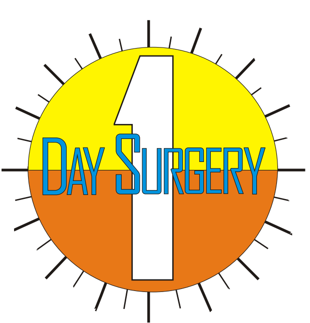

One Day Surgery Times

Volume 8 no. 8 Issue: Aug.-Nov. 2015

A monthly publication of **O**ne **D**ay **S**urgery India Private Limited Free for Distribution

www.onedaysurgeryindia.com

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Announcement: **ADSCON 2016, of The Indian Association of Day Surgery, 23rd-24th April, 2016, Bangaluru, Karnataka.**

Happy Deepawali

Development of Outpatient Laparoscopic Surgery in Hong Kong

Chok Siu Ho Kenneth, Lau Hung, Yuen Wai Key.
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Continued........

DISCUSSION:

Our results showed that most patients undergoing laparoscopic surgery had a high level of satisfaction (3). Less than 3% of the patients refused an outpatient LC if they were to be treated again, reflecting that patient acceptance was high (3). Opponents against outpatient laparoscopic surgery, probably is because of its potential complications, and more importantly, delayed diagnosis due to early discharge. Previous studies showed that most postoperative complications related to LC such as bile leakage, retained ductal stones and biliary pancreatitis were not apparent on the first 2 days of postoperation (11-13). After patients were discharged from the hospital, the nursing staff in DSC would perform telephone follow-up on postoperative days 1 and 3. Possible complications such as abnormal discharge from wound, unusual degree of wound or abdominal pain and fever would be noted. After initial assessment on the phone, patients would be arranged to have a follow-up by the operating surgeon at their earliest convenience. So far, no major complications have been encountered.

There is still much room for developing other outpatient procedures as well as refining the techniques of the present procedures. Reports showed that laparoscopic anti-reflux surgery, laparoscopic adrenalectomy and laparoscopic splenectomy were all feasible in an outpatient setting (10). Different laparoscopic procedures, however, would have different learning curves. As illustrated in our experience, when the majority of patients were operated by experienced laparoscopic surgeons, the training for surgical trainees might be hampered. A recent study showed that outpatient LC could be performed safely by surgical trainees under direct supervision (14). We were in the same situation and hopefully, trainees could do more outpatient laparoscopic procedures in the future.

The training of laparoscopic surgeons should ideally start with the relatively "easy-mastered" outpatient procedure, such as LC before embarking on other more advanced techniques. Apart from the surgeons' perspective, other associated "hard and soft wares" such as the establishment of the DSC, availability of well-trained nursing and anaesthetic staff, etc, should be ready before the commencement of outpatient laparoscopic surgery. It would be disastrous if potential complications are overlooked. Without great courage, successful outpatient laparoscopic surgery would not be possible.

A Surgeon's View on Ambulatory Surgery

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Introduction:
In many countries, it's impossible to imagine healthcare without Ambulatory Surgery. Accumulating evidence indicates that outpatient surgery offers significant advantages over inpatient surgery. Patients operated on an ambulatory basis report faster recovery and better psychological adjustment, given that selection of the procedure, preoperative preparation, the surgery performed and postoperative care, all were optimal.

The pronounced shift towards outpatient surgery has been made possible, for an important part, by an equally impressive technological revolution both in anaesthesia as well as in surgery, which has led to the development of approaches that require less postoperative care.

Moreover, ambulatory surgery is highly cost-effective. In its early days Ambulatory Surgery was the hobby of enterprising physicians, today, more and more health care insurers have to acknowledge that ambulatory surgery has financial advantages as well. From place to place, however, it appears that neither physicians nor healthcare governments are fully convinced of the advantages day surgery has to offer, and it will take much time and energy to change this attitude.

After a few remarks on history, this article focuses on strategies to emphasize the advantages Ambulatory Surgery has to offer.

For the individual surgeon it includes not only a perfect operative technique: proper selection both of the procedure and the patient, and attention for the management of postoperative pain as well. The central theme should be: let's first improve surgical treatment; a reduction in postoperative length of stay will follow then. Close collaboration with anaesthetists and nurses is essential to achieve this goal.

