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Abstracts of Session 3b

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3b1

Significance of a dermatological service affering to day surgery unit.

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The management of neoplastic skin disease in hospital structures not provided with dermatological department could be difficult because of the impossibility to ensure to the patients a referring center for diagnosis and treatment.

For this purpose, a dermatological service was recently located in our Day Surgery facilities.

From January to October 2000, we treated 792 patients with cutaneous lesions diagnosed with clinical examination and dermatoscopy. All these patients were submitted to excisional biopsy, 156 in Day Surgery and 636 in ambulatorial regimen, and histological examination.

In 43 patients (17 males, 12 females; mean age 72.1 years, range 46–92), we diagnosed a malignancy as follows: 26 basalomas, eight melanomas, six spinocellular and two squamocellular carcinomas, one metastases from adeno-carcinoma.

Two patients with melanoma and one with squamocellular carcinoma underwent enlargement of excision because of infiltration of surgical margins at histological examination.

All patients suffering from malignant disease are submitted to clinical and instrumental follow-up.

Our experience allows us to point out several opportunities: screening and diagnosis of neoplastic skin disease in the population; availability of Day Surgery regimen in case of extended surgical procedure or risk patients; availability of hospital facilities for diagnosis and stadiation; referring center for the treatment and follow-up of these patients.

In conclusion, Day Surgery facilities could represent an ideal location for dermatological activity in absence of hospital structures appointed on.

3b2

Outpatient laparoscopic fundoplication for gastroesophageal reflux disease

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BACKGROUND: Based on a series of successful outpatient laparoscopic cholecystectomies, outpatient laparoscopic fundoplication for gastrooesophageal reflux disease was introduced in January 1997. The results of the patient series are presented.

METHODS: Inclusion criteria were ASA grade I–II, living within 30 min travel from the hospital and adult company at home. Initially only selected patients were offered outpatient treatment, later it was adopted as routine. They had a general intravenous anesthesia with propofol and remifentanil, and were given ketorolac, propacetamol, droperidol and ondansetron as prophylaxis against postoperative pain and nausea. Surgical methods were Nissen Rosetti fundoplication or semifundoplication depending on esophageal manometric results.

RESULTS: Until October 2000, 71 patients were included, 30 females and 41 males, mean age 44 years, range 22–69 years. Nine patients were admitted. Sixty-two patients were discharged as planned 2–8 h postoperatively, mean 6.5 h. Eight of these patients were readmitted due to pain, nausea or inadequate nutrition. One underwent a reoperation due to necrosis of the gastric fundus. Another seven patients visited the outpatient department without need for admission. At follow-up 47 patients were satisfied with the outpatient treatment, nine were indifferent, and six were dissatisfied due to pain. In case of a similar operation in the future, 42 patients would have preferred and ten would have accepted an outpatient treatment, and ten would not.

CONCLUSION: Outpatient laparoscopic fundoplication is safe and well tolerated by the majority of the patients, and has now been established as our routine for patients fulfilling the selection criteria.

3b3

Study on the optimization of ambulatory nasal surgery

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Over the past few years, it has become increasingly evident that nasal septum surgery can be readily performed in an ambulatory operation.

Problems are, however, still encountered in some cases, both with sacuring the postoperative adaptation of the nasal mucosa to the nasal septum and in preventing postoperative bleeding through a nasal tamponade.

From October 1999 to September 2000, we investigated two tamponade materials in a randomized study with 80 patients:

- the Vaseline tamponade,

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- the foam-filled rubber tamponade.

All the operations were performed by the same operating surgeon employing the same anaesthetic technique and the same anesthetist.

The results show:

The use of foam-filled rubber tamponades leads to:

- less OP time,
- less post-operative change in the position of the tamponade,
- less of a psychological burden of the patient,
- lower consumption of post-operative painkillers,
- lower consumption of post-operative antibiotics.

It can be clearly shown, that the use of this new tamponade type makes the ambulatory nasal operation safer and more pleasant.

3b4

Adenotomie, Tonsillectomie in ambulatory surgery in the doctors operation room

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We present a report of 15 years of experience in ambulatory adenotomie and tonsillectomie done in private operation rooms of three ENT-surgeons during 1984 and 1999.

