



Audit of Structured Perioperative Risk Stratification in a Preoperative Anaesthesia Clinic at a Tertiary Cancer Care Centre

Compliance with 2024 AHA/ACC and 2025 ESAIC Standards

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BACKGROUND

- Structured risk stratification — **ASA-PS, functional capacity, RCRI, and frailty** — underpins safe surgical planning, informed consent, and resource allocation.
- The **2024 AHA/ACC** and **2025 ESAIC** guidelines now both recommend validated RCRI calculation and routine frailty screening.
- Oncology patients carry high comorbidity within compressed timelines — exactly where stratification matters most, and had not previously been audited here.

Aim — determine documentation compliance for ASA-PS, functional capacity, RCRI, frailty score, and overall risk category against AHA 2024 / ESAIC 2025 benchmarks.

METHODS

- Retrospective audit of **100 consecutive patients** assessed in the PAC, SKMCH&RC, Lahore (1–31 May 2026).
- Proforma reviewed for six items: ASA-PS, functional capacity, RCRI, frailty score, overall risk, and a stated risk category.
- RCRI assessed only among patients with **≥1 AHA-defined qualifying factor** (diabetes, hypertension, IHD, current smoking, age >45 yrs).
- Compliance = proportion of the relevant denominator with 95% Wilson CI; benchmark target = **100%** per item.

RESULTS

100

patients audited
mean age 57.0 ± 11.1 yrs

93%

met ≥1 AHA criterion —
eligible for RCRI calculation

1.1%

of those eligible patients
actually had RCRI documented

ASA physical status class	100%
Functional capacity	89%
RCRI (of 93 eligible)	1.1%
Frailty score	2.0%
Overall perioperative risk documented	9.0%
Risk category stated (low/int/high)	6.0%

Parameter	Denom.	95% CI
ASA-PS	100	96.3–100%
Function. capacity	100	81.4–93.7%
RCRI	93	0.2–5.8%
Frailty score	100	0.6–7.0%
Overall risk	100	4.8–16.2%
Risk category	100	2.8–12.5%

Quick, single-judgement items (ASA-PS, functional capacity) approached the guideline target, while every parameter requiring a **calculation or structured instrument** — RCRI, frailty, and the final synthesised risk statement — was documented in fewer than 1 in 10 patients.

DISCUSSION

- Fields needing a **calculation or structured tool** lag well behind quick, intuitive fields — a pattern also seen in other preoperative documentation audits.
- 89% functional-capacity documentation is not reassurance alone: this audit captured only *whether* a value was recorded, not whether it used a validated tool (e.g. DASI).
- The proforma had **no mandatory field** for RCRI or frailty; high patient volume and limited consult time likely compound the gap.

RECOMMENDATIONS

- Auto-prompt **RCRI calculation** whenever a qualifying risk factor is entered.
- Add a brief validated **frailty screen** (e.g. Clinical Frailty Scale) as a standard field.
- Make an explicit **overall risk category** a mandatory close-out field.
- Short, targeted clinician education on the AHA 2024 / ESAIC 2025 updates, then **re-audit** to close the loop.

CONCLUSION

Simple, single-item risk parameters were documented close to guideline targets, but calculated and multidimensional tools — and the final synthesised risk category — were captured in only a small minority of patients. This is a clear, low-cost, and actionable target for structured quality improvement in oncology preoperative care.

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