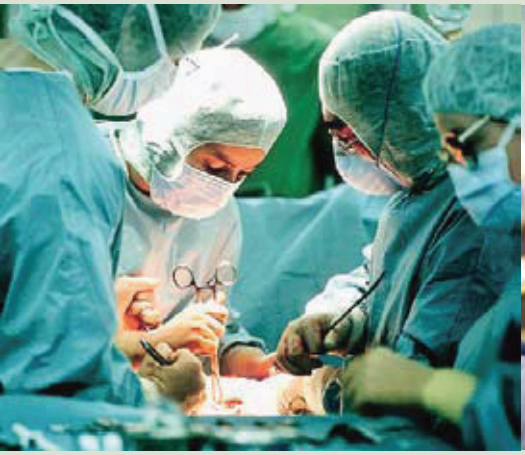
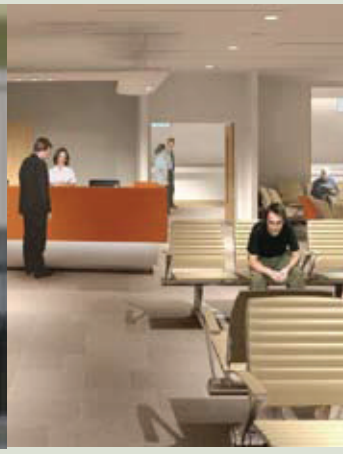
AMBULATORY SURGERY

International Journal covering Surgery, Anaesthesiology, Nursing and Management Issues in Day Surgery



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Editorial

Mark Skues, Editor-in-Chief

This edition of the *Journal* contains four contributions from variety of sources. Suárez Grau and co-workers present a full paper from their preliminary abstract presented in Barcelona in 2015, where they evaluate the use of a new anatomical mesh in the repair of bilateral inguinal hernias using the laparoscopic technique. While the rationale for management of bilateral hernias is well established with guidelines advocating laparoscopic repair, with consequent faster return to work, and reduced incidence of chronic pain post-operatively, the authors present preliminary results where they followed patients for six months to evaluate post operative complications. They attribute the absence of such symptoms to the use of different meshes reducing the degree of trauma associated with repair, though the rapid operative times (20–45 minutes) for laparoscopic bilateral repair is something to aspire to.

Jan Eshuis provides an eloquent tribute to a beloved stalwart of the International Association for Ambulatory Surgery, who sadly passed away in June of this year. Those who worked with Bob Williams while he was the Honorary Secretary of this organization will recall his affability and incisiveness, while being saddened at his unexpected death.

Paul Rawling, as Honorary Secretary of the British Association of Day Surgery, presents a review of the Annual Scientific Meeting that was held in Nottingham in June of this year. I would hope we may be able to replicate this with reports of other national meetings in due course, so if you are aiming to attend such meetings in the future, why not consider writing a paper describing the event and the speakers who lectured?

And finally, an offering that I hope will be of use and value to all readers. Having spent many 'happy' hours searching the database of the IAAS website for previous editions and abstracts enclosed in *Ambulatory Surgery*, I have collated every paper into a spreadsheet searchable by author name and keyword that allows download of relevant papers to your own computer since inception of the *Journal* in 1993. The bibliography can now be found on the IAAS website for download; I hope you find it useful.

Mark Skues

Editor-in-Chief

Initial experience in laparoscopic bilateral inguinal hernia repair (TEP) with new anatomical mesh with large pore and low weight (Dynamesh Endolap) in short stay (6 months follow-up)

Juan Manuel Suárez Grau [1,2], Isaias Alarcon del Agua [2,3], Juan Antonio Bellido Luque[1,2], Julio Gómez Menchero[1,2], Juan Francisco Guadalajara Jurado [1], Fernando Docobo Durántez[2,3]

Abstract

Introduction: Laparoscopic surgery for inguinal hernia remains a controversial issue. Its use for surgery of bilateral inguinal hernia is the most established and indicated. The anatomical 3D meshes have a major role in the development of the technique. Today meshes with large pores and scarce materials are used in order to obtain low pain rates and faster recovery with the similar recurrence rates.

Material and methods: We present an initial series of 20 bilateral TEP inguinal hernia repairs using PVDF anatomical 3D macroporous mesh (Dynamesh) fixed with fibrin glue with 6 months follow-up. The patients' mean age was 43 years. Inclusion criteria were: male, bilateral inguinal hernia diagnosed, ambulatory surgery criteria, type of hernia: L1-2, M1-2. The follow-up was determined at discharge, a week, first month and 6 months after surgery. Visual analogue scores for pain was conducted in all the patients at follow-ups.

Results: The results have been positive, with follow-up of all patients without recurrence at 6 months after surgery. No surgical infection or other major complications in the series were detected. Seromas were detected in medial hernias (9%), disappearing at one month. The mean surgical time was 35 min (20-45 min range), with a mean time of 3 min for each mesh placement. No conversion was made to TAPP in any case. The rates of pain were decreasing to 0 at 6 months with no chronic pain in any case.

