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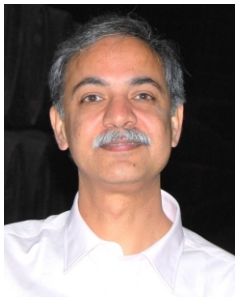
ADSCON 2016 will be held on 29th-30th April,2016 at Bangaluru.

Merry Christmas & A Happy, Healthy New Year



A Surgeon's View on Ambulatory Surgery

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Prevention of pain is better than relief (6). In the selection of operative procedures, the amount of postoperative pain should be taken into account. For example, endovenous obliteration of varicose veins requires the extra investment of the necessary device and disposable catheters, but advantages as less post-operative discomfort and faster return to normal activities, as compared to conventional stripping, have been documented (7).

Preoperative education of the patient is important, surgeons should not only explain exactly what they are planning on doing (give procedural information), but also provide their patients with sensory information, i.e. information about possible unpleasant feelings postoperatively (8). Only combined sensory-procedural information gives the most benefit in reducing pain. During the operation, everything should be done to lessen postoperative pain; hence the use of nerve blocks and/or infiltration of wound edges are highly recommended. Also, pain management at home deserves attention to detail.

Clinical indicators:
It is recommended that units for Ambulatory Surgery use clinical indicators to monitor the overall quality of procedures. The International Association for Ambulatory Surgery (IAAS) advises the continuous registration of:

1) Cancellation of booked procedures, either failure of the patient to attend the day surgery unit ('no show' or 'do not attend, DNA') or after arrival of thepatient, due to medical or organisational reasons,
2) Unplanned return to the operating room on the same day,
3) Unplanned overnight admission and
4) Unplanned return to the hospital after discharge home.

These indicators might be compared by data from other units or from the literature (benchmarking!) and might provoke the adaptation of certain procedures, when unsatisfactory results are obtained (9).

Professionals, unite! The Dutch experience:
Ambulatory surgery, in the Netherlands rather differently defined as a surgical procedure with a post-operatively required nursing time of at least 2 hours (up to a maximum of 8), is by now well established. The first units were founded in the seventies of the last century. In the beginning incentives didn't come from the government but from local hospital managers who visited ambulatory surgical centres in the UK and the USA. From 1985 onwards day surgery expanded tremendously partly due to a greater awareness of doctors and patients, but also due to a government-induced reduction of the number of hospital beds, also leading to the fusion of many smaller hospitals with large ones. At this moment departments for ambulatory surgery are present in almost all hospitals, even in university hospitals: a few years ago, three university hospitals (Amsterdam, Groningen and Rotterdam) reopened their completely rebuild units for day surgery. In addition to these in-hospital units, many free-standing ambulatory surgery centres have been established. In 2004, 49 percent of all operative procedures were performed on an ambulatory basis, and this figure is expected to increase to 65 percent in the years to come. The data of the IAAS international survey on ambulatory surgery from the Netherlands are quite comparable with those from other countries like the United Kingdom, with minor exceptions only (10). For example, almost 65 percent of all tonsillectomies with or without adenoidectomies (and even 97 percent of all adenoidectomies) are done on an ambulatory basis in the Netherlands, against only 15 percent in the United Kingdom. In both countries, a laparoscopic cholecystectomy still is seldom performed in day surgery, but it seems reasonable to believe that this figure will increase in the upcoming years.

But of course, the accumulated data of all hospitals in a country don't tell the whole story: there might be huge differences in the amount of procedures performed between hospitals.

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This issue was investigated by Kroneman et al in 2003, who tried to link the number of certain procedures performed (curettage, cataract surgery and laparoscopic cholecystectomy) to available hospital-dependent variables as hospital size, number of beds available (a relative shortage of beds would promote ambulatory surgery?), number of GP's (less burden on social network?), age of the population in the area (less ambulatory surgery in an elderly population?), etc.(11). Unfortunately this approach wasn't effective in explaining the results found, and it was concluded that more detailed data on physician partnership and hospital circumstances are needed to do so.

But a much more important issue than volume and types of procedures performed is quality improvement of day surgery. In 1994, the Dutch Association for Day Surgery (NVDK) was established for this purpose. The executive committee organises an annual congress for its members, and stimulates the publication of a quarterly journal (titled 'KORTOM' what can be translated as 'in short'). But a very important step was recently taken by the publication of a National Standard for Ambulatory Surgery. The development of this standard was initiated by the government, who asked the Dutch Normalisation Institute (NEN, Delft, the Netherlands) to organise things. All parties involved in ambulatory surgery (departments for ambulatory surgery, patients/consumers, anaesthetists, surgeons, insurance companies, government) were invited to contribute to the composition of a protocol for ambulatory surgery. The Dutch Association was supposed to represent all departments for ambulatory surgery. The Standard focuses on the patient passing through the process of day surgery. An essential step in this process was strict requirements to be met. For example, in the guidelines, preoperative assessment has been given an important place. The role of the consulting nurse and the anaesthetist was clearly defined. But likewise the representatives of the patients/consumers appreciated the fact that it was agreed by all participants that in at least 80 percent of cases the waiting-time for a scheduled appointment with a consultant should not exceed 15 minutes. The updated version of this National Standard is now in the process of evaluation. Once accepted every department for ambulatory surgery has the choice to use it or not. But certification of the unit might become difficult when the Standard is completely rejected.

The International Association for Ambulatory Surgery (IAAS):

In 1995, the International Association for Ambulatory Surgery was established in Brussels, Belgium. The Dutch Association was one of its founding members. One of the major challenges of IAAS is to maintain a high quality of ambulatory surgery, and to improve the development of ambulatory surgery all over the world. To do so, IAAS initiates the organisation of an International Congress every 2 years. The next congress will be organised in Amsterdam, the Netherlands, from April 15th–18th, 2007 (www.iaascongress2007.org). Since 1993, IAAS also publishes the journal Ambulatory Surgery. Membership of IAAS is available for all National Associations for Ambulatory Surgery.

To promote the understanding of people active in ambulatory surgery, IAAS documented all national definitions, with translations in English, of the words day surgery, office-based surgery, extended recovery, etc. This list of definitions is available at the IAAS Central Office.

In order to keep track of the numbers of ambulatory surgical procedures performed, IAAS initiates from time to time (preferably every two year, but this seems to be too frequent due to the labour-intensity of the task) the collection of national data, not from member countries only: provided the availability of a reliable contact, every country might participate. The core-issue was the selection of a basket of 20 procedures, suitable to cover all essential aspects of day surgery. Procedures in the final basket included not only hernias and varicose veins, but also laparoscopic cholecystectomy and laparoscopic-assisted vaginal hysterectomy. The collected data were first published in 1998 (12), the second set in 2000 (10), a third survey of this kind will be published soon. These surveys document the variability in the number of procedures performed, and stimulate the discussion of reason and outcome, for example during the annual meeting of the representatives of all member countries, where delegates after reporting their local data discuss the obstacles present. No country is perfect yet, or maybe ever will be perfect! Obstacles almost always focus on problems with reimbursement of the procedures performed, and/or lack of interest of the medical profession in ambulatory surgery: both problems are not easily solved.

It might be concluded that IAAS played and will continue to play a significant role in the promotion of Ambulatory surgery (14).

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