ELSEVIER

Ambulatory Surgery 9 (2001) S59–S65

Ambulatory Surgery

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# Abstracts of Session 11c

# Poster session

**P26c**

**A French survey of ambulatory surgery (AS). General practitioners (GPs), surgeons and anaesthesiologists: do they speak their same language**

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INTRODUCTION: Successful AS needs a specific organization and reliable communications among medical actors. Insufficient implication of GPs in the course of AS may result from a lack of dialogue. The aims of the study were to analyze the relationships between physicians.

PATIENTS AND METHODS: A questionnaire including more than 100 items was sent in 1998 to 1709 GPs in the south of France (Gard and Hérault states).

RESULTS: Replies were obtained from 388 GPs (22.7%).

Relationships between GPs and the ambulatory team

| | Always (%) | Frequently (%) | Sometime (%) | Rarely (%) | Never (%) |
|---|---|---|---|---|---|
| Pre-operatively | | | | | |
| Anesthesiologist | 3.4 | 8.1 | 13.5 | 24.1 | 49.5 |
| Surgeon | 13.5 | 19.5 | 15.9 | 20.4 | 29.3 |
| Post-operatively | | | | | |
| Anesthesiologist | 1.7 | 3.0 | 9.1 | 18.8 | 66.7 |
| Surgeon | 60.6 | 27.6 | 7.7 | 3.4 | 0 |

Satisfaction from GPs regarding informations received from

| | Satisfied (%) | Unsatisfied (%) | No opinion (%) |
|---|---|---|---|
| The anesthesiologist | 44.3 | 17.5 | 38.2 |
| The surgeon | 82.7 | 9.8 | 7.5 |

GPs wanted more informations on the immediate post-operative period (from surgeon 85.2%, from anaesthesiologist 51.5%), a systematic written report (81.8 and 16.2%, respectively), recommendations on long-term care (73.1 and 42.4%, respectively). Some declared to need communication only in case of surgical (14.5%) or anaesthetic problems (23.5%), 61.1% are waiting for a report on the patient and the surgical procedure.

Interest of communication after patient's discharge between GPs and:

| | Useless (%) | Useful (%) | Essential (%) | No opinion (%) |
|---|---|---|---|---|
| Anesthesiologist | 9.8 | 63.3 | 13.6 | 13.3 |
| Surgeon | 6.6 | 65.2 | 19.6 | 8.5 |

CONCLUSION: Severe communication problems existed between OPs, surgeons and anesthesiologists. Solutions must be found to solve this problem that is responsible for a poor implication of OPs in the care of AS patients and purportedly of inadequate management of these patients.

**P27c**

**Outpatient surgical unit: our experience after a year of operation**

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INTRODUCTION: Our organization is an Ambulatory Surgery Unit hospital-based, with independent activity, multidisciplinary, involved with workman compensation cases. Our activities started August 2, 1999.

OBJECTIVE*:* To carry out a retrospective-descriptive study of the first 12 months of activity.

METHOD: It analyzed the electronic records of patients made during this period.

RESULTS: The attended population was 1282 patients that underwent 1426 procedures (surgical–non surgical nursery), 3/4 part of our population underwent surgery and 1/4 underwent diagnostic and/or therapeutical procedures. Our activity represented 23.7% of the surgical procedures referred to the Hospital. Thc demographic parameters were, age $x = 40$ years (14–93); sex, relation male/female = 2:l; height $x = 1.68$ m (l.43–1.94); weight $x = 93$ kg (35–l30). The 2.4% of our population had a weight equal or superior 100 kg. In pre-admission clinic, evaluation was made by physician in 18.3% and by nurse in the 90% of the population. Patients who underwent surgical procedures (3/4 of population) had the following distribution, plastics 13.92%; general surgery 2.46%; head-neck surgery 14.87%; neurosurgery 0.3%; ophthalmology 1.12%; NET 1.12%; orthopedics 70.25%; urology 2.66%. The most frequently procedures were, removal of implanted devices from bone 14.4%, knee arthroscopy 12.4%; carpal tunnel release 5.9%; remotion of tumor from soft tissues 4.8%; extraction of foreign body 4.1%; nasal fracture rediction 3.7%. We employed regional anaesthesia in 85% of our cases (local anaesthesia plus sedation; regional intravenous anaesthecia; spinal anaesthesia; supraclavicular or axilar brachial plexus block) and in nearly 15% of cases we employed general anaesthesia. The most frequently non surgical


