## Where is IR[[1]](#footnote-1) anyways?

The code to get into the IR suite is 888\* if you take the first double doors closest to the OR

**Pre-op:**

* Routine neuro pre-op
* Make sure to document a neuro exam if they have any deficits
* Monitor for signs of increased ICP if applicable

**Setup:**

* Machine: your AAA tech might need to bring you a machine and cart, make sure you have the right room (IR doesn’t open until 8 AM, so I usually have all my stuff set-up and carry it around in a bag)
  + You’ll need a circuit extension
* Suction
* Monitors: always need an arterial line (may be able to place it post-induction depending on the patient)
* Airway: always a GETA
* IV: you shouldn’t need a hotline
* Drugs:
  + Have Phenylephrine on a pump and in line (put a microtubing extension on it)
  + Have Nicardipine ready (get from Pharmacy) but usually you won’t need it until the end of the case (2.5-15 mg/hr)
  + Drug box
  + Fentanyl or Remifentanil if you want to be fancy (no Sufentanil since you never know when the case is going to end)
  + Doesn’t hurt to have a bottle of Albumin depending on the patient, since you’re so far away from everything

**Intra-op:**

* They can rotate the head of the bed towards you to facilitate airway management but it’s always helpful to have a second set of hands
* Standard induction with arterial line pre- or post-induction depending on the patient
* You need to have all of your cables below the nipple line so that it’s not in their way
* Make sure you don’t have any extraneous cables around the head (temp probe goes axillary)
* If you put an accordion on your ETT, you can make sure your circuit is out of the way
* Your arterial line transducer will need to be within reach so you can draw blood samples for ACTs
* Plug your phenylephrine into the most proximal port
* Place the nerve stimulator on the left hand and make sure you can check it under the drapes without disrupting the surgeon
  + If you are going under the drapes, wait until it’s a good stopping point for the surgeon because for obvious reasons, the patient has to be really still when they are coiling
  + Check your twitches regularly because if the patient bucks, it is not good!
* Limit your IVF and UOP because they get a lot of IVF from the surgeon
* Long story short: keep them paralyzed and keep the BP under control
* The surgeon will repeatedly ask you to hold ventilation, just make sure to remember to resume ventilation because sometimes the surgeon forgets to tell you
* If it’s an elective coiling, always plan on extubating
* If they came to you intubated or they have a very bad head bleed and were obtunded, obviously you are not going to extubate
* They never tell you when they are going to be done so you have to keep them reversible (maybe one twitch at all times?)

**Post-op:**

* These coilings always go to the SICU even if they are elective so you’ll need the SICU handoff sheet
* Monitor your BP during transport and have rescue drugs such as Propofol, uppers, and downers ready as well as a port to inject into

1. Interventional Radiology (aka Angiography) [↑](#footnote-ref-1)