

Pre-Op Pediatric Clinical SOAP Note – NURS 5912
Outpatient Surgery Center

CC

MD is a 16-year-old who presents with his mother, who serves as the primary historian, and maternal grandmother for preoperative evaluation prior to his surgical management of nasal septal deviation, bilateral turbinate hypertrophy, nasal valve collapse, post-traumatic nasal deformity, chronic nasal congestion, and nasal obstruction. The patient is scheduled to undergo septoplasty, nasal valve repair, open reduction of nasal fracture with nasal bone osteotomy and midline realignment, and bilateral turbinate reduction with microdebrider-assisted outfracture.

HPI

MD's nasal symptoms began several years ago following multiple facial and nasal injuries. At age 9 (2019), he sustained a chin laceration during a bicycle accident with concern for nasal injury and was evaluated by his primary care provider (PCP); however, facial radiographs were negative for nasal fracture or deformity. At age 11 (2021), he fell from monkey bars and landed on his face, reporting secondary nasal pain at the time, he was evaluated in the emergency department (ED) though no nasal deformity or fracture was identified. In 2023, he experienced multiple nasal traumas, including running into a pole, falling off a bicycle, and being struck in the face by a soccer ball. Following this second bicycle accident, he was evaluated again in the ED and was not informed of a nasal fracture.

At age 14 (2024), the patient was evaluated by his PCP for a progressively crooked nose that had been present for approximately one year. His mother reported worsening nasal deformity following the soccer-related facial injury in 2023. An otolaryngology referral was placed. During his initial ENT evaluation in October 2024, he was diagnosed with severe leftward nasal septal deviation and leftward bony nasal deformity. Surgical intervention versus observation was discussed. With clinical decision making, MD, his mother, and surgeon agreed that observation was an appropriate course at that time.

MD reports that his symptoms began after the first nasal injury in 2019 and have progressively gotten worse over the past 7 years. His symptoms include chronic bilateral nasal obstruction described as a "stuffy nose" with associated clear rhinorrhea, headaches, mouth breathing, and intermittent sore throat. Symptoms are bilateral, moderate in severity, and consistent in frequency. He denies a history of recurrent sinus infections. Aggravating factors include chronic nasal structural abnormalities following repeated trauma. Previous treatments have included nasal saline irrigation, intranasal corticosteroid spray, and allergy medications without symptom improvement. He is not currently on any medications, has stopped all other treatments, and reports no changes in the symptoms listed above.

Most recent ENT examination in 2025, showed a more severe presentation of right nasal sidewall collapse, leftward septal deviation, leftward deviation of the nasal dorsum with depression of the nasal bone, and bilateral inferior turbinate hypertrophy. Following discussion of treatment options, the patient and family elected to proceed with surgical correction after the patient reached 16 years of age. In April 2025, the patient was evaluated by his PCP for dizziness, lightheadedness, vomiting, and tachycardia that occurred at school. Cardiology clearance was required prior to proceeding with surgical planning. He subsequently underwent a Holter monitor evaluation and was cleared by cardiology several weeks later.

After cardiology's clearance the surgery was scheduled, and preoperative and postoperative instructions had been reviewed via telephone and MyChart communication.

ROS

GENERAL: Denies fever, chills, fatigue, weight loss, or weight gain.

HEENT: + nasal obstruction, chronic nasal congestion, clear rhinorrhea, headaches, mouth breathing, intermittent sore throat, history of nasal trauma, nasal deformity, wears glasses/contacts. Denies vision changes, eye pain, eye redness, hearing loss, ear pain, tinnitus, epistaxis, dysphagia, hoarseness, or neck pain.