PII: S0966-6532(01)00100-7

procedures were, Lumbar facet block 62.2%; epidural infiltration with steroids 22.6%; sympathetic block 11.8% and Lumbar discographies 1.9%. Associated comorbidity (ASA II) was 42.9%; intra-operatory morbility was 12.6% and immediately post-operatory morbility was 2.4%. Complications, neumothorax (two cases), post-dural puncture cephalea (one case) and bleeding (two cases). About times, average waiting time for surgery was 4.2 days (1–41), average operation time was 34 min (5–240) and length of stay was 230 min (40–620). Clinical indicators were, failure to arrive 0.73%; cancellation of procedure after arrival 0.36%; unplanned delayed discharge 0.078%; admission 0.078% and readmission 0.078%.
CONCLUSION: Our unit looks like a mixed medical–surgical unit, we can explain our results by the nature of the attended population, the legal normative of our Hospital and careful selection in the pre-admission clinic. The rare admission/readmission was in connection with anaesthesia.

**P28c**
**Ambulatory surgery during the year of 1999**

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The authors present a revision of the surgical interventions made in the Unit of Ambulatory Surgery in the Hospital Geral de Santo António, with the presence of an anaesthesist, during the year of 1999.
These Unit exists as independent from the year of 1994. Since then, there was a big improvement in the number of consultations, but also in the total number of surgical interventions.
In 1999, there were operated 401 patients, and the main pathologies were:

- Hernias of several locations (mainly Inguinal), Pilonidal Cysts, Haemorrhoids, Fissures and Fistulas, Varicosed Veins, Breast Nodes, Excisional Biopsies, Hidrocels, Epididymal Cysts, Thyroglossal Duct remnants, Volumous Lipomas and Cholelithiasis.

From each patient it was studied the following.

- Sex (male, 60% and female, 40%), age (average of 45), residence, profession, origin, time of waiting for the first consultation, time of waiting for the surgery, pathological antecedents, surgical antecedents. Related to the surgical procedure, it was analyzed the type and median duration, and the type of anaesthesia used.

During the surgery, there were registered some occurrences.

- Haemorrhagy, 1; Bradicardia, 4; Hipotension, 1 and some technical difficulties.

On the early post-surgical period (during the stay in the Ambulatory Unit) the main occurrences were:

- Pain, 76 patients (19%).
- Haemorrhagy, 4 (0.9%).
- Pain, nausea and vomiting, 4 (0.9%).
- Nausea and vomiting, 3 (0.7%).

The number of patients that, by surgical or anaesthetic criteria, spent the night at the hospital, was 5 (1.2%).

- Three cases of vagal reaction, one case of pain and one case of hematoma. All of them left of the hospital in the morning after the surgery.

On the post-surgery, it was evaluated the average number of consultations, time of follow-up and rate of complications, that in the present study was 14.2%.

**P29c**
**Post-operative complications in ambulatory surgery**

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Complications are uncommon after ambulatory surgery. The selection of patients and procedures and the application of guidelines avoid incidents after day surgery.
The aim of this study is to point out the most frequent complications encountered in a multidisciplinary day surgery unit in order to prevent them.
Demographic data, diagnosis, pre-medication, characteristics of procedures and recovery during the first thirty days have been registered over the last 5 years, creating a database of more than 4000 patients. The distribution among specialties was, general surgery 34%, orthopedic surgery 17.4%, urology 16.3%, ophthalmology 15.6%, ENT 9.3%, vascular surgery 5.2%, plastic surgery 1% and gynecology 0.9%. The StatView 5.1 program was used to elaborate the database and to obtain statistics.
A case of septic shock appeared after a prostatic biopsy as a major complication, 0.02%. Minor complications were registered in 12% of patients, including among them incidents such as urinary retention, 2.9%, never mentioned after inpatient surgery. Wound infection was present in 2% of patients, inadequate pain control in 2.2% and wound dehiscence in 1.1%. There were differences among procedures, $P < 0.0001$. Morbidity was higher in hernia surgery, 23.5%, anal surgery, 15.5% and cataract surgery, 13.7%. Urinary retention was related to hernia repair procedures, 10.2%, inadequate pain control was related to hallux valgus correction, 3.4% and cataract surgery, 6.3%, wound hemorrhage to anal surgery, 2.4% and wound infection to subcutaneous tumor excision, 5.2%, anal surgery, 4.8% and hernia repair procedures, 3.5%.
Major complications are uncommon in ambulatory surgery, but some minor complications and incidents occurred in 12% of cases.
Morbidity is related principally to hernia repair procedures, anal surgery and cataract surgery.
It is necessary to introduce improvements in order to avoid complications such as urinary retention, post-operative pain and wound infection.