Moreover, it is advised that the individual day surgery unit should register clinical indicators, in order to keep an eye on overall quality of procedures. And finally, physicians and nurses should unite and strive to establish a national day-surgery association: some experiences in the Netherlands and with the International Association will be discussed.

Development of Ambulatory Surgery:
Ambulatory or day surgery is a clinical admission for a surgical procedure, with discharge of the patient on the same working day. In the early days of surgery all operations were done on an ambulatory basis, since hospitals, both conceptually and as an institution, developed later in history (1). Ambulatory surgery in its present form is commonly said to have started in 1909 when James Nicoll, a paediatric surgeon from Glasgow, reported a series of 8988 children, operated upon on an ambulatory basis (2). The first report of Ambulatory Surgery performed in a free standing unit came from Ralph D. Waters, anaesthesiologist from Sioux City, Iowa, USA, who reported in 1919 on his Down-Town Anesthesia Clinic, equipped for surgical and dental procedures under general anaesthesia (3). Finally in 1969, Ford and Reed, anaesthesiologists from Phoenix, Arizona, presented their concept of the Surgicenter®, designed 'to provide quality surgical care to the patient whose operation is too demanding for the doctor's office, yet not of such proportion as to require hospitalisation'(4). From that time on, the number of admissions for day surgery increased strongly in many countries, especially in the USA, Australia and Europe (United Kingdom, Belgium, France, the Netherlands and the Scandinavians). This increase was highly facilitated by innovations in surgical and anaesthetic techniques.The implementation of new surgical procedures, for example minimal invasive surgery like endoscopy, and new short-acting anaesthetics with minimal cardiovascular side effects made early discharge possible in a fast increasing number of cases. However, there is still quite some variation in the use of day surgery, at least among countries, but also in individual hospitals in many countries. The attractiveness of day surgery can be increased only when professionals in individual units render excellent patient care.

Selection of procedures and patients:
A large number of surgical procedures can be done on an ambulatory basis. Day surgery (rather than inpatient surgery) must be regarded the standard for all elective surgery. It should be considered the principal option and no longer an alternative form of treatment.

However, not all patients can be treated on a day surgical basis. It is not the operation that is ambulatory, it is the patient! It is of paramount importance that all patients are carefully selected, taking social, medical (co-morbidity) and surgical criteria into account.

Preoperative assessment, the providing of information to patients and caretakers, appropriate treatment and follow-up after discharge: all require meticulous attention for detail.

For day surgery commonly acceptable general surgical procedures are operations for inguinal hernia, breast lesions and proctologic problems. Varicose vein surgery, venous access surgery and access surgery for haemodialysis are all performed by vascular surgeons on an ambulatory basis. But new techniques evolve rapidly, enabling an increasing number of general surgical and vascular procedures to be performed in day care with or without extended recovery.

Management of postoperative pain:
Effective pain management after ambulatory surgery is important, not only for humanitarian reasons, but also because incomplete pain control contributes to postoperative nausea and vomiting (PONV), reduced mobility of the patient and delayed resumption of normal activities (5). Inadequate postoperative pain control is a significant cause of patient dissatisfaction with ambulatory surgery, may lead to many undesired effects, and sometimes unanticipated (re)admission.

To be continued........

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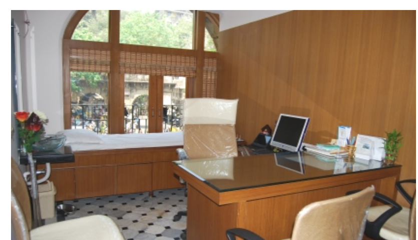

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Printed by: Dr. T. Naresh Row**, Published by:** Dr. T. Naresh Row, **Owned by**: Dr. T. Naresh Row, **Printed at**: Gemini Printing Press, 33/A, Kanbai wadi, Khadilkar Road, C.P. Tank, 1st fl., Opp. Pooja Cards, Mumbai-400 004. **Published at** One Day Surgery Center, 15, Sadguru sadan, Babulnath Road, Mumbai-400 007. **Editor:** Dr. T. Naresh Row