Conclusions: The laparoscopic technique is still showing its great advantages, especially in the bilateral inguinal hernia. Using new generation meshes with large pores and low quantity material with atraumatic fixation is positioned as a good choice for laparoscopic surgery for inguinal hernia in ambulatory surgery.

An abstract of this paper was presented at the 11th International Congress of the International Association for Ambulatory Surgery in Barcelona in May 2015, and published in *Ambulatory Surgery* 2015;**21.2**:93.

Keywords: Inguinal hernia, short stay, laparoscopic surgery, mesh, TEP.

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Introduction

Laparoscopic surgery is still controversial, yet its use in the surgery of bilateral inguinal herniae is the most established and undisputed. There are few publications on bilateral inguinal hernia surgery specifically, as results in most cases are intermingled with unilateral inguinal hernia. This makes it difficult to arrive at definitive conclusions regarding their clinical management. Today we have multiple studies in inguinal hernia but the issue of bilateralism is approached from several perspectives: bilateral inguinal hernia diagnosed, hidden or incipient and "future".

Clinical examination for bilateralism should be performed in every patient who presents with a detected inguinal hernia. Sometimes inguinal ultrasound is necessary, but most of the time it is physical exploration that reveals the existence of bilateral inguinal herniae.

Anatomical 3D meshes help much to its development with decreased operative time. Today increasingly, meshes with large pores and scarce materials are used, which may favour the absence of chronic pain and can improve recovery in the immediate postoperative period. In this study, we analyzed the results (recurrences, pain, surgical time and complications) using this type of approach and this type of mesh with atraumatic fixation (fibrin glue).

Objective

To evaluate the results after 6 months after the intervention of bilateral inguinal hernia by TEP using new 3D anatomical large pore mesh (Dynamesh Endolap, Cardiolink, Germany) fixed with fibrin glue.

Material and Methods

Patients: We selected 20 patients with bilateral primary inguinal herniae, who completed 6-months follow-up after bilateral TEP hernia surgery. All patients were male with a mean age of 43 years (Range 28–77yrs). All patients were operated on an ambulatory basis.

Selection: Patients with primary bilateral inguinal hernia L1-2 and/or M1-2 (European Hernia Society classification). (In recurrent hernias and hernias bigger than L2 and M2 we used absorbable

tackers, and these patients were not included in the actual study).

Inclusion criteria: hernias L1-2, M1-2, non recurrent hernia with previous hernioplasty, suspected or confirmed primary bilateral inguinal hernias, male gender (in women we perform systematically TAPP), with normal weight, and suitable criteria for ambulatory patients.

Exclusion criteria: Recurrence with previous mesh, female (we performed TAPP), unilateral hernias (we performed only unilateral TEP), no possibility of ambulatory patients (in such patients we planned a laparoscopic inguinal hernia repair with overnight and no more than one day hospital stay).

Technique: We performed bilateral totally extraperitoneal inguinal (TEP) using anatomical Dynamesh Endolap large pore mesh and fixation with fibrin glue in all the cases analyzed. (Figures 1 and 2)

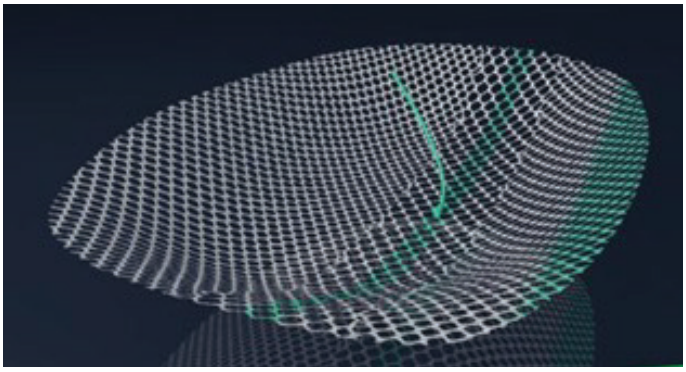

Figure 1 3D anatomical PDVF mesh (Dynamesh Endolap) for inguinal laparoscopic repair.

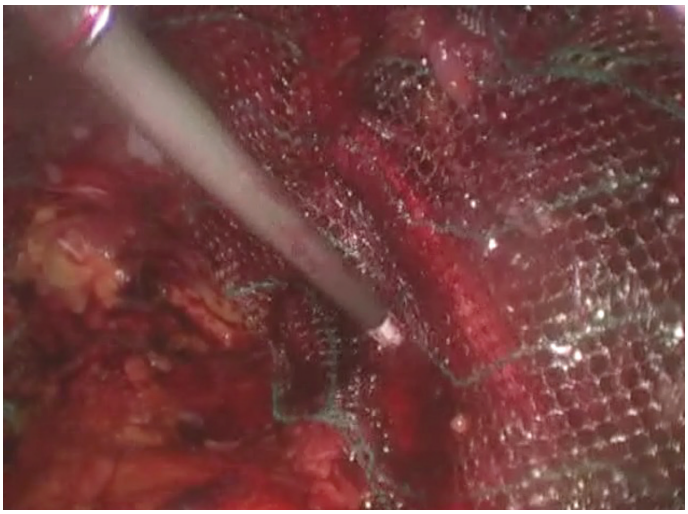

Figure 2 TEP using Dynamesh Endolap fixed with fibrin glue.

