuals:** BMI tends to underestimate obesity in people taller than 6'3
- **Athletes:** BMI can overestimate body fat in athletes with more muscle and bone mass
- **Older Individuals:** Loss of muscle tone as we age leads to underestimate
- **Racial/ethnic groups:** BMI tends to overestimate obesity risk for Black population and underestimate the Asian population.

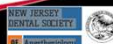


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Can BMI Be Inaccurate?

Dwayne Johnson

- Ht: 6'4
- Wt: 260 lbs
- BMI: 31.6
- BMI Category: Obese



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Can BMI Be Inaccurate?

Shaq

- Ht: 7'1
- Wt: 324 lbs
- BMI: 31.5
- BMI Category: Obese



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Can BMI Be Inaccurate?

Regular Joe

- Ht: 6'0
- Wt: 230 lbs
- BMI: 31.2
- BMI Category: Obese




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Can BMI Be Inaccurate?




23

Can BMI Be Inaccurate?

Dwayne Johnson

- Ht: 6'4
- Wt: 200 lbs
- BMI: 24.3
- BMI Category: Healthy




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Consultation Appointment

What can we accomplish with the consultation appointment?



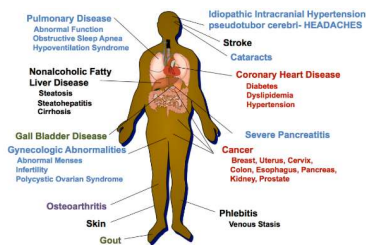
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Health History

- Does the patient have comorbidities that would affect my anesthetic plan?
- Does the patient seek regular medical care? Are there any undiagnosed medical conditions?
- What medications is the patient taking?
- Any history of bariatric surgery?
- Complete a thorough review of systems

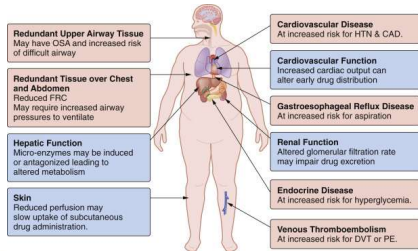
26

Obesity increases the risk of:



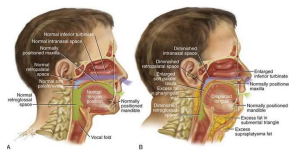
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Anatomical Differences in the Obese Patient



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Increased Adipose Tissue: Upper Airway



Airway obstruction is the most common sedation complication in the obese patient

- Fat deposits in and around the pharynx can lead to blockage or collapse of the airway during sleep/sedation

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STOP BANG

Analyzed variable	Question to be asked/examination findings
S Snoring	Do you Snore Loudly? Louder than talking or loud enough to be heard through a closed door?
T Tiredness	Do you often feel Tired? Do you sleep during the daytime?
O Observed apnea	Has anyone observed you stop breathing during sleep?
P Pressure	Do you have high blood pressure?
B BMI	BMI > 35 kg m ⁻²
A Age	Over 50 years
N Neck	Circumference >40 cm
G Gender	Male

High risk for OSAS: ≥3 positive responses.

Low risk for OSAS: <3 positive responses.

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Airway Assessment

- Mallampati score
- Maximum Incisal Opening
- Upper lip bite test
- Neck range of motion
- Thyromental distance
- Neck circumference (men > 17 in, women > 16 in are higher risk)
- Perceived difficulty to mask: significant facial adipose tissue, beard, retrusive mandible



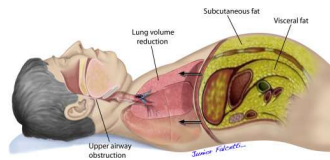
Mallampati I Mallampati II Mallampati III Mallampati IV



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Increased Adipose Tissue: Chest and Abdomen

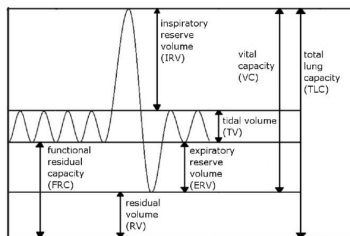
- Higher BMI results in cephalad displacement of abdominal contents which puts pressure on the diaphragm and reduces lung volume
- Reduced lung volumes means quicker desaturations



