

Correspondence

Prefilled insulin syringes for peri-operative care

The multidisciplinary consensus statement on the peri-operative management of diabetes mellitus from the Association of Anaesthetists and the Joint British Diabetes Societies for Inpatient Care group does not recommend the routine use of prefilled insulin infusion syringes wherever possible [1]. Previous iterations recognised that preparation errors occur when insulin infusions are prepared and recommended the use of prefilled insulin syringes. A decade later, the new guideline still describes in detail the hazardous manual preparation of intravenous insulin for peri-operative care. There has been a rapid expansion of wearable technologies in this area, which is at odds with the archaic practice of bedside insulin infusion preparation.

Insulin is a high-risk medicine. One-third of inpatient medication errors leading to death within 48 h involve insulin administration and manually prepared syringes are more likely to introduce infection [2]. Freshly prepared insulin infusions show early instability in concentration and absorption. These are problems not seen with quality-assured prefilled syringes that have achieved stability before supply. To continue endorsing manual preparation of such a drug, when safer ready-to-administer alternatives are widely available, falls below the safety standards applied to many other injectable medicines in modern practice.

National professional guidance elsewhere is unequivocal [3, 4]. Prefilled insulin syringes have been available for > 15 years and their feasibility, availability and system-level adoption present clear advantages for clinicians and patients. By omitting a clear directive to use ready-to-administer insulin infusions wherever possible, the new guideline falls short of its stated aims. A formal

clarification explicitly recommending the use of prefilled insulin infusion syringes wherever possible is therefore warranted.

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DW is a Past President of the Association of Anaesthetists, Chair of the Patient Safety Committee of the European Board of Anaesthesiology and has received lecture fees from Aguetant Ltd, donated to Lifebox, Global Capnography Project. He has contributed to, but has no financial interests in, the development of an independent, non-sponsored, educational website (prefilledsyringe.info).

References

1. Levy NA, El-Boghdady K, Lobo DN, et al. Peri-operative management of diabetes mellitus: a multidisciplinary consensus statement from the Association of Anaesthetists and the Joint British Diabetes Societies for Inpatient Care group. *Anaesthesia* 2026. Epub 16 February. <https://doi.org/10.1111/anae.70181>.
2. Whitaker DK, Lomas JP. Time for prefilled syringes – everywhere. *Anaesthesia* 2023; **79**: 119–22. <https://doi.org/10.1111/anae.16181>.
3. Royal College of Anaesthetists and Association of Anaesthetists. Safe drug management in anaesthetic practice. 2020. <https://anaesthetists.org/Guidelines-and-publications/Guidelines/Safe-Drug-Management-in-Anaesthetic-Practice> (accessed 31/03/2026).
4. NHS Specialist Pharmacy Service. Assessing risks when reconstituting injectable medicines. 2026. <https://www.sps.nhs.uk/articles/mitigating-the-risks-of-manipulating-injectable-medicines/> (accessed 31/03/2026).

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