Parameters analyzed:

1. Recurrences after 6 months.
2. Analysis of postoperative pain (Visual analogue scale: VAS): before surgery, at discharge, at one week, one month and 6 months after surgery.
3. Physical examination: seroma, hematoma, wound infection and other complications.
4. Surgical Time: Duration of surgery and duration of the placement of the mesh.

Results

Twenty male patients with bilateral inguinal herniae were operated upon in ambulatory care, with laparoscopic extra-peritoneal repair (TEP). A total of 40 hernioplasties were performed (20 bilateral) with a distribution of: 22-L2, 4-L1, 12-M2, 2-M1 types.

The results have been excellent, with no recurrence after follow-up of all patients at 6 months after surgery. No surgical wound infection or other major complications were noted in the series. The mean surgical time was 35 min (20-45 min range); the mean surgical time placing the mesh was 3 min (1-8 min range). Seroma rates were over 9% at week (only in four M2 cases) and no seroma were detected at one month. No conversion was made to TAPP in any case. Discharge took place at less than 24 hours in all patients (mean of 12 hours).

The analysis of Pain during stress (VEA-s) and at rest (VEA-r): prior to surgery: 3-4 VEA-s / 2 VEA-r, at discharge: 3-4 VEA-s / 2 VEA-r, at week: 1-2 VEA-s / 1 VEA-r, at month: 1 VEA-s / 0.5 VEA-r, at six months: 0 VEA-s / 0 VEA-r. (Figure 3).

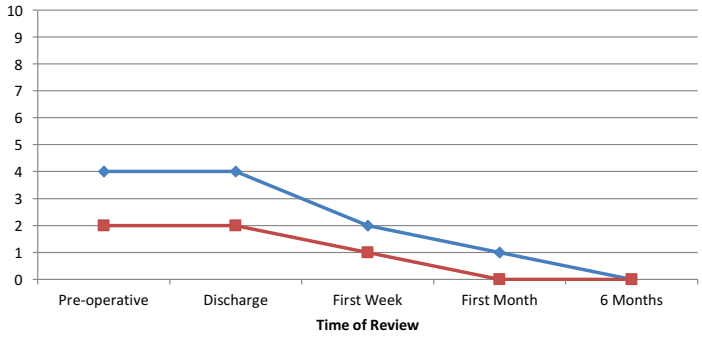

Figure 3 Visual analogue pain scores for patients at rest (■), and under stress (◆).

Return to normal lifestyle occurred after 6 days post-operatively (Range 5–10 days).

Discussion

Only 10-15% of papers about interventions on bilateral inguinal herniae are uniquely collected in the literature with most studies referring to such hernias secondarily. One of the main indications where laparoscopic surgery is more appropriate is in the field of repair of bilateral inguinal hernia and recurrent inguinal hernia. In a patient with bilateral inguinal hernia, unless a specific contraindication for laparoscopic or general anesthesia exists, laparoscopic repair can be currently considered the gold standard according to clinical guidelines of the European Hernia Society (EHS) and Americas Hernia Society (AHS).[1,2]

The use of laparoscopic surgery in bilateral inguinal hernia has great advantages, saving the time involved to perform both interventions through a unique approach as well as the possibility offered to explore both inguinal regions, bearing in mind that for 11–20% of cases of unilateral hernia, there is a subclinical contralateral hernia.[3]

McCormack et al. analyzed the effectiveness and economic cost of laparoscopic surgery versus open surgery, having an economic advantage for open surgery for the treatment of primary inguinal hernia, but a clear economic advantage in the use of laparoscopy for the treatment of recurrent inguinal hernias and bilateral inguinal hernias.[4]

The advantages of the laparoscopic approach in relation to the reduction in postoperative pain and accelerated return to work, make this minimally invasive approach a socio-economically cost effective option compared with the open approach for bilateral inguinal hernias.

With regard to the other two types of bilateral inguinal hernia (hidden / incipient and "future") stands out concerning the occult or incipient contralateral hernia, Koehler et al. found hidden contralateral hernias in 13% of patients undergoing unilateral TAPP [5], Thumbe et al. found 22% of contralateral inguinal hernia also hidden in TAPP [6] while Bochkarev et al. reported 22% occult contralateral hernias in TEP in 100 patients.[7]

Therefore, we assume there are almost a quarter of patients undergoing surgery for unilateral inguinal hernia have at that time a bilateral inguinal hernia. It is logical to apply the laparoscopic approach in patients with contralateral discomfort to the intervention area or any sign, both exploration and complementary tests.[8]