**P30c**
**Anaesthesia in ambulatory surgery: our experience**

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The development of ambulatory surgery (AS) will go on, both in terms of widening the scope of procedures eligible for ambulatory care and, in most countries, exploiting fully potentials of extensive ambulatory programs. The aim of this study was the descriptive analysis of anesthetic techniques for AS in our hospital.
METHODS: A 4 years retrospective study was made. We studied 2.056 surgical procedures. Data analysis was performed with Statview 5.0. The results are shown in the table:

| | 1995 | 1996 | 1997 | 1998 | Σ |
|---|---|---|---|---|---|
| Epidural anaesthesia | 10 | 21 | 15 | 20 | 66 |
| General anaesthesia | 38 | 123 | 142 | 153 | 456 |
| Spinal anaesthesia | 61 | 202 | 183 | 229 | 675 |
| M.A.C* with sedation | 129 | 158 | 177 | 222 | 686 |
| Plexus block | 5 | 5 | 3 | 9 | 22 |
| Intravenous regional | 7 | 34 | 52 | 58 | 151 |
| Σ | 250 | 543 | 572 | 691 | 2.056 |

*M.A.C., monitored anaesthesia care.

CONCLUSIONS: The experience of anesthesiologists in AS and the introduction of new drugs in anesthesiology, short-acting opioids such as remifentanil, computerized pumps for delivery of drugs such as propofol or end-tidal inhalational agent measurements, will be used to increase the number of surgical procedures who need to practice a general anaesthesia in AS. The preferred anesthetic techniques in our department are, monitored anaesthesia care with sedation, spinal anaesthesia and general anaesthesia.

**P31c**

**Benzodiazepines, delay emergence from propofol/remifentanil anaesthesia and sedation for day case surgery**

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Aim of this study has been to compare recovery times following propofol and remifentinil with or without benzodiizepine (BDZ) anxiolysis, administered either for general anaesthesia (GA) or conscious sedation (CS). Two hundred and eighteen patients undergoing various surgical operations (rhinoseptoplisty facial lifting, brest augmentation scar revision, liposuction, inguinal hernia repair, proctology) as ambulatory day cases were studied GA was induced with piopofol 1.5–2 mg/kg followed by a continuous infusion of 10 mg/kg per h and remifentanil infused it 10 μg/kg per h. CS was started with propofol 3 mg/kg per h and remifentinil 4 μg/kg per h during the maintenance phase drug infusion rates were adjusted according to clinical needs. Diazepam (0.05 0.06 mg/kg p.os) and/or midizolam (2–3 mg i.v.) were given as pre-medication or coinduction as necessary. All patients received field infiltration with local anesthetics (lidocaine or mepivacaine); patients under GA were artificially ventilatede with $O_2$/air through ETT or LMA.
Times to reach defined end points from end of anaesthesia or sedation (EA, eyes opening, orientation, spontaneous breathing extubation, sitting, walking, dressing, drinking, micturition, discharge) following EA were collected and data are analyzed with parametric and nonparametric analysis of variance between AG and CS, with and without bdz supplementation.
Diazepam and midazolam caused a significant prolongation of all times intervals for GA:EA-sitting $17 \pm 8$ without bdz versus $33 \pm 23$ with bdz; EA-standing $35 \pm 18$ versus $94 \pm 49$, EA-dressing $33 \pm 18$ versus $107 \pm 63$, EA-walking $42 \pm 23$ versus $96 \pm 41$; EA-discharge $45 \pm 22$ versus $128 \pm 76$. Under MAC EA-sitting: $13 \pm 7$ versus $19 \pm 10$, EA-discharge: $46 \pm 27$ versus $92 \pm 64$.
In conclusion, propofol and remifentanil gave excellent conditions for a wide variety of day surgery procedures, offering smooth anaesthesia with quick emergence; the addition of low dose bdz prolongs significantly discharge times.

