

Fasting Before Surgery: What You Can Eat and Drink, and Why

Fasting before an anaesthetic: nothing to eat or drink for the time advised.

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On the day of surgery, two things matter most for your safety: the type of anaesthetic you have, and how strictly you follow the fasting instructions you were given.

Why we ask you to fast

A general anaesthetic relaxes the muscles that normally stop stomach contents from coming back up the throat. If your stomach is full, that material can spill into your lungs while you are unconscious, which is serious.

Fasting empties the stomach so this cannot happen. The standard rules are:

- **No food or milk for seven hours** before your scheduled arrival time. This includes lollies, chewing gum, and tea or coffee with milk.
- **Clear fluids are allowed up to 2 hours before:** water, black tea, black coffee, apple juice, clear cordial. Sip, don't gulp.
- **Stop all clear fluids 2 hours before arrival.**

If you have your normal blood-pressure or epilepsy tablets in the morning, take them with a small sip of water unless your anaesthetist has told you otherwise. Diabetic medications and blood thinners are different; follow the specific written advice you were given.

Types of anaesthesia we use

Most upper-limb surgery is done under one of three approaches, sometimes combined:

- **General anaesthetic:** you are fully asleep. The anaesthetist puts you to sleep through a small drip in the back of your hand and looks after you the whole time.

- **Regional block:** local anaesthetic is injected around the nerves in your neck or armpit, numbing the whole arm for several hours. You may also be sedated so you sleep through the surgery, but you are not on a ventilator.
- **Local anaesthetic:** small operations (like a trigger-finger release) can often be done with the area numbed and you fully awake, sometimes with light sedation.

Your anaesthetist will discuss the options with you on the day. The choice depends on the operation, your general health, and what you prefer.

What to expect on the day

You'll arrive 1–2 hours before your scheduled theatre time. A nurse will check your fasting, place a drip, and go through a final consent form. The anaesthetist will see you in person before you go to theatre.

After surgery you'll wake up in the recovery area. If you had a regional block, your arm will feel heavy and numb; this is normal and lasts 8–24 hours. **Protect a numb arm:** keep it in the sling, don't lean on it, and keep it warm. Sensation comes back gradually, often with some pins and needles.

Nausea, drowsiness, and a sore throat (from the breathing tube) are common in the first few hours. Drink slowly, eat lightly, and rest.

In more depth

This section goes further than you need for your own treatment decisions. Anaesthesia is worth the extra reading because the two things patients most want reassurance about – nerve damage from a block, and whether being “awake” is safer than being asleep – both have decent numbers attached, and neither answer is the one intuition supplies.

THE RISK OF LASTING NERVE TROUBLE FROM A BLOCK

Almost everyone having upper-limb surgery is offered a nerve block, and almost everyone asks whether the needle can damage the nerve. It is a fair question, and the honest answer needs a distinction: temporary altered sensation is not rare, and lasting injury is.

A systematic review pooling **12,532** patients examined postoperative neurologic symptoms after regional anaesthesia for upper-extremity surgery, and its central point is methodological but important to you: the aggregate risk looks very different depending on how it is measured. Prospectively assessed randomised trials – where someone actively asks every patient – report far higher rates than retrospective series, where only patients who complain loudly enough get counted [1].

The practical reading: if a study quotes you a very low figure, ask whether anyone went looking. Symptoms that resolve are common enough that they should be described to you as expected rather than as a complication; symptoms that persist are genuinely uncommon.

AWAKE IS NOT AUTOMATICALLY SAFER

There is a widespread belief, held by patients and not only patients, that avoiding a general anaesthetic must be safer – particularly in older people, and particularly regarding confusion afterwards.

The most direct test of that comes from hip fracture surgery, where the question has been studied at scale because the patients are old and frail. Pooling **3,736** patients, regional anaesthesia did **not** significantly reduce postoperative delirium or mortality compared with general anaesthesia [2].

That is a genuinely surprising result and it deserves care in interpretation. It does not mean the choice is irrelevant – it means the choice should be made on the specifics of your heart, lungs, airway and the operation planned, rather than on a general belief that one category is safer. Modern general anaesthesia in a fit patient is very safe, and a block is not a free pass.

WHERE BLOCKS GENUINELY EARN THEIR PLACE

The strongest case for regional anaesthesia is not safety, it is pain. A systematic review of **1,872** patients undergoing surgical repair of proximal humerus fractures concluded that regional anaesthesia is a good option for postoperative analgesia [3] – the first hours after a shoulder operation are the worst, and a block covers precisely that window.

There is also more than one way to do it. For shoulder arthroscopy, a review of **1,382** patients found suprascapular nerve block was **not** more effective than interscalene block for pain control, but had a more favourable side-effect profile [4]. Interscalene blocks reliably produce a temporarily weak arm and can affect the nerve to the diaphragm, which matters if your breathing is already marginal. Where that is a concern, a different block is not a compromise – it is the better operation-specific choice.

WHY FASTING IS THE WAY IT IS

Fasting exists for one reason: an anaesthetised airway cannot protect itself, so stomach contents that come up can go down into the lungs. That event is rare and serious, and the fasting rule is the cheap insurance against it.

The common error is treating “nil by mouth” as a competition. Prolonged fasting does not add safety, and arriving dehydrated makes you feel worse, makes cannulation harder and does nothing for your stomach. Clear fluids empty from the stomach quickly, which is why modern guidance permits them much closer to surgery than food. Follow the times you are given rather than the times you assume – and if surgery is delayed, ask, rather than sitting parched on the assumption that more fasting must be better.

REFERENCES

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CQ HAND + UPPER LIMB

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