As for "future" bilateral inguinal herniae, Zendejas and co-workers conducted a study in 409 patients with a negative exploration using TEP for the contralateral inguinal region, to review the risk of occurrence. They found that for a median review time of 5.9 years (0–14), 33 patients (8.1%) developed a hernia on the previously healthy side. The incidence rates at 1, 5 and 10 years was 1.6, 5.9 and 11.8% respectively. The median time to hernia development was 3.7 years.[9]

Prophylactic contralateral repair area has advantages in avoiding future interventions, but has the disadvantages of increasing the surgical time and the possibility of minor injuries (being mainly chronic pain, which is currently very low with laparoscopic techniques and new materials such as self-adhesive mesh, wide-pore and atraumatic fixation incorporated or by adhesives)

The use of the new meshes with large pores and less quantity of material fixed with adhesives is one of the most interesting fields in the advances in laparoscopic inguinal hernia repair because at present good results are reported in terms of less pain and faster recovery in short stay or ambulatory surgery.[10]

Conclusions

The laparoscopic technique is still proving its great advantages, especially in bilateral inguinal herniae. Using this new mesh (which allows reduction of the amount of repair material and has large pores) and atraumatic fixation (fibrin glue), we are able to reduce the aggressiveness of the technique which might explain the excellent results about postoperative pain that we analyzed in our series of patients. The future of these materials is the key to getting better results and achieves ambulatory surgery of the laparoscopic hernioplasties process.

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OBITUARY

ROBERT CURTIS WILLIAMS

21 December 1943 – 23 June 2016

This summer, our IAAS community was suddenly faced with the sad news that Bob Williams, our former Secretary, had passed away on June 23, 2016. This sad news came to our association entirely unexpectedly and we learned that Bob had died of lung cancer.

For those in our IAAS family who knew him this message had a big impact as many of us have had the pleasure of knowing and working with Bob as he was active from 2002 in our association. As an official on our General Assembly he represented the Federated Ambulatory Surgery Association in the IAAS. After he had prepared the excellent IAAS / FASA Congress in 2003 in Boston, he was elected as a member of the Executive Committee. The IAAS proved to be very privileged having had the opportunity to enrol such an eminent scholar of Ambulatory Surgery into its ranks. One of the unique characteristics of Bob was the fact that he has worked as the Executive Director with Wallace Reed and John Ford in their archetypal Freestanding Ambulatory Surgery Center in Phoenix, Arizona, the first of its kind and an example for many of us. Together with his other nationwide activities in the field of ASCs and accreditation organizations in the USA this made him a beacon of knowledge for the IAAS. He was also soon Secretary of our organization serving alongside and supporting the Presidents de Jong, Bacaglini, Toftgaard and Lemos. During eight years he enriched us with his presence and knowledge. He always achieved this in an extremely amiable and unassuming manner. He was the one who could steer the discussion in the right direction at the right times with his impressive background. He was also very punctual and organised as Secretary and to the point when needed. In 2012 he left IAAS after the Porto meeting. He has transferred the Secretariat very conscientiously and carefully to me as his successor.

Bob was a fine and human guy who was inseparable from his lovely wife Paula who faithfully accompanied him on the many foreign trips he made. We are greatly indebted to him and miss him very much, but our thoughts are especially with Paula and their children- for them it is huge loss. We wish her and the family all strength.

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Conference Report of the 27th Annual Scientific Meeting of the British Association of Day Surgery, June, 2016

Paul Rawling

Abstract

A report of the 27th Annual Scientific Meeting of the British Association of Day Surgery (BADS), that took place on June 23rd –24th, 2016 is presented. BADS is the national Association for the United Kingdom, and the meeting provided an opportunity to highlight national developments in Ambulatory Surgery, together with the ability for consideration of free papers and posters by delegates attending the meeting..

Keywords: British Association of Day Surgery, Annual Scientific Meeting, Report.

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I must apologise in advance for my words in this reflection, but I do get excited at the thought of the Annual Scientific Meeting (ASM) beginning each year. 2016 was a little different for me as I was involved in the organisation of the event. Upon arrival in Nottingham for the British Association of Day Surgery (BADS) Annual Scientific Meeting the weather was pleasantly warm in Nottingham, unlike the first time I visited the venue in March 2015 at the earliest stage of planning for this event. The venue, at Nottingham Trent University, was both bright and modern and contained large spaces which gave it a pleasant ambience that did not feel crowded. The meeting was opened by the outgoing President of BADS, Dr Anna Lipp, providing a warm welcome to all the speakers and delegates the ASM was under way and immediately in full swing.

The programme design was to allow engagement and discussion of the contemporary emergence of emergency ambulatory surgery within the Day Case environment and included a number of what proved to be excellent speakers and some very dynamic discussion.