RESPIRATORY: Denies cough, wheezing, shortness of breath, chest tightness, or pauses in breathing while asleep.
CV: + history of palpitations and tachycardia with normal cardiology evaluation and Holter monitor study, denies current palpitations. Denies history of hypertension or hypotension, chest pain, dyspnea on exertion, syncope, dizziness, edema, cyanosis, or exercise intolerance.
GI: Denies abdominal pain, nausea, vomiting, diarrhea, constipation, reflux, dysphagia, hematochezia, or melena.
GU: Denies dysuria, urinary frequency, urgency, hematuria, flank pain, or changes in urinary habits.
MSK: Denies joint pain, joint swelling, muscle pain, muscle weakness, back pain, neck pain, or limitation of movement.
INTEGUMENTARY: Denies rashes, lesions, itching, bruising, discoloration, or changes in skin, hair, or nails.
NEUROLOGICAL: + headaches. Denies dizziness, syncope, seizures, weakness, numbness, tingling, tremors, gait disturbances, or focal neurologic deficits.
PSYCHIATRIC/BEHAVIORAL: + for hyperactivity and history of suicidal ideation (SI) and homicidal ideation (HI). Denies current SI and HI. Denies anxiety, depression, mood changes, behavioral concerns, sleep disturbances, hallucinations, or self-injurious behaviors.
GROWTH AND DEVELOPMENT: Appropriate for age. No developmental delays reported. MOC denies him ever needing an IEP or 504 plan but he did at one time have a BIP.
IMMUNIZATION STATUS: Up to date on school required vaccines, MOC reports that she does not want him to have the influenza or COVID vaccines.
PAST HISTORY
PMH: Full-term birth at 40 weeks' gestation following an uncomplicated pregnancy with routine prenatal care. No perinatal complications, NICU admission, supplemental oxygen requirement, or neonatal respiratory distress. His medical history is significant for eczema, tachycardia, palpitations, sleep disordered breathing, chronic nasal obstruction, nasal septal deviation, and a history of behavioral concerns, including attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and multiple episodes of SI, HI, and running away from home which began in 2021.
PSH: Significant for circumcision in 2010 and esophagoscopy with removal of a gastric foreign body (glass marble) in 2017. No previous complications with anesthesia have been reported.
FMH: Family history is significant for asthma in the mother, thyroid disease in the maternal grandmother, and heart disease in the maternal grandfather. The patient's father is not involved, and paternal family medical history is unknown. Family history is negative for anesthesia-related complications, bleeding disorders, clotting disorders, T2DM, immunodeficiencies, or other known hereditary conditions.
MEDICATIONS: No current prescription or over-the-counter medication use. MD and his mother deny routine use of vitamins, supplements, or herbal products.
ALLERGIES: NKDA, NKFA. Positive for environmental allergy to pollen extract, resulting in nasal congestion, per family report.
SOCIAL: MD is an only child who lives with his mother and maternal grandmother. His father is not involved due to past domestic violence and substance abuse in the home which resulted in his father's parental rights being terminated. His mother is his primary caregiver and works two jobs. She had to coordinate work and financial arrangements for this scheduled surgery. She denies needing help with obtaining additional support and there are no concerns with transportation or providing food for the family. The patient reports current nicotine and marijuana use through both combustible and electronic cigarette (vaping) products. He denies alcohol and other substance use.

DIFFERENTIAL DIAGNOSIS

This encounter was a preoperative clearance evaluation rather than a diagnostic visit; the differential diagnosis represents the potential perioperative risk conditions that could increase anesthetic or surgical complications and justify postponement of elective surgery. This approach is consistent with the goals of perioperative risk assessment described in the 2026 American Academy of Pediatrics (AAP) preoperative risk assessment guideline (Agarwal et al., 2026).

RISK ASSOCIATED WITH:

F17.210 Nicotine dependence, cigarettes, uncomplicated and **F12.90** Cannabis use, unspecified and uncomplicated