**P32c**

**A blend of remifentanil and propofol for anaesthetic induction and maintenance for short gynecological procedures**

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In daycenter treatments ambulatory anaesthesia to minor procedures is of great importance owing to time expenditure. In order to reduce time and staff requirements we tried to blend remifentanil and propofol although this mixture is not considered to be stable. It would, however, make induction easyer as focus could be on the patient as syringes/pumps needed less attention.
METHOD AND MATERIAL: The method was tested on consecutive gynecological patients on 3 different days. They were admitted for D & C and termination of pregnancies. All were ASA I–II. Group I (day 1; $n = 11$) received propofol, 1 mg/kg, group II (day 2; $n = 7$) $-1.5$ mg/kg and group III (day 3; $n = 11$) 2 mg kg. All patients received remifentanil, 1 μg/kg for both induction and maintenance of anaesthesia. The mixture of remifentanil and propofol was prepared in the morning and all procedures were ended within 5 h. Rescue anaesthesia for both induction and maintenance was given on clinical conditions with a bolus inhalation of sevoflurane. Demographic data were comparable. Vital signs were recorded before induction and every minute thereafter.
RESULTS: There were no complications related to anaesthesia. Mean BP decreased in all groups of patients. In group I to 82–84, group II to 68–76 and group III to 71–75 mmHg. HR varied between 61–72 in all three groups. In group I only, we suspected opioid related rigidity in approximately half of the patients, but no treatment was indicated nor given. In group I and after 3–4 min in group II and III as well sevoflurane was given as rescue anaesthesia, 8% initially, and reduced to about 2% within 1 min and continued throughout surgery. All patients were on controlled manual ventilation due to apnoea.
DISCUSSION: The blend of propofol and remifentanil seemed to be stable under the above conditions. A volatile, potent and fast acting anaesthetic was necessary for maintenance. We opted for remifentanil in equal dosage for all three groups and propofol at 1 mg/kg seemed to be insufficient whereas 2 mg/kg did not add any advantage to 1.5 mg/kg. All patients were hemodynamically stable under controlled ventilation. The method was easy and simple to administer and we did not notice a change in potency in the course of the day. The supplement of sevoflurane seemed to fulfil all demands for potency and fast acting agent as surgery could proceed without delay. The patients received the staff's full attention and the procedure was not disturbed by other duties. If secured, this blend of drugs could be a useful tool in anaesthesia to short procedures.

**P33c**

**Sevoflurane–remifentanil or propofol–remifentanil. A retrospective study in a day case centre**

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Day care treatment of surgical patients is challenging in regard to the quality of medical care and patient satisfaction. Complications owing to the treatment are unacceptable especially those who appear after discharge when the patients have no direct access to professional medical care and observation. Patients often judge the quality of their hospital treatment in total by pestering symptoms like nausea/vomiting (PONV), dizziness and pain. This brings the anaesthetic agents and techniques in focus.
MATERIAL AND METHOD: Retrospectively, we evaluated the anaesthetic records of 165 patients treated in April and May 1999. The duration of anaesthesia was over 30 min but no more than 90 min. The patients were treated for disorders within the specialties of orthopedics, gynecology, ENT, general surgery.
Two existing models of anaesthetic techniques were to the discretion of the anesthetist, (A) induction and maintenance of anaesthesia by sevoflurane (Abbott) and continuous infusion of low dose remifentanil (Glaxo, Welicome) 10 ml/h (50 μg/ml) or (B) induction by propofol 2.0–2.5 mg and maintenance 20 ml/h (1% of propofol). For post-operative pain treatment lornoxicam 16 mg (Nykomed, DK) was administered i.v. during anaesthesia. The patients' vital signs were monitored in the PACU as was PONV, pain, wellbeing.
RESULTS: One hundred and sixty charts were suitable for this study. Patients' demographic data were comparable. No patients suffered major events. Three patients were converted to in hospital observation/care. One (tonsillectomy, group A, $n = 96$) with bleeding diathesis, one (group B, $n = 64$) for over-hydration after TCRE and one

(group A) for social reasons. Patients were discharged after less than 2 h of observation except the tonsillectomies who stayed for 3 h. Most patients received a booster dose of i.v. or oral lomoxicam 8 mg, and 66% an additional dose of paracetamol 1000 mg in combination with codeine 60 mg. Opioides were not used, nor found necessary. In spite of focus on PONV we found only three patients, two in group (A) and one in group (B), and after treatment with ondansetron their course was uneventful.

