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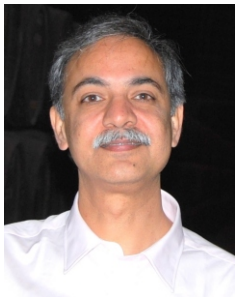

Surgery in the new millenium-all in a day's work.

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global acceptance of ambulatory surgery as a highly favored option. Day surgery has proven to be beneficial to and accepted by both patients and the medical faculties. It is a win-win situation for both parties trying to cope with the changing times and ever renewing standards of medicine for less invasive, cost-effective, and complication-free therapy, that's all in a day's work.

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Development of Day Surgery in Italy.

Coda Andrea*

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The concept of Day Surgery in Italy was first put to use in the late '80s at the Children's Hospital, "Bambin Gesu", in Rome, close to the Vatican City. The project had a very good outcome and was extended to adult care, but still as an individual initiative.

Being a pioneer in prosthetic inguinal hernia repair under local anaesthesia (1), allowed patients early ambulation and oral intake; and a pain free post operative period; staying in the hospital for a week was unacceptable. Whereas, the trend in the country was a hospital stay of eight days for inguinal hernia repair! However, I couldn't go against the "common sense" of that age. Therefore, my patients experienced a strange kind of 'holiday': playing cards, chattering, watching football matches and movies together.

In 1995, the Italian Society for Ambulatory and Day Surgery (SICADS) was founded, primarily to promote the scientific basis of this innovative way of care. The 1st National Congress was held in Milan in January 1997. My presentation was "The Ambulatory Surgery, between mirage and reality" (2), an apt title for that time.

Initially, for less than 48 hours stay in the hospital, only 40% of the expense was reimbursed by medical insurance.

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Therefore, the hospital administration had no advantage promoting Day Case Surgery (DCS).

But, the patients stay of two nights, admitted the day before surgery and discharged the day after, was a big progress, compared to the eight days of earlier years.

In 1999, due to government pressure, hospitals were forced to perform 70% of cases, in some pathology, in DCS, but to reduce costs for public administration, these cases reimbursed at 80%.

In 2001, finally government did the more obvious and wanting thing: stated that DCS would include a stay in the hospital of less than 24 hours: as One Day Surgery (ODS), or without overnight, as Day Surgery (DS). 80% of surgical cases, like inguinal hernia, would be treated this way. Therefore, hospital stay of longer than 24 hrs, needed a justification; for example: operation for strangulation, associated severe illness, complications, etc. But, staying in hospital longer than 24 hrs, if exceeded 20% of all operated cases, would not be reimbursed.

This year there has been an explosion of the DCS in Italy. Many DCS unit were founded. Since then, the annual National SICADS Congress has been one of the most attended meetings! Encouraging a flourish of regional SICADS meetings.

Any surgeon with five years of experience, or a patient exposed to Day Case Surgery, would always opt for this option of treatment. The government may or may not have saved on expenses, but, surgical care has greatly improved. Over a period of time, a great deal has been discussed, proving Day Case Surgery to be better a modality, not only from a surgical point of view, but, also it has improved over hospital-stay-treatment as a whole.

Our hospital has an independent multidisciplinary Day Surgery unit, which works 12 hrs every day. Patients arrive early in the morning, ready for surgery, having consulted and prepared few days before. Every step is regulated by protocols and rules of the DCS unit. Operations are performed in the morning; then the patient is in observation for a few hours. At 4 pm, the surgeon checks the patient, at 5 pm the anaesthesiologist does the same by her/his point of view and then, by 6 pm, patient is ready to be discharged. If a patient has a problem that can't be solved promptly, she/he is transferred to inpatient service. The unit is finally closed for the day at 7 pm.

This unit caters to surgical cases from General surgery, Urology and Orthopaedics.
ENT-Oculist Service, patients operated for Cataract, has only a reclining chair, instead of a bed and is discharged quickly, same as patients undergoing excision skin neoplasm.

In this service we have 2-3 ODS beds for patient having 'social living problems' (living alone or with a non-reliable person, living in a high-rise building without lift, living too far away from hospital, without telephone, mental disorder, etc.) or having had spinal or general anaesthesia (not as a rule), or having been operated late in the afternoon.
However, still the stay in hospital for these patients is no longer than 24 hrs.

The organization of ODS must be very meticulous to get best results. It begins with selection of the patients, which needs a very careful history and a meticulous description of the pathway they have to go through.

If operation is possible with local anaesthesia, it is essential to have a very good rapport with the patient to get her/his confidence, because in this case the patient is not passive, but acts as an active-apprehensive subject and we need her/his co-operation. When operation is completed without experiencing pain, she/he is the happiest person!

In this way, we have more and more patients asking to be treated in DCS and are particularly satisfied when they hear that it will be possible to perform this particular surgery under LA. This means, in the patients' eyes, the surgical pathology is not so severe. Therefore, operation will not be difficult and they can be home for dinner with their family.

An independent multidisciplinary unit is the best way to manage DCS, because if you have some dedicated beds for DCS along with in-door service of General Surgery, then, you will have patients operated for inguinal hernia or varicose veins recouping beside patients with gastrectomy, colectomy or peritonitis, for instance. With the same nurses having to care for both these category of patients. The striking difference of illness will invariably result in more care for operated supra-major cases, causing a lack in the care for DCS patients, making outcome in these patients unfavorable.

Concluding part, to be continued, In the next issue.....



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