- **Airway hyperactivity/bronchospasms** (J98.01)
 - o PERTINENT POSITIVES: Current nicotine and marijuana smoking/vaping, chronic nasal obstruction, chronic nasal congestion, mouth breathing, sleep disordered breathing, FMH of asthma, and planned airway instrumentation under general anesthesia
 - o PERTINENT NEGATIVES: Denies cough, wheezing, dyspnea, chest tightness, apnea, no PMH of asthma, and no neonatal respiratory disease
- **Tachycardia** (R00.0)
 - o PERTINENT POSITIVES: Current nicotine and cannabis use, history and evaluation of tachycardia, dizziness, lightheadedness, which required a cardiology evaluation and clearance
 - o PERTINENT NEGATIVES: Cardiology clearance obtained and Holter monitor normal, denies current palpitations, chest pain, syncope, dizziness, and exercise intolerance
- **Cardiac arrhythmia** (I49.9)
 - o PERTINENT POSITIVES: Nicotine and cannabis use, prior palpitations, and history of tachycardia
 - o PERTINENT NEGATIVES: Cardiology clearance obtained and Holter monitor normal, denies current palpitations, chest pain, syncope, or dyspnea on exertion
- **Coronary vasospasm** (I20.1)
 - o PERTINENT POSITIVES: Active nicotine and cannabis use and a family history of heart disease (maternal grandfather)
 - o PERTINENT NEGATIVES: Adolescent with no known coronary artery disease, cleared by cardiology, denies chest pain, dyspnea on exertion, and exercise intolerance
- **Acute myocardial infarction** (I21.9)
 - o PERTINENT POSITIVES: Current (day of) nicotine and cannabis which increases perioperative sympathetic stimulation and a family history of heart disease (maternal grandfather)
 - o PERTINENT NEGATIVES: Adolescent who denies chest pain, PMH negative for coronary disease, normal cardiology evaluation with Holter monitor study
- **Infection following a procedure, other surgical site, initial encounter** (T81.49XA)
 - o PERTINENT POSITIVES: Current nicotine and cannabis use both combustible and vaping modalities, and undergoing an elective nasal surgery with mucosal incision planned
 - o PERTINENT NEGATIVES: No current infection s/s, afebrile, denies recent fever or chills, UTD on immunizations (except for influenza/COVID), no PMH or FMH of T2DM, immunodeficiencies, and negative PMH for chronic systemic comorbidities
- **Delayed wound healing, initial encounter** (T81.89XA)
 - o PERTINENT POSITIVES: Current nicotine and cannabis use and undergoing an elective reconstructive nasal surgery
 - o PERTINENT NEGATIVES: Negative PMH of poor wound healing, malnutrition, and no chronic corticosteroid use, there is no PMH or FMH of T2DM or vascular disease
- **Respiratory failure** (J96.90)
 - o PERTINENT POSITIVES: Active smoking and vaping of nicotine and cannabis, planned general anesthesia with airway manipulation, and a positive hx of chronic upper airway obstruction, sleep disordered breathing, and nasal septal deviation
 - o PERTINENT NEGATIVES: Denies dyspnea, cough, wheezing, apnea, and chest tightness, PE unremarkable, PMH is negative for chronic lung disease, and no previous anesthesia complications

- **Postoperative nausea and vomiting (R11.2)**
 - o PERTINENT POSITIVES: Prior episode of vomiting during tachycardia event in April 2025, current cannabis use, and planned general anesthesia for surgery
 - o PERTINENT NEGATIVES: Denies current nausea or vomiting, denies PMH or FMH of postoperative nausea or anesthesia complications

RISKS SPECIFICALLY FOR:

