Fasting guidelines apply to patients 19 years and older receiving anesthesia from the Department of Anesthesia, including general, regional, monitored anesthesia care, and procedural sedation. The purpose of these guidelines is: 1) to reduce the risk of pulmonary aspiration for patients receiving anesthesia services; 2) to assist health care providers and patients in decisions about fasting intervals; and 3) to be consistent with accepted standards of clinical care and evidence-based practice.

Guidelines may need to be modified by the anesthesia provider for patients with co-existing conditions (difficult airway) or conditions that might affect stomach emptying or fluid volume, such as diabetes, hiatal hernia, gastro-esophageal reflux disease (GERD), ileus or bowel obstruction, and emergency care. Patients with these conditions are at greater risk of aspiration when airway reflexes are compromised by sedative medications and may alter anesthetic management.

**UNLESS OTHERWISE INSTRUCTED, BEFORE ELECTIVE PROCEDURES, THE MINIMUM DURATION OF FASTING SHOULD BE:**
- 2 HOURS AFTER CLEAR FLUIDS*
- 6 HOURS AFTER NON-CLEAR FLUIDS
- 8 HOURS AFTER ENTERAL FEEDS OR A MEAL CONTAINING FRIED FOODS, FATTY FOODS, OR MEAT

*Clear fluids are limited to water, apple juice, black coffee or tea (NO milk, cream or creamer), Gatorade®, infant electrolyte solutions (Pedialyte®) and carbonated beverages (Coke®, 7-Up®).

Clear fluids should be utilized to take prescribed medications prior to the procedure. Crushed medications may be administered with up to 2 tablespoons of plain apple jelly.

**These fluids should not include alcohol!**

*Noncompliance may result in delay or cancelation of the procedure! When these fasting guidelines are not followed, consideration of the amount and type of contents ingested along with the risks and benefits of proceeding must be weighed.*

Frequently Asked Questions (FAQ) further elaborate these guidelines and provide guidance for special situations.

**QUESTIONS? CALL THE ANESTHESIA DESK at (319) 356-2724**

Adapted and liberally paraphrased from practice guidelines by the American Society of Anesthesiologists (© 2017) and the European Society of Anesthesiology (© 2011)
QUESTION: Why can’t I eat or drink before my procedure/surgery?

ANSWER: The purpose of fasting guidelines is to minimize the volume of stomach contents. Depression of our protective reflexes occurs during anesthesia. One of the most basic protective reflexes is to keep stomach contents from entering the airway. When stomach contents enter the airway, aspiration occurs. Aspiration is less likely to happen when the stomach is empty. To prevent this risk, the patient’s procedure may be delayed or canceled if guidelines are not adhered to.

QUESTION: Why is aspiration so bad?

ANSWER: Solid or semi-solid stomach contents may make exchange of gases in the lungs impossible. Liquid stomach contents that are acidic may burn the lungs and make gas exchange impossible. Both types of aspiration may lead to brain damage or death. It is possible to treat aspiration once it occurs and most people survive aspiration, but treatment in an intensive care unit is often necessary. Aspiration may prolong the patient’s hospital stay by days to weeks.

QUESTION: Can I chew gum or suck on hard candy while waiting for my procedure or surgery?

ANSWER: Adults (18 years and older) can chew gum or suck hard candy until their procedure. Patients should not have their operations cancelled or delayed just because they are chewing gum or sucking hard candy. Swallowing gum or hard candy is considered a meal and will require an 8-hour fasting period for elective procedures.

QUESTION: If I take food through an enteral or nasogastric tube (e.g., gastric/stomach tube, enteral/jejunostomy tube, etc.) should I observe the same fasting intervals?

ANSWER: Eight hours fasting from enteral feeds is preferred. For patients in whom residual volumes are checked, four hours fasting following the last feeding is safe if residual volumes are not increasing. Feeding should be stopped at the first sign of increasing stomach residual volumes. Continuous duodenal feedings pose a lesser risk of aspiration than stomach feeding. The urgency of the procedure and the need for continuous nutritional support versus the increased risk of aspiration need to be considered by patients and all the medical specialists involved in patient care.

Intubated patients with cuffed endotracheal tubes or with gastric feeding tubes documented to be post pyloric may have enteral feedings continue up to and throughout surgery.

QUESTION: What about perioperative enteral feeding in burned patients?

ANSWER: Burned patients have special metabolic requirements because of increased caloric needs and nutritional support. Intubated patients with cuffed endotracheal tubes or with gastric feeding tubes documented to be post pyloric may have enteral feedings continue up to and throughout surgery.

Non-intubated patients or with enteral feeding tubes in the stomach can have enteral feeding up to 4 hours before surgery unless the gastric residual volume (GRV) is greater than 200% above the hourly volume of feed. For example, if the hourly volume of feed is 30/hr and the GRV residual is 60cc, enteral feeding should be stopped and residual volume suctioned 4 hours before induction of anesthesia.

Tube feeds may need to be discontinued earlier based on co-morbidities of the patient that might make airway management more difficult.

This is only a few of our FAQs. If you would like to comment on these guidelines or for additional FAQs, go to: http://www.anesth.uiowa.edu/ and click on “Fasting Guidelines.”