Delegate numbers for 2016 appeared down marginally on 2015 but the enthusiasm of those in attendance was extremely pleasing. The theme of the opening session was "Global Day Surgery: Are we all the same?". The two presenters were Professor John Appleby, Chief Economist at the Nuffield Trust (though described by his son as an "E-Communist"!) whose current work is around the economic issues within the governments' reform agenda and supports the philosophy of Day Surgery as a way to moderate NHS spending. John had previously written a briefing paper in the British Medical Journal1 emphasising that the development of Day Surgery had contributed around £2.75bn to limited NHS resources, with a likelihood that 2 million patients would be treated for no real increase in spending over the next decade. His presentation centred around this hypothesis, as well as concentrating on other aspects for which there had been significant changes, notably generic prescribing, and overall reduction of length of stay for the last thirty years. Our second presenter, Dr Arnaldo Valedon, is a widely known senior Anaesthesiologist from Washington DC with a special interest in outpatient anaesthesia and surgery for which he has 22 years experience. As readers will know, Arnie is also a member of the Executive Committee of the International Association for Ambulatory Surgery, so probably well known to us all. Dr Valedon's focus was on the challenges and successes of Ambulatory care in the United States, explaining first of all, the differences between Ambulatory Surgical Centres, Hospital Outpatient Departments and Office Based Surgical Facilities, the regulations that are in place for each facility, and how there is a maturing market with a reducing growth rate of Medicare certified ASCs since 2007. He then went on to describe current morbidities and mortalities for Day Surgery, the fact that reimbursing agencies are implementing quality based outcome measures with the potential for performance related pay, before explaining the potential for developing day surgery for more complex procedures including spinal surgery and hip or knee replacements.

The free paper sessions interspersed throughout the programme on day one are always popular. I find these sessions continually prove to be a very good way for all staff who wish to present their own or colleagues' work from practice to a broader more diverse audience. The topic areas were presented this year including length of hospital stay factors (including following simple mastectomy), improving nurse led discharge and the use of oral morphine solution in day surgery which is an area of interest for me. Pain relief will be an almost permanent entry on the ASM programme until Day Surgery practitioners do develop pain relief strategies that are effective and value for money. A concurrent workshop on Education in Day Surgery for Allied Health Professionals also took place. The focus being this year, on the changing and removal of current government funding streams for both pre-registration and post-registration education for health care professionals which will become more visible during the autumn of 2017. This issue will impact on practice significantly as practice areas and staff will be required to fund educational opportunities for themselves and their staff. It should be remembered that staff are obliged by their respective registering bodies that they will remain up to date with current practice.

The second plenary session included Professor Karol Sikora Dean of Medicine at Buckingham Medical School and past Chief advisor to the World Health Organisation Cancer Programme. Professor Sikora has spent his career working at the forefront of Cancer care within the UK for around 30 years. The session was aimed to highlight that the services we currently provide for cancer patients can and should be improved significantly, and that day surgery has a significant role to play in that area. Professor Sikora has focused his recent work on the

theory of a streamlined one stop approach for diagnosis, and staging. The belief that the time span for getting cancer treatment started is perhaps too long and may not be ambitious enough. The major focus being on innovation and enthusiasm was clear and was perhaps an invitation to all of us to consider changing the practices that we now consider normal to improve the care we provide to patients.

New this year at the ASM were the mini auditorium sessions which were ongoing over both the Thursday and Friday lunchtime periods. Sponsored by our trade partners, these were ten minute sessions in the trade area. The sessions were generally well received by both delegates and trade partners as the sessions took place within the trade area and delegates continued to view the trade stands. The areas of interest presented were again diverse, relevant and above all interesting. An overview of the Urolift System presented by Mr. Mark Rochester, 3 award winning clinical mastership programmes from East Anglia being Regional Anaesthesia, Oncoplastic breast surgery and Coloproctology presented by Dr. Ben Fox. Is Desflurane cost effective in day case surgery? Presented by Dr. Marco La Malfa. All of the sessions were evaluated extremely well by delegates who enjoyed the short sharp messages being put across. Friday lunchtime session was Boston Scientific, Green Light Laser Therapy in day case surgery urology, this session was delivered by Mr. Stuart Lloyd and highlighted the introduction of the new NIHCE guidelines. Again a very useful session in relation to urological surgery as another potential growth area in day surgery.

This year saw a lot of high quality posters accepted and on display, all of which were professionally formatted and clear to view. The posters received a lot of views and I spoke with a number of presenters and onlookers during the break periods and the feedback was on the whole very positive. The variety of topic areas were numerous and included Laparoscopic skills for junior surgeons, discharge processes, Laparoscopic Cholecystectomy, urology surgery, patient experience of post-operative nausea and vomiting (PONV), DVT Prophylaxis, an audit of perioperative hypothermia and day case cancellations on the day of surgery. Two of the posters that appealed to me personally, were focussed on White coat Hypertension in pre-assessment clinic as I have had experience of this within my family and an ethnographic exploration of pre-operative pain planning for day surgery patients which is an area of interest of mine along with patient education.

Professor Simon Parsons delivered a thought provoking session on Informed Consent including what information should be included in the process and how can it best be delivered. The session included an overview of the current consent laws and the consent process including what information the patient may require. Professor Parsons has worked in this area for the past 15 years and has experience of providing this information to patients. Risk was also discussed and this is a complex area which Simon made relatively easy to understand.