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Reduced Lung Volume

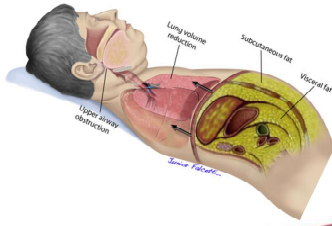
- Compression from excess abdominal adipose tissue leads to decreased functional residual capacity, expiratory reserve volume, and total lung capacity
- To offset ventilation-perfusion mismatch, the respiratory rate typically increases to meet demand



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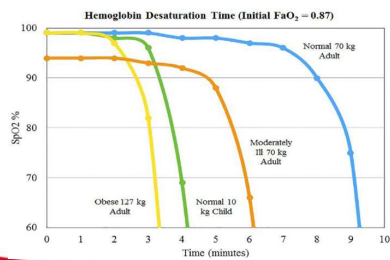
Increased Adipose Tissue: Chest and Abdomen

Consider placing patient at 45 degree angle instead of laying flat



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Reduced Lung Volume



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Increased Adipose Tissue: Peripheral



- Can we get an IV?
- What adjuncts do you have?



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Pharmacokinetic Changes

If anesthetic drugs are weight based, how do I make the proper adjustments?



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Pharmacokinetic Changes

TABLE 5.4. Selected Weight Scales

Weight Scale	Comments
Total body weight (TBW)	The total weight of an individual
Ideal body weight (IBW)	The total weight of an individual
Ideal body weight ^a	The ideal weight associated with maximum life span
Lean body weight (LBW)	of the formula is that at extremes of weight, lean body weight becomes increasingly variable.
Lean body mass (LBM)	Use LBW, accounts for total weight, height, and sex. The TBW formula has addressed the limitation of the LBW formula at extremes of weight.
Adjusted body weight (ABW)	Accounts for increased lean body mass and thereby increased volume of distribution in obese individuals.
Pharmacokinetic mass	Increased for females only. Estimates the apparent pharmacokinetic mass (PK mass) relative to drug weight.
Lean body weight (LBW)	Proportional to TBW and normalized for sex, weight, and height.

TABLE 5.6. Recommended Weight Scales for Selected Intravenous Anesthetics

Drug	Notes	Infusion
Sedatives		
Propofol	Loading dose titrated to target processed EEG level ¹⁰⁴	ABW ¹¹
Midazolam		IBW ¹²
Etomidate		IBW ¹³
Remifentanyl		IBW ¹⁴
Sufentanil		TBW ¹⁵
Hydroxycarbonyl		LBW ^{16, 17, 18}
Morphine		LBW ^{19, 20}
Neuromuscular Blocking Agents and Reversals		
Succinylcholine		TBW ²¹
Rocuronium		IBW ²²
Vincuronium		IBW ²³
Cisatracurium		IBW ²⁴
Signamides		IBW ²⁵

IBC, bicarbonate-phosphate; PK, pharmacokinetic; TBW, total body weight; LBW, lean body weight; LBM, lean body mass; PK mass, pharmacokinetic mass.

Not All Anesthetic Drugs Are Altered Equally By Obesity!!!!!!

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TABLE 5.5. Scaled Weights and Induction Doses of Common Intravenous Anesthetics for a Lean and Obese Male Individual of the Same Height^a

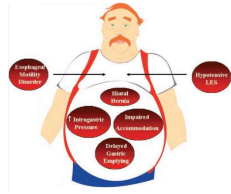
Dosing Scalar	Scaled Weight (kg)		Propofol (2 mg/kg)		Fentanyl (2 µg/kg)		Rocuronium (0.6 mg/kg)	
	Lean	Obese	Lean	Obese	Lean	Obese	Lean	Obese
Total body weight	60	120	12	24	2	5	4	7
Ideal body weight	66	66	13	13	3	3	4	4
Lean body weight	51	70	10	14	2	3	3	4
Fat-free mass	51	73	10	15	2	3	3	4
Adjusted body weight	64	88	13	18	3	4	4	5
Pharmacokinetic mass	58	93	12	18	2	4	4	6

^a Induction doses are shown in milliliters. The lean individual weighs 60 kg with body mass index of 20 kg/m². The obese individual body mass index is 40 kg/m². The lean and obese individuals are of the same height (175 cm).

