

GLP-1 Agonists, Aspiration Risk, and Anaesthetic Consent in Ireland

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The rapid rise of glucagon-like peptide-1 (GLP-1) receptor agonists such as semaglutide is transforming the management of diabetes and obesity. In Ireland, prescribing now extends beyond endocrinology clinics to general practice and private weight-loss services. Others obtain them through unauthorised supply routes, including informal resale or purchase from unregulated online suppliers. As a result, anaesthesiologists are now regularly encountering patients who use these agents.

This presents a specific clinical challenge: by inhibiting gastric motility, these drugs can result in residual gastric content despite adherence to standard fasting guidelines, thereby elevating the risk of pulmonary aspiration. While pulmonary aspiration is a rare event – with the 4th National Audit Project citing an incidence of death or brain damage of approximately 1 in 350,000 cases¹ – the nature of the aspirate is critical. Aspiration of particulate food matter carries a higher mortality than fluid aspiration. Given that GLP-1 agonists specifically cause the retention of solid gastric contents, the specific risk profile for these patients arguably exceeds that of the general population.

It was this concern that prompted the UK Medicines and Healthcare products Regulatory Agency (MHRA) to issue a Drug Safety Update in January 2025 regarding GLP-1 agonists². The Royal College of Anaesthetists endorsed this warning and advised clinicians to ask about GLP-1 use during pre-operative assessment. Despite this risk, recent guidelines from the UK³ and USA⁴ advise against routine cessation prior to elective surgery.

This stance is primarily due to the drugs' long and variable half-lives. Withholding medication for the requisite duration (often weeks) to ensure gastric emptying may lead to deleterious metabolic effects. Furthermore, there is evidence of tachyphylaxis, suggesting that long-term users may regain normal gastric motility over time. Therefore, the consensus has shifted towards continuation of therapy combined with enhanced assessment. Instead of routine cessation, these guidelines recommend precautions in selected cases, such as extended fasting, assessment for

gastrointestinal symptoms and, where expertise exists, gastric ultrasound to evaluate stomach contents.

No Irish authority has yet issued national recommendations, and this absence of a domestic framework leaves anaesthesiologists in Ireland in a difficult position: the aspiration risk is recognised internationally, yet there is no national standard to guide peri-operative management. In the absence of national guidance, the clinician must revert to first legal principles.

The duty of care exists independently of published protocols. Given the publicity surrounding GLP-1 drugs, failure to ask about their use could be interpreted as a breach of duty should aspiration occur. This responsibility applies regardless of how the medication was obtained; patients may not volunteer the information unless prompted, and medication lists may be incomplete.

In Irish law, the test for negligence established in *Dunne v National Maternity Hospital*⁵ asks whether a doctor acted in accordance with a practice accepted as proper by a responsible body of medical opinion, unless that practice is obviously defective. The Supreme Court reaffirmed this in *Morrissey v HSE*⁶, holding that the courts do not have a direct role in imposing a standard of approach on a medical professional; rather, the standard is determined by expert evidence relevant to the activity concerned. Although Irish courts determine the standard based on Irish law, case law from other common law jurisdictions is persuasive. In the absence of specific Irish guidance, clinicians are expected to be aware of relevant international recommendations and to justify any departure from them.

The duty to obtain informed consent is judged by whether the patient was warned of material risks – those that a reasonable person in the patient’s position would wish to know. This principle, articulated in *Walsh v Family Planning Services Ltd*⁷, refined in *Geoghegan v Harris*⁸, and affirmed in *Fitzpatrick v White*⁹, marked Ireland’s shift towards a patient-centred approach. In this context, the material risk is pulmonary aspiration. Although rare, its gravity – hypoxia, critical-care admission, or death – means it must be discussed whenever a patient is known to be taking a GLP-1 agonist. It is not enough to record “standard fasting discussed”; the note should show that delayed gastric emptying was considered and that any altered fasting plan was explained.

Consider a patient presenting for elective hernia repair on weekly semaglutide, last taken three days prior. They have fasted for six hours. The anaesthesiologist should discuss the residual risk and the alternative anaesthetic options. A defensible entry in the anaesthetic record would read:

On GLP-1 agonist (Semaglutide). Last dose 3 days ago. Discussed risk of delayed gastric emptying and aspiration despite standard fasting. Options discussed: 1. Regional Anaesthesia (Spinal) to avoid airway manipulation. 2. General Anaesthesia with Rapid Sequence Induction (RSI) to mitigate aspiration risk. Patient prefers General Anaesthesia. Understands material risk. Plan: RSI discussed and agreed.

This entry demonstrates awareness of the specific drug, recognition of the physiology, communication of the material risk, and the offer of a safer alternative. This provides legal protection by showing that the anaesthesiologist acted in accordance with accepted professional standards. Under the Dunne and Morrissey principles, Irish courts would likely regard the recommendations of UK and US bodies as reflecting that standard.

The role of point-of-care gastric ultrasound is increasingly prominent in international guidelines. While it offers a definitive method to assess gastric content, it presents a distinct medico-legal challenge in Ireland due to low levels of formal training¹⁰. Clinicians must ensure they do not operate beyond their scope of competence. If gastric ultrasound is employed to rule out aspiration risk, the images should be saved to the patient's record to evidence the clinical decision, akin to other diagnostic imaging.

Hospitals can help bridge this gap through local policy. A practical interim framework should require specific enquiry about GLP-1 use, define fasting advice aligned with international consensus, advise when to consider gastric ultrasound, and prompt documentation of the discussion. Such measures will not eliminate risk but can ensure a consistent, defensible approach. Until the Health Products Regulatory Authority issues a national safety communication like the MHRA's, anaesthesiologists should apply the same simple discipline: ask, explain, document. By embedding these steps into routine assessment, clinicians safeguard their patients and themselves while awaiting national direction.

Declarations of Conflicts of Interest:

None declared.

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