Final session of day 1 was a further session of free paper presentations. Again a varied selection of discussion areas and something of interest for all delegates in attendance. The topic areas were discharge guidelines, preoperative fluid policy, Cholecystectomy services, TURBT in the Daycase environment in the context of performance indicators and the use of day surgery facilities for in-patients in times of crisis. Parallel to the free papers a further session was provided on education in day surgery for AHPs.

The prize paper presentations are always hotly contested and 2016 was no exception. I am amazed at the diversity of these presentations was a joy to behold and demonstrates that Day Surgery is at the cutting edge (excuse the pun) of current surgical care. Diversity within topic areas were very much forward thinking and included Reversal of ileostomy in the day case environment, the potential for patient discharge delays were discussed, learning from patient's: clarity in patient information, the functional ability and adult support for the first 24 hours post operatively following day surgery, quality of discharge instruction following Day Case Breast Surgery which remains relatively new in day surgery and this presentation highlights that it can and does work efficiently and effectively and patient information and instruction is an important aspect of this process. The evaluation of patient perceptions in the use of one stop pre-assessment appointments was very interesting and continues to create debate around resource management and overall effectiveness.

Professor Doug McWhinnie and Miss Sarah Richards explored the classifications of an emergency and how the context of emergency surgery can be appropriate in the day surgery environment. This will involve unplanned admission and discharge on the same day which I am sure will be discussed and debated at length in the months and even years to come. This strategy should be more cost effective and efficient than the current process of dealing with some emergency surgery. Sarah focused on similar processes to Professor McWhinnie in that the delivery of high quality emergency care is possible when planned well. Bath now has a fully commissioned Emergency Surgery Ambulatory Care Service with dedicated daily emergency day surgery lists, which is great to see and a very positive step forward. This provides further evidence that Day Surgery does has a progressive future as indicated on day one by Professor Appleby. Bed days saved per month in Bath are approximately 160 and this is significant. Miss Richards highlighted that process and flow of patients in an expedited manner is key to success of emergency day case surgery.

The final presentations of this year's ASM were two fascinating talks, which I personally had been waiting for since summer 2015 and delivered by Professor Paul Edwards and Mr Liam Horgan. The session theme was clearly "Day Surgery on Tour" (well the official title is abroad). Both speakers presented the work they had carried out in the recent past, Professor Edwards on his visit and work in Peru on Laparoscopic Hernias and Mr. Horgan who has worked in Tanzania for the past 10 years teaching local surgeons to undertake Laparoscopic Cholecystectomy surgery. The presentations were indeed enlightening and not a little scary to be truthful, but delivered in a light hearted and accurate manner. Professor Edwards informed us about the travelling involved in Peru and the delivery of surgical services which at times leave a great deal to the imagination. Mr Horgan informed us that the very first Laparoscopic Cholecystectomy was performed in 2015 by a surgical team wholly from Tanzania which is a great achievement from a zero starting point. Both presentations were fascinating and thought provoking and is an area we may be able to develop further in the coming years.

This presidential handover took place at the ASM this year. The handover took place from Dr. Anna Lipp to our new BADS President Dr. Mary Stocker. Dr. Stocker gave thanks to Dr. Lipp for her period of presidency and to those council members who were now stepping down after many years of loyal service to BADS.

My final thoughts are that the 2016 BADS ASM in Nottingham was a fascinating meeting and a great success, thought provoking, eye opening, progressive and reflective. It was great to meet up with colleagues and friends again this year and to discuss current issues that everyone is experiencing. That said I would just like to say I would be delighted to see you all at the next ASM in Southport in June 2017.

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The 'Ambulatory Surgery' Bibliography

Mark Skues

Abstract

The journal *Ambulatory Surgery* is now in its 22nd year of publication and offers an invaluable resource for authors and reviewers evaluating the international status of the sub-speciality. A bibliographic database containing details of all publications written since inception has been constructed and is now available on the website of the International Association for Ambulatory Surgery. Specific search details for author or specific keyword can be entered, with the database 'filtered' to provide search results. In addition, a download facility can be actioned, allowing the specific paper(s) to be loaded to searchers' computers. It is hoped that the bibliography provides a more focussed approach to the Journal for aspirant authors.

Keywords: *Ambulatory Surgery*, Journal, Bibliography.

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Introduction

The Journal *Ambulatory Surgery* has been disseminated for twenty two years by a variety of publishers, before being adopted by the International Association for Ambulatory Surgery in (year) and disseminated online at **http://www.iaas-med.com/index.php/current-and-past-content**. The available downloads provide a valuable resource of the progress and development of the sub-speciality on an international basis, yet, to date, there has been no easily accessible dataset that allows simple interrogation by author(s) or keyword(s) and subsequent filtering of output. This paper describes the development of such a bibliography and its subsequent publication on the website.