Adenotomie is done in children older than 2 years while tonsillectomie is done in patients older than 4 years.

Postoperative bleeding is the main complication and has to be treated most of the time in the hospital. After adenotomie, it occurs in about 0.5% and is most of the time an early week bleeding, that stops within 24 h. Operative revision is rarely necessary. Postoperative (late bleeding), bleeding after tonsillectomie occurs in about 3.5% and starts twice as much after 48 h than the early bleeding (until 48 h postoperative). About 33% of the patients with early bleeding had to be operated while 66% were with late bleeding.

This ambulatory procedure has a very high acceptance not only in adults but also in parents of the children to be operated. It is the procedure of choice and is done about ten times more than the operation in the hospital. A very routine anesthesia team is to our disposition. This procedure is possible, because the main complication is rare and occurs most of the time after some days postoperative and because we have a hospital to our disposition to treat these complications.

3b5

Cataract surgery and anesthesia in a Spanish ambulatory surgical center

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BACKGROUND AND GOAL OF STUDY: The use of phacoemulsification surgical technique in cataract surgery has allowed the use of new anesthetic techniques with minimum aggressiveness, carried out in many cases by the ophthalmic surgeon.

In our Center, we study cataract surgery with the aim of valuing if the anesthesiologist had to continue being present in this surgical procedure.

MATERIAL AND METHODS: Retrospective study of the cataract surgery in our center from the year 1998 until the present time, analyzing the following variables: age, sex, ASA criteria, associated pathology, surgical technique, anesthetic technique, substitution index, mean procedure time, unplanned admissions and cancellations rate.

RESULTS: From January 1998 to November 2000, 2890 patients were operated. Mean age 73–74 years; women's prevalence; distribution ASA 4% I, 52% II, 38% III and 6% IV. The most frequent associated pathologies were hypertension (25%), respiratory diseases (13%), cardiac diseases (12%) and diabetes mellitus (11%). The most frequent surgical technique was phacoemulsification; the anesthetic technique was retro/peribulbar block or topical anesthesia (only 0.7% general anesthesia), always with sedation. The substitution index was 97%, with a mean procedure time of 5.5 h. Unplanned admissions rate was 0.35%, and cancellations for any cause 2.29%.

CONCLUSIONS: Given the age, the great incidence of associated pathologies, and the quality results, we continue believing that the presence of the anesthesiologist is necessary in the cataract surgery, so much in its status of anesthetist (for anesthesia or intravenous sedation for anesthetic injections) or reanimation or informant, to maintain some appropriate quality levels.

3b6

Is visual acuity a useful predictor of operative time in phacoemulsification cataract surgery in the ophthalmic ambulatory care department?

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PURPOSE: A reliable indicator of predicted operating time would be a useful factor in determining the optimum number of cataract cases to be scheduled in an operating session. Visual acuity (VA) is an easily obtained measure of ocular function that can be recorded by nursing or paramedical personnel without specialist knowledge or equipment. This study aims to investigate whether VA per se, can be used to predict operative time for cataract surgery in an ambulatory care setting

METHOD: Fifty consecutive patients scheduled for routine phacoemulsification cataract surgery under local anesthesia in the ambulatory care (ACAD) department were examined. The preoperative best-corrected VA was recorded. The operative time for cataract surgery from placing to removing surgical drapes was recorded. Surgery was performed either by consultant or by skilled junior staff. Operative time was compared with preoperative VA.

RESULTS: The mean operative time was 25 min. This did not vary statistically between operations done by junior or by consultant staff. Patients with VA 6/60 or less took statistically longer than those with 6/36 or better.

CONCLUSIONS: Visual acuity is a useful predictive factor in determining operating time for cataract surgery in cases where VA is severely impaired. In-patients with better VA (6/36 and better), operative time varies independently of the preoperative VA.

