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The results of direct access day surgery for minor operations

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Direct access surgery (DAS) is a method of patient management which eliminates many of the common delays in providing treatment. It relies on accurate correspondence from general practitioners and a degree of confidence in these referrals so that preoperative assessment is made on the day of surgery and postoperative wound management performed in the community. This is a retrospective study of 5776 patients treated over 5 yr for minor surgical procedures under the care of one consultant at Kingston NHS Hospital Trust. Half of these patients, mostly with skin lesions, were dealt with using the direct access approach. No clinical problems were experienced in those patients treated by DAS and a very significant reduction in waiting time for more serious conditions was achieved in the outpatient department. It is concluded that DAS is the method of choice for minor skin lesions and that the technique should be used in the future for more complex procedures.

Key words: Day surgery, local anaesthesia, direct access surgery, minor procedures

Introduction

Due to increased demand in the outpatient department more efficient ways for the management of minor surgical procedures were sought. The standard mechanism of referral was by letter from general practitioners (GPs) which generated an outpatient appointment to assess the suitability of the referral and plan a date for the procedure. After surgery an appropriate date for removal of sutures was made at which the results of histology and any further treatment were advised. Although this was the traditional method, it was felt to be time consuming and an inefficient use of resources.

Direct access surgery (DAS) gets rid of all the outpatient appointments except that for the surgery itself. It was felt that this might be the ideal way of dealing with increased minor surgery workloads.

Method

All GP referral letters were seen by the consultant surgeon and, if deemed suitable, the patients were immediately sent an appointment for same day surgery in the Surgical Day Unit (SDU). The factors of importance in the letter of referral related to the age of the patient – very young children are often not suitable for local anaesthetic procedures, the mobility and social circumstances of the patient, any drug therapy such as anticoagulants, availability of patient- or relative-supplied transport and if possible relevant dates of social commitments such as holidays, in order that non-attendance could be minimized. It was also important to know the site and size of the lesion and the GP's working diagnosis. If, from this information, there was any doubt about DAS an outpatient appointment was sent to avoid wasting time at a Day Unit operating session.

On arrival at the Day Unit each DAS patient was assessed by the consultant for their suitability for surgery and a note made of those not suitable. Non-attendance was also recorded.

Following surgery the patients were advised about wound care and the date on which their sutures should be removed by the practice nurses. They were also told that their pathology results would be sent to their GPs as well as a letter to them indicating whether the lesion was benign or would need further surveillance or treatment.

A record of the histological diagnoses of the DAS patients and conventional surgery patients was made.

Results

Over a 6 yr period (May 1988–May 1994) 5136 patients underwent minor surgical procedures at the SDU of Kingston Hospital NHS Trust. Some patients treated at satellite local hospitals were not included.

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Table 1. Diagnosis in minor surgery under local anaesthetic in SDU between May 1988 and May 1994

	DAS		*Conventional*	
Malignant skin lesions	389	(13.9%)	223	(9.5%)
Benign skin lesions	1783	(63.6%)	826	(35.3%)
Nail surgery	27	(1.0%)	333	(14.2%)
Other	601	(21.4%)	948	(41.0%)
Total	2800	(100%)	2336	(100%)
		Total 5136		

A total of 2800 (55%) operations were performed as DAS. Of those selected by letter, 198 (6.6%) did not attend and this compared with 51 (2%) who did not attend in the control group. A small number of patients, 25 (1%) were deemed unsuitable for DAS treatment when assessed on the day of attendance.

The diagnostic differentiation between DAS patients and those assessed conventionally is shown in Table 1. Non-malignant skin lesions accounted for 63% of the DAS patients compared with 35% of the control group and this was the largest subgroup in both. The DAS group mainly had skin lesion excision whereas the control group also contained nail surgery and vasectomy.

Malignant skin lesions were found in 389 (13.9%) of DAS patients compared with 223 (7.5%) of those assessed in outpatients (χ^2 $P<0.025$) and were made up of basal cell carcinoma, Bowens disease, squamous carcinoma and malignant melanoma (Table 2).

The DAS patients did not have a pre- or postoperative outpatient consultation which released a total of 5604 outpatient attendances in a 6 yr period. Assuming three clinics per weeks of 50 consultations, this was a saving of 37 weeks. Patients with non-urgent referrals were seen 9 months earlier as a result of using this method.

Discussion

Over the past 5 yr we have shown DAS under local anaesthetic to be extremely beneficial in terms of time saved in hospital specialist appointments. This form of surgery has so far been used only for minor surgery. If it is to be expanded to include more complex procedures, a series of rigorous guidelines will need to be achieved for GPs to select patients appropriately.

DAS provides an efficient route for skin lesions to be removed by a skilled hospital surgeon instead of within the primary health setting, where lesions are more likely to be inaccurately diagnosed and under-excised[1,2]. The clinic appointments which are saved by DAS would have served not only to assess lesions but also to provide an opportunity for the patient to acquire further information and relieve any anxiety. The lack of these beneficial factors in DAS is reduced by good pre- and postoperative communication to both patient and GP, especially concerning the outcome of histological analysis.

Table 2. Histological diagnosis of malignant skin lesions removed in the SDU between May 1988 and May 1994

	DAS		*Conventional*	
BCC	239	(61.4%)	124	(55.6%)
Bowens disease	70	(18.0%)	30	(13.5%)
Squamous carcinoma	36	(9.3%)	26	(11.6%)
Malignant melanoma	40	(10.0%)	41	(18.4%)
Others	5	(1.3%)	2	(0.9%)
Total	389	(100%)	223	(100%)

Some patients for vasectomy and hernia repair have been referred for DAS by a small group of GPs but the information imparted regarding side-effects and complications in these procedures and the time required for the patient to make up their own mind, especially in the case of vasectomy, may make the method difficult. It is unclear how much extra work will be needed by the GPs or their nurses to make DAS work effectively. As only local anaesthetic was used in this series it is likely that the time needed is considerably less than that experienced by Bradshaw et al.[3] where patients having DAS under general anaesthetic were assessed by GPs.

Smith and Gwynn[4] suggest that there could be savings in outpatient appointments, which is borne out by this report. For the first time the consequences of DAS for minor lesions has been quantified and the benefit to those patients who do need outpatient consultations clearly shown.

DAS under local anaesthetic is shown to be most suitable for skin lesions and will have a place in more complex procedures in the future, thereby saving even more outpatient consultations.

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