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Gastroesophageal Reflux Disease (GERD)

- Higher prevalence of GERD in Obese patients
- Delayed gastric emptying may result in the presence of gastric contents despite adherence to NPO guidelines



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February 1st, 2023

"Did you know that pulmonary aspiration of gastric contents during propofol sedation for colonoscopy has been an increasingly noted event over the last decade?"

"Aspiration accounts for 5% of the claims in the American Society of Anesthesiologists Closed Claims Project with death occurring in 57% of these claims and permanent severe injury occurring in an additional 14% of claims."



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Identified Risk Factors in Closed ASA Claim Cases

- GI obstruction or intraabdominal process
- BMI >35, clear liquids <2 hours prior to procedure
- Recent opioid administration
- Treatment for gastroesophageal reflux disease
- Treatment for diabetes
 - Gastroparesis
 - GLP1 receptor agonists
- Previous gastric bypass or gastric sleeve surgery
- History of neurologic disease that could impair oropharyngeal coordination

***Excessive positive pressure ventilation**



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Glucagon Like Peptide Receptor Agonists -1 (GLP-1 RAs)

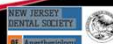
- 12% of people in the US have tried a GLP-1 RA
- How does this affect our treatment?



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GLP-1 RAs

- The GLP-1 RA medications may cause delayed gastric emptying or gastroparesis
- In many cases it may be most prominent the first 12 weeks of initiating therapy and subsides after 20 weeks, but this may not be the case with every patient.
- What are the current recommendations for perioperative management?



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GLP-1 RAs

American Society of Anesthesiologists Guidelines on GLP-1 (2023):

Prior to the Procedure

- If weekly dosing: Hold dose 1 week prior to the procedure
- If daily dosing: Hold dose day of surgery

Day of Procedure

- If GI symptoms are present, delay the procedure



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GLP-1 RAs

ASA updated recommendations in October 2024

ELSEVIER
Surgery for Obesity and Related Diseases 29 (2024) 1143–1160

ASMS guidelines/consensus
Multisociety clinical practice guidance for the safe use of glucagon-like peptide-1 receptor agonists in the perioperative period

Tammy L. Kiehl, M.D., Ph.D.^{1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100,101,102,103,104,105,106,107,108,109,110,111,112,113,114,115,116,117,118,119,120,121,122,123,124,125,126,127,128,129,130,131,132,133,134,135,136,137,138,139,140,141,142,143,144,145,146,147,148,149,150,151,152,153,154,155,156,157,158,159,160,161,162,163,164,165,166,167,168,169,170,171,172,173,174,175,176,177,178,179,180,181,182,183,184,185,186,187,188,189,190,191,192,193,194,195,196,197,198,199,200,201,202,203,204,205,206,207,208,209,210,211,212,213,214,215,216,217,218,219,220,221,222,223,224,225,226,227,228,229,230,231,232,233,234,235,236,237,238,239,240,241,242,243,244,245,246,247,248,249,250,251,252,253,254,255,256,257,258,259,260,261,262,263,264,265,266,267,268,269,270,271,272,273,274,275,276,277,278,279,280,281,282,283,284,285,286,287,288,289,290,291,292,293,294,295,296,297,298,299,300,301,302,303,304,305,306,307,308,309,310,311,312,313,314,315,316,317,318,319,320,321,322,323,324,325,326,327,328,329,330,331,332,333,334,335,336,337,338,339,340,341,342,343,344,345,346,347,348,349,350,351,352,353,354,355,356,357,358,359,360,361,362,363,364,365,366,367,368,369,370,371,372,373,374,375,376,377,378,379,380,381,382,383,384,385,386,387,388,389,390,391,392,393,394,395,396,397,398,399,400,401,402,403,404,405,406,407,408,409,410,411,412,413,414,415,416,417,418,419,420,421,422,423,424,425,426,427,428,429,430,431,432,433,434,435,436,437,438,439,440,441,442,443,444,445,446,447,448,449,450,451,452,453,454,455,456,457,458,459,460,461,462,463,464,465,466,467,468,469,470,471,472,473,474,475,476,477,478,479,480,481,482,483,484,485,486,487,488,489,490,491,492,493,494,495,496,497,498,499,500,501,502,503,504,505,506,507,508,509,510,511,512,513,514,515,516,517,518,519,520,521,522,523,524,525,526,527,528,529,530,531,532,533,534,535,536,537,538,539,540,541,542,543,544,545,546,547,548,549,550,551,552,553,554,555,556,557,558,559,560,561,562,563,564,565,566,567,568,569,570,571,572,573,574,575,576,577,578,579,580,581,582,583,584,585,586,587,588,589,590,591,592,593,594,595,596,597,598,599,600,601,602,603,604,605,606,607,608,609,610,611,612,613,614,615,616,617,618,619,620,621,622,623,624,625,626,627,628,629,630,631,632,633,634,635,636,637,638,639,640,641,642,643,644,645,646,647,648,649,650,651,652,653,654,655,656,657,658,659,660,661,662,663,664,665,666,667,668,669,670,671,672,673,674,675,676,677,678,679,680,681,682,683,684,685,686,687,688,689,690,691,692,693,694,695,696,697,698,699,700,701,702,703,704,705,706,707,708,709,710,711,712,713,714,715,716,717,718,719,720,721,722,723,724,725,726,727,728,729,730,731,732,733,734,735,736,737,738,739,740,741,742,743,744,745,746,747,748,749,750,751,752,753,754,755,756,757,758,759,760,761,762,763,764,765,766,767,768,769,770,771,772,773,774,775,776,777,778,779,780,781,782,783,784,785,786,787,788,789,790,791,792,793,794,795,796,797,798,799,800,801,802,803,804,805,806,807,808,809,810,811,812,813,814,815,816,817,818,819,820,821,822,823,824,825,826,827,828,829,830,831,832,833,834,835,836,837,838,839,840,841,842,843,844,845,846,847,848,849,850,851,852,853,854,855,856,857,858,859,860,861,862,863,864,865,866,867,868,869,870,871,872,873,874,875,876,877,878,879,880,881,882,883,884,885,886,887,888,889,890,891,892,893,894,895,896,897,898,899,900,901,902,903,904,905,906,907,908,909,910,911,912,913,914,915,916,917,918,919,920,921,922,923,924,925,926,927,928,929,930,931,932,933,934,935,936,937,938,939,940,941,942,943,944,945,946,947,948,949,950,951,952,953,954,955,956,957,958,959,960,961,962,963,964,965,966,967,968,969,970,971,972,973,974,975,976,977,978,979,980,981,982,983,984,985,986,987,988,989,990,991,992,993,994,995,996,997,998,999,1000}