F12.90 Cannabis use, unspecified and uncomplicated

- **Atrial fibrillation (I48.91)**
 - o PERTINENT POSITIVES: Active cannabis use and previous tachycardia episode
 - o PERTINENT NEGATIVES: No hx of atrial fibrillation, normal cardiology evaluation with surgical clearance, denies current palpitations, syncope, chest pain
- **Orthostatic hypotension (I95.1)**
 - o PERTINENT POSITIVES: PMH of dizziness and lightheadedness and current cannabis use
 - o PERTINENT NEGATIVES: Denies current dizziness, syncope, weakness, and no PMH of hypotension
- **Acute cannabis intoxication (F12.920)**
 - o PERTINENT POSITIVES: Reports current marijuana use including use prior to admission
 - o PERTINENT NEGATIVES: Alert and oriented x3, bradycardic, appropriate participation in interview and PE, and both MD and his mom denies hallucinations or behavioral changes during the evaluation
- **Altered mental status (R41.82)**
 - o PERTINENT POSITIVES: Active cannabis use including use prior to admission, and has a psychiatric hx of ADHD, ODD, and multiple psych evaluations and admissions for SI/HI
 - o PERTINENT NEGATIVES: Alert and oriented x3 with no s/s of confusion, denies hx of hallucinations, no focal neurologic deficits on PE, and denies current SI/HI
- **Impaired thermoregulation (R68.89)**
 - o PERTINENT POSITIVES: Active cannabis use including use prior to admission, planned prolonged anesthesia d/t complex surgical case
 - o PERTINENT NEGATIVES: Afebrile, denies recent fever or chills, and his PMH and FMH unremarkable for endocrine disorders or metabolic concerns

PHYSICAL EXAMINATION FINDINGS

GENERAL

Vitals:

Pulse: 53
 Resp: 18
 SpO2: 95% on RA
 Temp: 36.5 °C
 BP: **135/71 – (91st %ile per the AAP 2017 guideline)
 Height: 191.8 cm
 Weight: 67.7 kg
 BMI: 18.41 kg/m²

No apparent distress, well developed, and well nourished

****FIRST ELEVATED BP AFTER PERFORMING A CHART REVIEW**

HEENT

Head: normocephalic and atraumatic

Eyes: external ears normal, ear canals clear, tympanic membranes intact without erythema or effusion bilaterally

Ears: PERRLA, sclera and conjunctiva clear

Nose: Leftward nasal deformity and severe septal deviation with bilateral turbinate hypertrophy and right nasal valve collapse, nasal obstruction and clear drainage present

Throat: oropharynx is clear without tonsillar inflammation or exudate, tonsils are grade 1 b/l, mucous membranes are pink and moist without lesions

NECK	Supple, full range of motion, no adenopathy
INTEGUMENTARY	Warm, dry, and intact, no rashes, lesions, or discoloration noted
PULMONARY	Lungs clear to auscultation b/l, respirations regular and unlabored, no wheezing, rales, or rhonchi, no WOB, equal chest rise and expansion
CARDIAC	Regular rate and rhythm, normal S1 and S2, no murmurs, rubs, or gallops
ADBOMEN	Soft, non-tender, and non-distended, bowel sounds present in all quadrants
GU	Exam deferred
NEUROLOGICAL	Alert and oriented x3, no focal neurologic deficits noted
BEHAVIORAL/MENTAL HEALTH	Alert, cooperative, and appropriately engaged during examination, with mood and affect appropriate
DIAGNOSTICS (Labs, imaging, other)	
No additional preoperative diagnostics were indicated. Previous cardiac evaluation and Holter monitor results were normal, and surgery was postponed because of active nicotine and marijuana use rather than an unresolved medical concern.	
DIAGNOSIS	
Z01.818 Encounter for preprocedural examination Z53.01 Procedure and treatment not carried out due to patient smoking Z53.09 Procedure and treatment not carried out because of other contraindication (Add-on ICD-10 code for the cannabis use) F17.210 Nicotine dependence, cigarettes, uncomplicated F12.90 Cannabis use, unspecified and uncomplicated F90.0 Attention-deficit hyperactivity disorder F91.3 Oppositional defiant disorder Z91.51 Personal history of suicidal behavior R46.89 Behavior concern Z86.59 Personal history of other mental and behavioral disorders G47.30 Sleep-disordered breathing J34.89 Nasal obstruction J34.2 Nasal septal deviation M95.0 External nasal deformity J34.3 Hypertrophy of nasal turbinates R09.81 Nasal congestion J34.2 Nasal septal deviation J34.820 Internal nasal valve collapse S02.2XXS Fracture of nasal bones, sequela	

MANAGEMENT PLAN

Reason for Postponing the Surgical Procedure: The decision to postpone the patient's septorhinoplasty, bilateral inferior turbinate reduction, nasal valve repair, and nasal bone osteotomies was based on his disclosure that he had used both nicotine and marijuana by vaping the morning of surgery. Following the discussion with my preceptor, the ENT, plastic, and anesthesiology surgery teams, and it was determined that proceeding with an elective procedure posed unnecessary perioperative risk.

