

One Day Surgery Times

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**12th International Congress on Ambulatory Surgery,
8th to 10th May, 2017, at Beijing, China.**

Register soon on: www.iaascongress2017.com

MASICON 2017

39th Annual Conference of Maharashtra State Association of Surgeons, was recently held in the city of Nanded, from the 9th to 12th Feb. 2017. A rich mix of scientific activities and deliberations were at display during the academic proceedings. Several members of The Indian Association of Day Surgery were present.



**Dr. Niranjnan Agarwal, Founder Treasurer,
Dr. Naresh Row, President, &
Dr. Kishore Adyanthaya, Vice-President.**



**'Excision & Primary Closure of Pilonidal Sinus as Day Surgery'
an invited video-lecture was presented by Dr. Naresh Row**

Adult Day Case Anesthesia- Present Day Scenario

Mangeshikar Tillottama

Consultant Anaesthesiologist.

(Continued from previous issue...)

Implementation and widespread use of this system has dramatically improved preoperative screening efficiency and patient satisfaction. This group has presented on cost analysis using the HQ patient assessment program. Over a 3 year period, total of 50,967 patients utilized their HQ system in the office, resulting in 22,694 patients, who were able to bypass a clinical visit. For those patients meeting HQ "express" criteria, an unneeded step in the preoperative process, was eliminated. The savings generated can be used to offset additional operating expenses.

Should Patients Age or ASA Physical Status Influence Case Selection?

Although the vast majority of individuals scheduled for outpatient surgery are relatively healthy (ASA physical status 1 & 2), practitioners are constantly being pressured to consider "simple outpatient surgery" for patients with significant baseline disease. In the past, many individuals had arbitrarily stated that freestanding ambulatory surgical facilities were severely limited in the type of patients they could anesthetize, particularly with regard to age and physical status. Recent clinical experience suggests otherwise. In a retrospective study of over 1500 cases of patients anesthetized for ambulatory surgery, Meridy was unable to demonstrate an age-related effect on the duration of recovery or on the incidence of postoperative complications. Natof concluded that ASA 3 patients whose systemic diseases were well controlled preoperatively were at no higher risk for postoperative complications than ASA1 or 2 patients. Furthermore, in 1987 the Federated Ambulatory Surgery Association (FASA) published the results of a survey involving over 87,000 patients and concluded that there appeared to be little or no cause and effect relationship existing between pre-existing disease and the incidence of peri-operative complications. In summary, outpatient surgery is no longer restricted to young healthy patients. Geriatric and higher risk (physical status 3 & 4) patients may be considered acceptable candidates for outpatient surgery if their systemic diseases are well controlled and the patient's medical condition is optimized preoperatively.

The Inappropriate Patient Who's OK and Who's Not

- Unstable ASA physical status 3 & 4.
- Malignant hyperpyrexia.
- Monoamine oxidase inhibitors.
- Complex morbid obesity/complex sleep apnea.

- Psychosocial difficulties.
- Acute substance abuse.

There are few data to reliably categorize the inappropriate adult surgical outpatient. As anesthesiologists have become more experienced with the anesthetic management of the problem surgical outpatient, the list of "inappropriate" patients has dwindled. We must individualize our decision with regard to each patient; with few exceptions, the appropriateness of a case for outpatient surgery is determined by a combination of factors including patient considerations, surgical procedures, anesthetic technique, and anesthesiologist's comfort level.

· Unstable ASA physical status 3 and 4: At the present time we are reluctant to proceed with elective ambulatory surgery in a medically unstable patient. Instead, we use our preoperative evaluation clinic to screen these patients, refer them to appropriate medical consultants, and together with the primary care surgeon, establish a plan to proceed with surgery after medical stabilization. Contrary to the original "ground rules" of ambulatory surgery, neither studies involving tens of thousands of patients seem to suggest that neither increasing age nor the presence of stable pre-existing disease alter the incidence of postoperative complications in the surgical outpatient.

· Malignant hyperpyrexia: Overnight hospitalization and observation is usually indicated for patients with a history of malignant hyperpyrexia. However, patients who are well educated, have a good understanding of their disease process, and have ready access to medical care may be treated as outpatients by some centers.

· Monoamine oxidase inhibitors: Because of the hemodynamic instability associated with the anesthetic management of patients currently receiving monoamine oxidase inhibitors, these medications are discontinued at least 2 weeks prior to elective surgery. However, this practice has recently been questioned particularly in light of the resurgence of monoamine oxidase inhibitor use in the general population.