ASA updated recommendations in October 2024

NEW JERSEY
DENTAL SOCIETY

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GLP-1 RAs Current Recommendations

1a) Combined discussion on the patient's risk of delayed gastric emptying

- Escalation phase:** Higher risk while ramping up or increasing the dose
- Higher Dose:** Higher risk of GI side effects
- Weekly Dosing:** Higher risk of side effects compared to daily dosing
- Presence of Gastrointestinal Symptoms:** nausea, vomiting, abdominal pain, dyspepsia and constipation band be suggestive of delayed gastric emptying
- Additional medical conditions leading to delayed gastric emptying:** such as bowel dysmotility, gastroparesis and Parkinson's

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GLP-1 RAs Current Recommendations

1a) There should be a combined discussion to determine the risk of delayed emptying.

1b) GLP-1RA therapy may be continued perioperatively in patients without elevated risk of delayed gastric emptying and aspiration based on 1a.

- If the patient is a higher risk of aspiration, a combined discussion should be had to determine the risk assessment of holding or bridging the the GLP-1RAs vs. continuing.
- Recommend not holding for obesity/overweight alone without additional risk factors.

1c) If the decision is made to hold the GLP-1RAs, the duration to hold therapy is unknown.

- Current recommendation is to follow ASA 2023 guideline of 1 week prior for weekly dosing and 1 day prior for daily dosing.

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GLP-1 RAs Current Recommendations

2) Efforts to minimize the risk of delayed gastric emptying in the setting of GLP-1 RAs in the perioperative period should be made. This includes diet modification, altering anesthesia plan to consider RSI in the patient undergoing intubation for general anesthesia.

2a) Preoperative liquid diet for at least 24 hours

2b) When clinical concern for retained gastric contents exists, point of care gastric ultrasound can be used to assess aspiration risk.

2c) When concern for retained gastric contents exists the procedure should be cancelled when possible. If the case must occur, rapid sequence intubation should be considered to minimize aspiration risk. This includes discussion of risks/benefits with the patient.