Materials and Methods

The bibliography was constructed by firstly considering the software program most suitable for upload from the IAAS website, and then identify the fields that would best encapsulate the search process. Given that the author utilises an Apple MacBook Pro as a laptop computer for editorial management of 'Ambulatory Surgery', and that to date, there is no true database available on the Mac platform, a decision was made to use Microsoft Excel as a searchable spreadsheet. Excel has a presence on Mac computers as part of the "Office for Mac" Programme suite for which programming could be developed.

The data fields for searching needed to include authors' names, title of the paper, reference within 'Ambulatory Surgery' as a minimum, to which could also be added, keyword(s), country of origin, and direct download address for individual papers. Keyword identification proved to be something of an issue, as while published papers have keywords within their rubric, abstracts published from IAAS international congresses do not. It was therefore decided that words by which the database might be searched should be a part of the title of the paper.

Information was then downloaded from the IAAS website, with harmonisation of Authors' names to initials and given surname, country of origin (where cited), title of paper, reference for the paper, and direct access download from the spreadsheet. Abstract publications were also included in the dataset where they were either published in the Journal, or available elsewhere on the website, that are shown in Table 1. [near here]. They were separated from full papers in the bibliography by the use of a red font in the reference column.

Search criteria on the main page were programmed using 'macros' to filter for name or keyword.

How to use the spreadsheet

a) Download from the IAAS website

The programme can be found in the left hand tab at **http://www.iaas-med.com/index.php/journal-home** as "Bibliography". Clicking on this tab will reveal the spreadsheet where, clicking will initiate download to the user's computer.

b) Opening the Program

Double clicking on the icon will automatically open the spreadsheet, with a warning about macros prior to initialisation (Figure 1). The spreadsheet has been screened and validated as being virus free, so click on the left hand icon," Enable Macros". The program will then display the opening page, within which are two writable boxes seeking input on either 'Author' or 'Keyword'. In this example, the name "Skues" is entered in the Author box. (Figure 2). Pressing the icon, "Search for Author" will result in a new page being displayed, showing the search results that are filtered to contain the name of the entered author (Figure 3).

Figure 1 Macro check for Macintosh computers.

Scrolling to the right across the tab of the spreadsheet will reveal the title of the publication, the reference that is in a red font if the publication is an abstract, and a direct link to the original paper on

Table 1 Published abstracts available in the Bibliography.

Meeting	Available in/as:	Website Address
IAAS AFCA, Paris 2016	Ambulatory Surgery 2016;22.1	http://www.iaas-med.com/files/Vol_22/amb_surg22_1v22.pdf
IAAS 11th International Congress Barcelona, 2015	Ambulatory Surgery 2015;21.3	http://www.iaas-med.com/files/Journal/21.3/AMB_SURG_21-33.pdf
IAAS 10th International Congress Budapest, 2013	Ambulatory Surgery 2013;19.	http://www.iaas-med.com/files/Journal/19.2/AMBSURG_19_2_IAAS10thCongress.pdf
IAAS 9th International Congress, Copenhagen 2011	Congress Abstract book	ttp://www.iaas-med.com/files/Journal/abstracts/IAAS_2011_Abstract_book.pdf
IAAS 8th International Congress, Brisbane 2009	Ambulatory Surgery 2009;15.	http://www.iaas-med.com/files/Journal/15/ambsurg15_3.pdf
IAAS 6th International Congress, Seville 2005	Ambulatory Surgery 2005;12(Supplement)	http://www.iaas-med.com/files/Journal/12/Volume12_2005_congress1.pdf
IAAS 4th International Congress, Geneva, 2001	Ambulatory Surgery 2001;9(Supplement)	http://www.iaas-med.com/files/Journal/Volume9/Volume9_2001_S1-S5.pdf

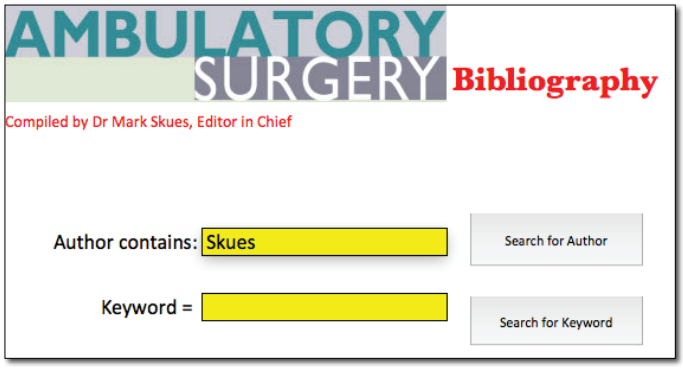

Figure 2 Author search.

Authors	Country
M Skues	England
M Skues	England
S Swift, A Ceney, S Eve-Jones, M Skues, C Ingham Clark	England
M Skues	England
M Smallbone, A Dunn, MA Skues, D McWhinnie	England
M Skues	England
M Skues	England
IJB Jackson, D McWhinnie, M Skues	England

Figure 3 Searched authors.