· Complex morbid obesity/complex sleep apnea: Although patients who have a history of sleep apnea or who are morbidly obese without systemic disease are acceptable candidates for ambulatory surgery, overnight hospitalization and postoperative observation for morbidly obese surgical patients with pre-existing cardiac, pulmonary, hepatic or renal compromise or those patients with a history of complex sleep apnea is preferred.

· Acute substance abuse: Because of increased likelihood of acute untoward cardiovascular responses when one administers an anesthetic to a patient who has recently abused illicit drugs.

· Psychosocial difficulties: Patients who refuse to electively

proceed with their surgery on an ambulatory basis cannot be forced to do so. Patients who have received anesthesia should be discharged in the care of a responsible adult.

What Labs Are Really Needed?

Under the false belief that "shotgun" labs are best for patient and doctor, many ambulatory surgery programs continue to obtain substantial batteries of preoperative laboratory studies for their patients. However, the majority of tests which are actually ordered and obtained do not contribute beneficially to peri-operative management. Although laboratory tests can help to optimize a patient's peri-operative condition once a disease is diagnosed, they inherently possess some shortcomings: (1) They frequently fail to uncover pathologic conditions, (2) The abnormalities they sometimes discover do not necessarily improve patient care or outcome, (3) They are quite simply inefficient in screening for diseases which are not identifiable through a careful history and physical examination, (4) Abnormalities which are discovered through laboratory screening are not appropriately followed up and (5) False positives on laboratory screening often lead to increased patient anxiety, increased operating room delays and costs, may lead to more invasive diagnostic tests and therapies, which may actually injure patients.

Many facilities now determine which pre-operative tests are "required" based on the operative feature procedure and the patient's age, pre-existing medical disease, and medication history. For example, Roizen suggests a bare minimum of pre-operative laboratory screening for healthy patients, but emphasizes that patients with significant baseline disease (hypertension, coronary heart disease, diabetes) will need additional studies (ECG, electrolytes, chest X-ray). However, age at above should not dictate the need for additional studies.

How Well Do We Manage Pain?

The international association for the study of pain has defined the word pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage". Acute pain is a complex and subjective response and may be produced in a variety of situations, including surgical settings, renal colic, and acute medical conditions. Acute pain, including "surgical" pain, following ambulatory surgery, results in a wide variety of physiologic changes, including the general neuro-endocrine stress response, as well as, secondary effects on respiratory, cardiovascular, gastrointestinal, genitourinary and musculoskeletal system. Inadequate pain relief is believed to lead to significant deleterious outcomes; relief of post surgical pain may in and of itself, play a role in mediating post-operative responses.

To be continued, in the next issue.....

Surgery & discharge on same day for:
 Hernia, Piles, Fistula, Fissure, Diabetic foot, Pilonidal sinus, Ingrown toe nail, Lipoma, Sebaceous cyst, Abscess, Circumcision, Vasectomy, D & C, Tubal Ligation, Diagnostic Lap; etc. (In selected cases)
Extended stay: Appendix, Gall stones, Hystrectomy, etc.

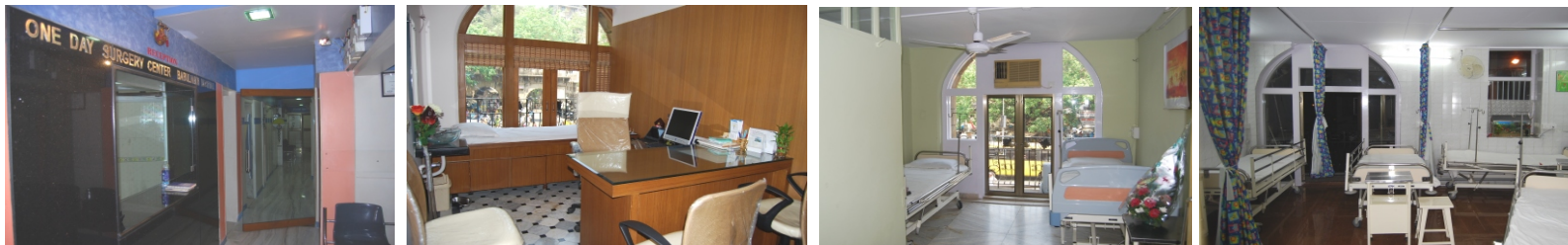
Other Surgeries related to: Paediatric, Urology, Plastic, ENT, Vascular. Chemotherapy & related treatment. (Please take prior appointment).




One Day Surgery Center

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Patient's convenience and safety is our prime concern.