Kruger D, Wang AY, Wadhwa A, Schreiber M, Shrivastava AC, Smith B, O'Brien J, Lee S, Jasti GP, Lefkowitz D, American Gastroenterological Association. Aspiration Risks in Patients with Retained Gastric Contents. *Journal of Gastroenterology and Hepatology*. 2023;38(12):1711-1718. doi:10.1093/gastro/gzab001. Epub 2023 Oct 12. PMID: 37924818. doi: 10.1093/gastro/gzab001. From: www.gastro.org



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What are we currently doing?

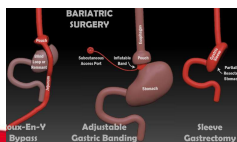
University of Cincinnati Anesthesiology has revised their protocol to liquid diet for 24 hours prior and NPO after midnight/8 hours.



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Bariatric Surgery

- Generally considered in individuals with BMI over 35 kg/m²
- Gastric Sleeve, Gastric Band, Gastric bypass
 - **Sleeve Gastrectomy:** Digestive hormones, gastrointestinal biome and vagal innervation may be affected in this surgery. There is reduced volume of food
 - **Roux-en-Y Gastric Bypass:** creates a small gastric pouch and anastomosis to roux limb of the jejunum that bypasses 75-150cm of the small bowel, restricting food volume and limiting absorption.
- Complications: aspiration, chronic nausea, vomiting, malnutrition and dumping syndrome



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Anesthetic Considerations

- What is my anesthetic plan?
 - Minimal, Moderate, Deep sedation, General Anesthesia
 - Which anesthetic drugs am I going to use?
 - How many different anesthetics am I going to use?
 - Route of delivery: PO, Inhalation, IV, IM
- What is the duration of the procedure?
 - Is this a quick case or longer duration?
- Is a deep level of anesthesia required?
 - Strong gag reflex
 - Painful procedure with difficulty delivering local
 - Extreme anxiety
 - Intellectual disability
- How old is the patient?
- What is my emergency plan? Can I manage an emergency with this patient if it were to happen in my office?



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Anesthetic Considerations

The Two Most Important Questions:

1. Can I sedate this individual safely?
2. Should I be sedating this individual in the office?
 - Are they better suited for a different setting (hospital)



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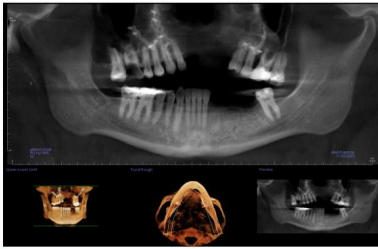
Case Presentation

- 28 y/o Male s/p work related accident with facial trauma leading to edentulous sites in the maxilla and mandible
- BMI 39.9 kg/m²
- Weight 144.7kg (319 lb)
- Height: 6'3



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Case Presentation



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Would You Sedate This Patient?

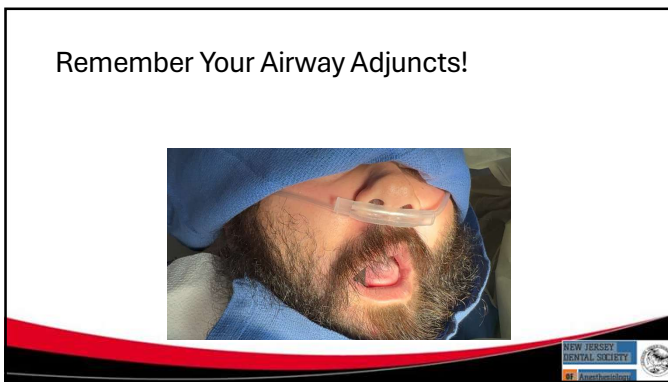
- By Definition ASA 2 (BMI <40)
- Big Beard (difficult mask?)



