ELSEVIER

Ambulatory Surgery 4 (1996) 105–106

Ambulatory Surgery

Meeting report

Report on Ambulatory Anaesthesia Symposium, Sydney, Australia

Received 1 June 1996; accepted 6 June 1996

Health budget restraints and improvements in technology are driving the trend to the ambulatory care of patients who need surgery. With this interest, there was an extraordinary high number of delegates who attended the Ambulatory Anaesthesia Symposium on the Economics and Quality in Ambulatory Anaesthesia, Convention Centre, Darling Harbour, Sydney, Australia. The conference was jointly organized by the Society for Ambulatory Anesthesia, Australian and New Zealand College of Anaesthetists, and Australian Society of Anaesthetists. It was a satellite symposium of the World Congress being held in Sydney, April 14–19, 1996.

The topic of the early morning section was on 'Pushing the Limits in Ambulatory Anesthesia'. The panelists were Ms. Robyn Johnston, Clinical Nurse, Manager, Day Surgery Unit, Queen Elizabeth Hospital, Adelaide, Australia; Dr. John Youngberg, Tulane University Center, USA; Dr. Surinder Kallar, Medical College of Virginia, USA and Dr. John Zelcer, St. Vincent's Hospital, Melbourne.

Dr. John A. Youngberg indicated that there were no absolute exclusions for outpatient surgery, whether a patient was acceptable depended mainly on the severity of pre-existing disease. In 1985 in the US, approximately 35% of elective procedures were performed on an outpatient basis whereas in 1993, this percentage increased to approximately 60%. By the year 2000, this is expected to increase to 75%.

Dr. Surinder K. Kallar said that procedures which could last up to 6–8 h, procedures that require blood transfusions, procedures such as vaginal hysterectomy, knee and shoulder arthroscopic procedures, laparoscopic cholecystectomies, laparoscopic herniorrhaphy, thyroidectomy, mastectomy, and tonsillectomy could be performed on an outpatient basis. These changes are due to (a) improvement in anaesthetic drugs and techniques, (b) advances in surgical equipment and techniques, and (c) changes in insurance reimbursement policies.

In the panel on Continuous Quality Improvement, the speakers were Dr. Frances Chung, University of Toronto, Toronto, Canada; Dr. Mark Hitchcock of Frenchay Hospital, Bristol, England and Dr. Glenda Rudkin, University of Adelaide, Adelaide, Australia.

Dr. Frances Chung discussed continuous quality improvement, North American experience. "Although complications in ambulatory surgery are relatively rare", she said, "it is important to have an ongoing quality improvement program in each ambulatory surgery facility". At the Toronto Hospital, Western Division, 82% of patients were discharged 2 h and 95.6% were discharged 3 h after surgery. Persistent symptoms such as pain, nausea/vomiting, and dizziness delaying discharge occurred in 4.4% of patients. Patient satisfaction with ambulatory anaesthesia was very high, 98.9%. Postoperative symptoms were part of the reasons given the patient for dissatisfaction with anaesthesia. Inadequate anaesthesia and lack of communication in the monitored anaesthesia care (local anaesthesia with sedation) patients accounted for 42% of patients.

Dr. Glenda Rudkin of the University of Adelaide reported on the extensive experience in Australia of Day Surgery Outcome Studies. The unanticipated hospital admissions varied from 0.1%–2.4%. Readmission rates varied from 0.7%–0.86% depending on the type of surgical procedures. When clinical performance was measured, it resulted in improvement. However, more bench-mark studies are necessary to achieve improved outcome in day surgery facilities. Dr. Mark Hitchcock indicated that cost-effective, qualitative care was a more powerful tool to assure quality in the day case surgery of the future.

In the afternoon panel on Factors Affecting Recovery and Discharge, the speakers were Dr. Sujit Pandit, University of Michigan; Dr. Lance Lichtor, University of Chicago; Dr. Michael Mulroy, Virginia Mason Medical Center and Dr. Johan Raeder, Ullevaal University of Norway.

PII S0966-6532(96)00113-8

Dr. Sujit Pandit discussed the Use of Premedication in Outpatient Surgery: Reduction of Anxiety, Prophylaxis Against Acid Aspiration, Postoperative Nausea/vomiting, Postoperative Pain. Patients scheduled for outpatient surgery were anxious. The non-pharmacological methods used to reduce anxiety were effective and were preferred, however, these methods were not always logistically possible. As a result, short-acting anti-anxiety agents like midazolam, diazepam, or temazepam were appropriate to use when needed. Small doses of these agents did not delay recovery. Routine prophylaxis against acid aspiration or against postoperative nausea were not cost-effective and were not recommended, however, they were cost-effective in high risk patients. Postoperative pain and nausea remained important causes of delayed recovery. Non-steroidal anti-inflammatory agents given before the operation often reduced the requirement for postoperative narcotic analgesics, especially in children and after certain types of surgery.

Dr. Lance Lichtor presented a lecture on 'Factors Affecting Recovery: General Anaesthesia'. He indicated that selection of drugs for general anaesthesia played a great role in determining how long patients stayed in the Post-Anaesthesia Unit after surgery, and for some patients whether or not they could be discharged home. Many considerations were involved in the choice among anesthetic methods: general anaesthesia, block, or a block with sedation. Certainly, some procedures were possible only with a general anaesthetic. For others the preference of patients, surgeons, or anaesthesiologists might determine selection. Cost may be a factor: the cost of sedation was usually less than the cost of a general anesthetic. Time to recovery might also influence the choice of anaesthetic method: the incidence of unexpected admissions, and postoperative nausea and vomiting might be higher and recovery stays might be longer after general anaesthesia compared to local anaesthesia and sedation.

Dr. Michael Mulroy stated that regional anaesthetic techniques offered significant advantages for the outpatient in providing rapid recovery, shorter discharge times, less nausea and vomiting, and excellent postoperative analgesia. They should be used more often in outpatients, not only for the improved analgesia, but also for the ultimate cost-effectiveness of improved outcome.

According to Dr. Johan Raeder, Ullevaal University Hospital of Norway, the more important aspects of surgical and anaesthetic after-effects delaying the recovery process were somnolence, pain, emesis and surgical complications.

Dr. Paul White was the Moderator on the panel 'Controversies in Economics and Quality in Ambulatory Anaesthesia'. The panelists were: Dr. John Wardess of Royal North Shore Hospital, Sydney; Dr. Richard Kemp of Hartford Surgical Centre, Connecticut Meir Hospital; Dr. Jean Millar of Oxford University; Dr. Robert Jedeikin of Israel Beth Hospital. The discussion was both interesting and lively and many interesting topics were debated.

In summary, the symposium was highly successful. There was a lot of exchange of ideas between participants from the different countries during the question period. This first successful satellite international symposium paved the way for similar future symposiums at the World Congress.

Frances Chung
MD, FRCPC
The Toronto Hospital
Ontario
Canada