Title	Reference (abstracts in red font)	Website address
Editorial	2016;22.2:67	http://www.iaas-med.com/files/Journal/22.2/22_2ED.pdf
Editorial: AFCA / IAAS European Congress of Ambulatory Surgery	2016;22.1:3	http://www.iaas-med.com/files/Vol_22/amb_surg22_1v22.pdf
Emergency Day Case Surgery for Abscess Drainage – Time for change?	2015;21.4:173-6	http://www.iaas-med.com/files/Journal/21.4/Swift_et_al.pdf
Editorial: 11th International Congress International Association For Ambulatory Surgery	2015;21.2:31	http://www.iaas-med.com/files/Journal/21.2/AMBSURG21_2.pdf
The Cost Benefit Ratio of Mobile Operating Theatres for Day Surgery Management	2013;19.3:106	http://www.iaas-med.com/files/Journal/19.3/AmbSurg19_3Complete.pdf
Algorithms for risk assessment of PONV	2013;19.2:60	http://www.iaas-med.com/files/Journal/19.2/AMBSURG_19_2_IAAS10thCongr
Benchmarking Day Surgery performance in the United Kingdom	IAAS 9th International Congress Abstracts; 2011:47	http://www.iaas-med.com/files/Journal/abstracts/IAAS_2011_Abstract_book.p
The British Association of Day Surgery Directory of Procedures	2010;16.4:87-9	http://www.iaas-med.com/files/Journal/16.4/JACKSON.pdf

Figure 4 Titles, references (abstracts in red) and Web links.

the IAAS website, which when clicked, will download the original publication and display it in the native web browser.

To access papers using the keyword function, enter a desired word or phrase into the "Keyword" box on the main page, and the programme will automatically filter publications with those words within the title of the paper or abstract.

Discussion

The journal *Ambulatory Surgery* has been in existence since 1993 with the first publishers being Butterworth Heinemann, who in 1995 co-published with Elsevier, before becoming an imprint of Elsevier in 2006. The journal was transferred to the auspices of the International Association for Ambulatory Surgery in 2007, with subsequent dissemination facilitated from the IAAS website (**http://www.iaas-med.com/index.php/journal-home**).

Development of the spreadsheet took approximately 300 hours to complete, with a total of one thousand, nine hundred and ninety seven publications collated. The top twenty countries of origin are shown in Table 2, with England contributing 297 publications since inception of the Journal, 164 of which were full papers. Comparison

of the percentage of full papers with the total number written reveals that Canada, the United States and England had the highest proportion of papers published with 80%, 60% and 55% respectively. This may be a reflection of the fact that a Journal published using the English language is more likely to attract full papers from countries where English is the native tongue. Alternative explanations may be the existence of other national journals for Ambulatory Surgery to which manuscripts are submitted, or the relative profusion of Editors for this journal who are English language speakers.

Journals with an 'on-line' presence invariably have a search feature that facilitates identification and download of relevant manuscripts, though most of these are a subscription based service. The development of this bibliography provides a resource where it is hoped both established and aspirant authors can search the existing literature database of this journal to evaluate the viability of proposed submissions and to establish cross references for existing papers. Similarly, the profusion of abstracts provides a fertile environment for exploring the potential for further work for those involved with care of the ambulatory surgery patient.

Table 2 Number of publications in the Journal by country of origin.

Country	Full papers	Abstracts	Total	% Full Papers
England	164	133	297	55.22%
Spain	63	196	259	24.32%
Italy	36	239	275	13.09%
USA	109	71	180	60.56%
Australia	43	80	123	34.96%
Denmark	18	83	101	17.82%
Portugal	16	66	82	19.51%
Germany	20	43	63	31.75%
France	9	52	61	14.75%
India	7	48	55	12.73%
Sweden	27	27	54	50.00%
Netherlands	20	31	51	39.22%
China	5	36	41	12.20%
Belgium	9	29	38	23.68%
Norway	5	30	35	14.29%
Switzerland	8	24	32	25.00%
Finland	10	21	31	32.26%
Hungary	1	26	27	3.70%
Canada	16	4	20	80.00%
Turkey	4	9	13	30.77%

Ambulatory Surgery is the official clinical journal for the International Association for Ambulatory Surgery.

Ambulatory Surgery provides a multidisciplinary international forum for all health care professionals involved in day care surgery. The editors welcome reviews, original articles, case reports, short communications and letters relating to the practice and management of ambulatory surgery. Topics covered include basic and clinical research, surgery, anaesthesia, nursing; administrative issues, facility development, management, policy issues, reimbursement; perioperative care, patient and procedure selection, discharge criteria, home care. The journal also publishes book reviews and a calendar of forthcoming events.

Submission of Articles

All papers should be submitted by e-mail as a Word document to one of the Editors-in-Chief. Anaesthetic papers should be sent to Mark Skues and surgical papers to Doug McWhinnie. Nursing, management and general papers may be sent to either Editor. Electronic submissions should be accompanied, on a separate page, by a declaration naming the paper and its authors, that the paper has not been published or submitted for consideration for publication elsewhere.

The same declaration signed by all the authors must also be posted to the appropriate Editor-in-Chief.

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