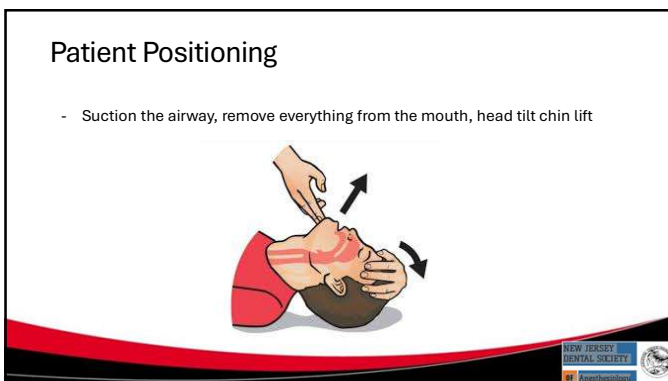
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Oral Airways

- Aid in opening the airway
- Decrease airway obstruction
- Difficult to operate around

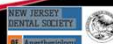
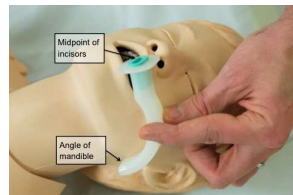


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Oral Airways

Measuring Correct Size

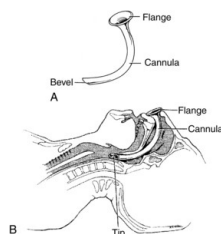
- Quick and easy method is from the angle to lips/incisors



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Nasopharyngeal Airways

- Aid in opening the airway
- Decrease airway obstruction
- Allows for continued, unobstructed operating in the oral cavity



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Nasopharyngeal Airways

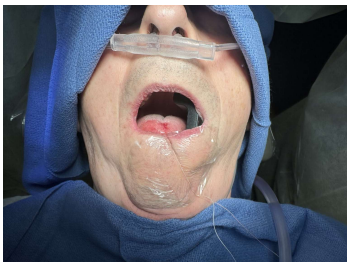
Measuring Correct Size

- Quick and easy method is from the earlobe to the nose



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Tongue Stitch



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Bag Valve Mask

One vs. Two person Masking



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LMA Advanced Airway

- Simple rapid insertion: blind insertion, takes the same time to place as oropharyngeal airway
- Unlike the mask, LMA permits > 20cm of pressure for patients with bronchospasm, emphysema, and/or obesity
- Venting models allow for releasing gastric pressure due to over zealous mask ventilation thus preventing emesis and aspiration

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Reversal agents

Flumazenil IV (Adult)	Flumazenil IV (Peds)	Naloxone IV/IM
Initial Dose: 0.5 mg	Initial Dose: 0.2 mg	Initial Dose: 0.40 mg
Drug Name: Flumazenil IV (Adult) Note: Adult (> 17 y.o.) 0.5 mg IV q1m MAX: 5 mg total dose until patient responsive	Drug Name: Flumazenil IV (Peds) Note: Pediatric (1 to 17 y.o.) 0.2 mg IV q1m MAX: 1 mg total dose until patient responsive	Drug Name: Naloxone IV/IM Note: < 40 kg 0.01 mg/kg IV/IM q2m prn until patient responsive > 40 kg 0.4 mg IV/IM q2m prn until patient responsive Second Dose: < 20 kg 0.1 mg/kg IV/IM q2m prn until patient responsive > 20 kg 2 mg IV/IM q2m prn until patient responsive

Consider utilizing anesthetics you can reverse!

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Considerations For Sedating Obese Patients

- Patient selection is crucial!!!!
- Does this patient fit into a category where BMI would be over or under estimated?
- What are the patient's comorbidities? Are they optimized?
- What aspects of their past medical history are going to affect my anesthetic plan?
- What depth of anesthesia can I safely provide the patient? Can the procedure be done with local or less sedation?
- In what setting should the sedation occur?
- Which medications am I going to use? Can I reverse them?



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Considerations For Sedating Obese Patients

- What positioning am I going to place the patient in? 45 degrees if possible
- Does the patient have a favorable airway exam? Are they at a high risk to obstruct and can I mask them?
- What is my plan to manage obstruction if it were to occur? (adjuncts, emergency equipment)
- Can I Intubate this patient if needed? (Mallampati Score, MIO upper lip bite test)



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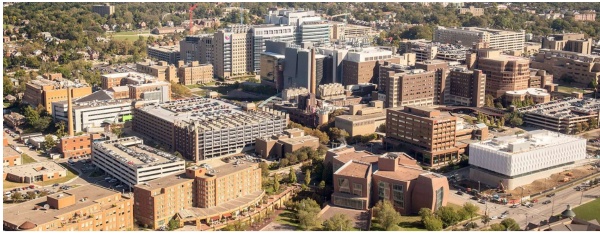
Sometimes you just have to say "No"



Sedation is a privilege not a right



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Thank You
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NEW JERSEY
DENTAL SOCIETY