Opinion: Bearded Patients Should Be Required to Shave Prior to Non-Emergent Surgery

David Kam, Catherine Chen, Roxanna Rasekhi
Miller School of Medicine, Department of Anesthesiology, Perioperative Medicine and Pain Management, University of Miami, Miami, USA

Mask ventilation is a fundamental airway management technique in daily anesthesiology practice. In situations of difficult intubation, adequate mask ventilation allows for procurement of adjunct airway devices and the option of ventilating the patient until the effects of induction medications have worn off. Difficult and impossible mask ventilation have both been associated with the presence of a beard. In a review of 50,000 anesthetics, Kheterpal et al. found presence of a beard had an adjusted hazard ratio of 1.9 times risk of impossible mask ventilation. Even more strikingly, presence of a beard is an independent risk factor for difficult mask ventilation combined with difficult laryngoscopy. This increased risk in patients destined to be both difficult to ventilate and to intubate is troubling, as each technique is a rescue for the other.

The presence of a beard impairs adequate mask seal and creates a slippery surface upon which gloved hands have difficulty achieving traction. Several compensatory techniques have been described in the literature, including the use of wet gauze around the mask, a large adhesive dressing to cover the patient’s entire lower face, or a viscous ultrasound gel. However, in clinical practice, removal of the face mask to attempt laryngoscopy displaces the dressing or gauze, and also perpetuates slippery conditions associated with a large volume of jelly.

In lieu of these imperfect maneuvers, we propose that patients presenting for non-emergent surgical procedures be required to shave the night before. Of all the risk factors for difficult and impossible mask ventilation, the presence of a beard is the only easily modifiable contributor. Shaving of a beard is by definition temporary, with continued growth of the beard to its preoperative baseline to be expected. This is therefore a low-risk, high-reward strategy that may save lives.

For patients who agree to shave prior to surgery, we recommend the patients perform the shaving themselves. This shaving can be done at home the evening prior, or in the preoperative area. We suggest that the preoperative area be stocked with safety razors for patients who wish to shave in the bathroom prior to surgery.

Concern for the ethical issue of infringing on patients’ bodily autonomy is justified but can be re-framed. There is no coercion involved, as patients are free to weigh the pros and cons of not proceeding with surgery if they choose to retain their beards. In the interest of patient safety, we similarly provide patients with a chlorhexidine body wash to use the night before, ask them to remove nail polish, and instruct them to be fasting prior to their procedure. These infringements on patients’ daily routines and personal grooming habits are well accepted when patients understand the associated risks and benefits. Religious exemptions should of course be accommodated, and analogously to a refusal of blood product transfusion or pregnancy testing, patients should be required to sign a waiver acknowledging their increased risks of airway management difficulties, hypoxemia, and irreversible neurologic injury.

The decision to move forward with surgery for...
patients who refuse to shave should ultimately be at the discretion of the anesthesiologist. The risk for individual patients is compounded by the presence of other predictors of difficult ventilation and intubation. In non-emergent cases, we therefore recommend a thorough conversation detailing individual risk between patient and physician. Selective cancellation of elective cases for patients with upper respiratory tract infections due to concern for heightened airway reactivity and the possibility of airway complications offers a compelling comparison. In our opinion, continuing with non-emergent surgery in the unaltered presence of a known risk factor for airway disaster is proceeding with a non-optimized patient at best, and causing harm to the patient at worst.

Conflicts of Interest

The authors have no conflicts of interest (or financial support) to declare.

References