This planned surgery requires adequate tissue perfusion, mucosal healing, and successful bone remodeling following nasal osteotomies. Nicotine causes sympathetic stimulation and vasoconstriction, reducing tissue perfusion and oxygen delivery to healing tissues. It also promotes endothelial dysfunction and impairs normal wound healing processes (Rose et al., 2023). Recent evidence demonstrates that nicotine exposure, regardless of whether it is delivered through combustible cigarettes, vaping products, or nicotine replacement products, is associated with increased postoperative wound complications (Sifil & Kahn, 2026).

Marijuana use further increased this patient's perioperative risk. THC has been associated with delayed bone healing, decreased bone mineral density, and impaired bone metabolism, all of which are particularly concerning in procedures involving nasal osteotomies (Heath et al., 2022). Available evidence also suggests cannabis users have higher rates of postoperative wound complications, infection, and delayed healing, with even greater complication rates when nicotine and cannabis are used alongside one another (Hamad et al., 2026).

Acute cannabis intoxication also creates important anesthetic concerns. Cannabis alters cardiovascular physiology through tachycardia and peripheral vasodilation, increases airway hyperreactivity, and affects the metabolism of several anesthetic medications, making anesthetic requirements less predictable. THC is a potent CYP enzyme inhibitor, affecting the metabolism of commonly used perioperative medications such as propofol, morphine, and lorazepam. Acutely intoxicated patients may require lower doses of propofol, whereas chronic users may require higher doses, which creates unpredictable anesthetic need and increasing the complexity of perioperative management (Rossi et al., 2026). Cannabis users may also experience prolonged sedation, respiratory complications, and delayed emergence from anesthesia (Mims et al., 2024; Rossi et al., 2026). Because the patient reported using marijuana the morning of surgery, these anesthetic risks were considered undesirable for an elective procedure.

Current pediatric perioperative recommendations emphasize identifying adolescents who use nicotine or cannabis during the preoperative evaluation and modifying perioperative management accordingly. The preoperative period is also recognized as an ideal opportunity to initiate substance use counseling and treatment (Agarwal et al., 2026; Rusy et al., 2021).

Patient and Family Education: The patient and his family were educated on the rationale for postponing surgery. The discussion focused on the physiologic effects of both nicotine and marijuana rather than solely stating that the substances were "unsafe."

They were informed that nicotine decreases blood flow, reducing oxygen and nutrient delivery to healing tissues while increasing the risk for wound complications, infection, and delayed recovery (Rose et al., 2023; Sifil & Kahn, 2026). They were also educated that vaping is not considered a safer alternative to traditional cigarettes in the perioperative setting because current evidence supports similar negative effects on wound healing (Ashour et al., 2023).

The effects of marijuana on bone healing were reviewed, including the risk of delayed bone healing and increased postoperative complications (Heath et al., 2022). There was an emphasis on how this surgical procedure involves intentional nasal bone fractures with reconstruction and that optimal bone healing is critical for both cosmetic and functional outcomes.

The patient and his family were also educated regarding perioperative respiratory risks associated with smoking and vaping, including airway irritation, bronchospasm, and complications during intubation and extubation. Additionally, discussed how marijuana use can affect postoperative recovery beyond wound and bone healing. Cannabis users may require additional prophylaxis for postoperative nausea and vomiting (PONV) and may experience greater postoperative pain, resulting in increased analgesic requirements compared with nonusers (Rossi et al., 2026).

Finally, emphasis was placed on the importance of complete abstinence from both nicotine and cannabis before and after surgery. Per the surgical team's recommendations, the patient must remain nicotine and cannabis free for six weeks before surgery and six weeks following surgery. The surgeon did inform MD that compliance will be verified with routine testing, drug screenings, before rescheduling the procedure and ongoing postoperatively (Agarwal et al., 2026).