3b7

The intra-operative experience of patients under-going local anaesthetic cataract surgery

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This study explores the experiences of day surgery patients who are undergoing local anesthesia cataract surgery. Existing research in this area tends to focus on preference for one anaesthetic and surgical technique over another. These studies inform the process of performing the surgery/delivering anesthesia rather than the experience of the patient in the specific intra-operative period. The need to investigate and understand the experiences of these patients reflects the importance of developing a sound knowledge base in preoperative care through systematic enquiry. Patients from two NHS Trusts in the south of England were included in this study, which had two distinct phases. Phase one involved qualitative interviews with a small cohort

(eight) of patients and findings revealed three main themes of importance to the patients, preparing the patient for the surgery; the intra-operative environment and the professionalism of the staff. Following this phase a survey was undertaken of 215 patients who had recently undergone cataract surgery. Findings revealed that 50% of the patients were unaware of the nursing presence in the operating theatre. That many patients, who experienced discomfort due to surgical and positional factors, did not report this to the staff and that the main strategy for 'coping' with the experience was to try and 'switch off' and relax. Recommendations include the need for operating theatre nurses to raise their profile in the experience of the patient, the development of pain/discomfort assessment and management strategies specifically for this group of patients. Further research should include replication of this study across a broader geographical area as well as more detailed research into the role of the nurse in the operating theatre and a more detailed understanding of patients coping strategies during local anaesthetic procedures.

3b8
Non-laser canalicular endoscopic lacrimal surgery

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PURPOSE: To evaluate retrospectively the 1 year success rate of a new approach to treat lacrimal obstruction by restoring the physiological patency of the lacrimal drainage system with miniature endoscopes and trephines introduced through the lacrimal puncta.
METHODS: Patients with acquired symptoms of epiphora and/or chronic dacryocystitis refractive to conservative treatments were referred for a lacrimal drainage system endoscopy. Under local anesthesia, 426 consecutive examinations (1997–1998) were conducted with a miniature endoscope (Ø: 0.9–1.3 mm, Karl Stortz, Germany) introduced into one of the horizontal canaliculi (after lacrimal puncta dilatation and/or ampullotomy). If an obstruction was visualized, the miniature endoscope was replaced by a Piffaretti lacrimal miniature trephine (Ø: 0.9–1.3 mm, Huco, Switzerland) and the obstruction removed. No tubing was used. Success was defined by a persistent and marked subjective improvement of the symptoms (retrospective chart review).
RESULTS: Using this approach, 215 canalicular and 126 nasolacrimal obstructions (partial or complete) were diagnosed and operated (JMP). In the remaining 85 cases, a simple ampullotomy was performed. The 1 year success rate was 70% for canalicular obstructions, 78% for nasolacrimal obstructions, and 90% for lacrimal punctoplasties. During or after the procedure, only minor, and no major, complications occurred, such as hematoma or edema (after lacrimal irrigation) of the surrounding soft tissues.
CONCLUSIONS: This new procedure aimed to restore the physiological patency of the lacrimal drainage system is safe, simple, and easy to perform in local anesthesia. The 1 year success rate appears to be remarkably high. This approach could represent a new option to treat symptoms of acquired lacrimal obstruction.

3b9
Day case protrate surgery — how we do it

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Endoscopic prostatectomy is normally carried out as an inpatient procedure. Pressure on inpatient facilities along with the expectations of patients for short stay surgery, have contributed to this procedure being considered as a day case procedure. Gyrus bipolar technology produces tissue vaporization of the prostate with reduced bleeding and no risk of TUR syndrome because of the saline irrigant used. Careful patient selection and detailed pre-assessment and advice on catheter care is essential. Six patients treated as inpatients with this technology were discharged within 24 h of surgery voiding successfully. This gave us confidence to attempt to perform day case prostatectomy. Six patients have so far been treated and more are planned for day case prostatectomy. Patients are admitted the morning of surgery and the prostate is vaporized under general anesthesia. If the urine is clear enough for trial of catheter, it is removed by 18:00 h the day of surgery. Patients were deemed fit for discharge on the day of surgery but given the availability of a hotel facility, they were kept overnight and discharged within 23 h of admission. The nurse specialist visits the patient on the day of surgery and plans to remove the catheter as soon as the urine is clear. The nurse is equipped with a bladder ultrasound scanner to record voided volumes and is in direct telecommunication with the hospital specialist. Five of the six patients have been discharged as planned; the remaining patient was kept during the following day out of caution but was sent home with a catheter and underwent successful trial without catheter at home. All patients listed for elective prostatectomy are considered for day case prostatectomy. Given careful case selection and a motivated nursing and medical team day case prostatectomy is feasible.