Nicotine and Marijuana Cessation and Ongoing Mental Health Assessments: Because the patient reports regular use of both nicotine and marijuana, treatment should address both substances simultaneously rather than independently.

Behavioral interventions should include motivational interviewing at each follow-up visit prior to the next scheduled surgery as well as reaching out to his PCP for ongoing support. MD should be directed to complete the CRAFFT 2.1+N screening tool to better characterize nicotine dependence, cannabis use, and other substance use behaviors (Camenga et al., 2022). Results can help determine the intensity of treatment and used as data when placing a referral to an adolescent substance use specialist or mental health provider. Camenga et al. (2022) found that cognitive behavioral therapy (CBT) and motivational enhancement therapy (MET) is the best method to address cannabis use in adolescents and reduces relapse risk. Additionally, family involvement should be encouraged throughout treatment, as parental support and modification of the home environment has been shown to improve adolescent cessation outcomes (Camenga et al., 2022).

Although he denied current SI, HI, or acute mental health concerns during the preoperative evaluation, reassessment should occur before initiating pharmacologic therapy. For nicotine cessation, current American Thoracic Society (ATS) guidelines support consideration of off label varenicline in adolescents 10 to 18 years of age who use nicotine products (Bauer et al., 2025). However, initiation should only be considered after a thorough mental health assessment. Clinical trials evaluating varenicline in adolescents excluded individuals with significant psychiatric disorders, aggression, homicidality, or suicidality, making careful screening particularly important in this patient given his history of mental health concerns (Bauer et al., 2025). If reassessment confirms there are no contraindications and the benefits outweigh the risks, a low-dose regimen would be appropriate based on his weight. The ATS recommended regimen for adolescents >55 kg includes 0.5 mg orally once daily for days 1 through 3, increasing to 0.5 mg twice daily on days 4 through 7, continue the 0.5 mg twice daily during weeks 2-12 for maintenance. A target quit date should be established on day 8 after medication initiation (Bauer et al., 2025). Given his history and intensive follow up needs it would be best to have a psychologist prescribe this medication and follow him closely.

Additional resources should be considered, such as enrollment in the Truth Initiative's "This is Quitting" text messaging program, referral to school- or community-based cessation programs, and use of Smokefree Teen or 1-800-QUIT-NOW as supplemental support (Bauer et al., 2025).

Follow-up: Within the next week he should be seen by a provider in the ENT clinic or with his PCP to determine his level of change. Motivational interviewing is the best strategy for this determination as it allows autonomy and limits confrontation in adolescents (Camenga et al., 2022). The CRAFFT 2.1+N screener should also be completed at this visit and a referral to a mental health clinician should be initiated. After this appointment, MD should see a mental health provider as soon as possible to begin nicotine and cannabis cessation treatment.

Continued abstinence should be verified according to the surgeon's protocol before rescheduling surgery. Once the patient has remained nicotine- and cannabis-free for 12 weeks, demonstrates sustained readiness for the procedure, and reconsideration by the multidisciplinary surgical team is completed the surgery should be rescheduled.

CONSULTATION WITH PRECEPTOR

After completing the HPI and physical examination, I reviewed my findings with my preceptor. I discussed the patient's nicotine and marijuana use, including use on the morning of the scheduled surgery. As part of the preoperative evaluation, CPNPs assess for any new or acute mental health concerns that could affect postoperative recovery. I reported that the patient denied current SI, HI, or other acute mental health concerns.

Following my SNAPPS presentation, my preceptor asked whether I felt the patient was appropriate to proceed with surgery. I recommended against proceeding due to the patient's ongoing nicotine and cannabis use and the potential negative impact on wound healing and postoperative recovery following an extensive nasal reconstructive procedure. My preceptor agreed with this assessment, and we discussed the case with the ENT and plastic surgeons involved in the patient's care.

After multidisciplinary discussion, the surgical team determined that the procedure would be postponed pending cessation of nicotine and marijuana use.

CODING

No additional coding is indicated for this patient encounter since the surgery was canceled

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