DISCUSSION: Less than 2% of the patients were admitted for in-hospital treatment. With the short acting and powerful anesthetics used post-operative pain problem would be anticipated. But a vigorous policy on pain, in which the anesthetist took responsible action even before surgery was started, minimized this to a fully controllable situation. Pain problems were easily managed. A common problem is PONV, by some reported to be in the range of 40–60%. We did not observe more than 1% of this unwanted post-operative condition. This could be due to an observation error or lack of sensitive objective measurements. We do, however, inform our patients that nausea and vomiting may occur (like pain) and the patients are therefore prepared for some discomfort. The balanced anaesthetic technique might also be of importance in the management of PONV as the dosage of the agents can be kept low. If a specific blood concentration triggers nausea and vomiting we may not have reached this level with the low dosage technique. Propofol is said to inhibit PONV. In this study, we did not observe any difference between the group given propofol and remifentanil and the group given sevoflurane and remifentanil.

We found it easy to administer two different techniques although three different drugs occur. We recommend these agents for ambulatory anaesthesia.

**P34c**

**ASA III patients and ambulatory surgery**

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Patients with ASA III physical status can be operated in day surgery units after a strict selection. The aim of this retrospective study is to determine if the clinical indicators in these kinds of patients are similar to the global indicators of the unit.

Among more than 4000 patients operated in a multidisciplinary day surgery unit, 125 of them were ASA III physical status. The causes for this status were chronic obstructive pulmonary disease 51%, arterial hypertension 26%, rhythm disorders 20%, neurological deficits 15%, coronary artery disease 14%, diabetes mellitus 12%, obesity 9% and heart failure 7%. The mean age of patients was 69.5 years (71% male and 29% women).

A 68% of patients were operated under local anaesthesia and 8% under general anaesthesia. The most important clinical indicators in the ASA III group of patients were, hospital admission 5%; hospital readmission 1.7%; cancellation of the procedure after arrival 5%; global morbidity 15.6% and wound infection 0%.

There are few differences between the clinical indicators in the ASA III patients and the global indicators of day surgery units. Because of this ASA III patients must be included in day surgery units after a selection of patients with stable physical status.

**P35c**

**Differences in delay of discharge from hospital depending on the type of anaesthesia used for groin hernia repair in day surgery**

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Choosing the best technique with the minimum morbidity and side effects as well as obtaining the shortest delay in discharge time is a challenge in day surgery anaesthesia.

We studied 80 patients undergoing ambulatory hernioplasty using the Nyhus technique and we choose four of our usual anesthetic techniques.

- Group I, dural block with 0.75 mg/kg prilocaine 5%.
- Group II, dural block with 0.5 mg/kg prilocaine 5%.
- Group III, dural block with 0.6 mg/kg lidocaine.
- Group IV: Ioinguinal block + sedation with 0.1 mg/Kg slice min remiphentanyl and 3 mg/kg/h propofol.

Demographic variables, hemodynamic changes, surgeon case of movement during operation, as well as patient comfort during and after the operation were take into account.

We turned the delay, before the first analgesic was given before the patient could walk, before the patient was discharged and we monitored side effects which could delay any of these.

Patients from group IV were discharged earlier and satisfaction rates were higher although the other three techniques still complied with criteria for day surgery.

**P36c**

**Effective post-operative pain control in a day case centre**

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In day case surgery the patient's contact with the medical staff is very short. In this respect, it is mandatory to inform the patients realistically of procedures and to treat unwanted incidents consequently and meticulously in order to improve medical quality and good patient satisfaction. Post-operative pain management is considered to be a cornerstone in this respect. This study aimed at improving standards already set.

MATERIAL AND METHOD: Pre-operatively a nurse informed the patients about surgery, anaesthesia, possible complications and especially pain, and the very same nurse was on duty on the day of surgery, either as scrub nurse or working in the PACU. Patients were anaesthetized by two anaesthetists and for induction and maintenance sevoflurane (Abbott) and remifentanil (Glaxo-Wellcome) was administered. Pre-medication was not given.

Patients were selected from categories where NSAID was given as a routine, and in that respect the patients studied were consecutive. Patients were recruited from the surgical specialties, orthopedia ($n = 53$; arthroscopies, minor osteostomies, Dupuyten's contracture), gynecology ($n = 65$, sterilization, TCRE, diag. laparoscopies), general surgery ($n = 23$; hernias, breast tumors), ENT-surgery ($n = 18$; myringoplastics, tonsillectomies).

Lornoxicam, 16 mg, (Nycomed, DK) was given i.v. after induction (except in tonsillectomies where it was postponed until homeostasis was secured). VAS score (scale 0–10) was recorded post-operatively every 15 min as were nurses' activities. A score of more than 4–5 were indication for treatment; otherwise treatment was given on the patients' request. Primary offer for treatment was a supplemental dose (i.v. or oral) of lornoxicam 8 mg, and thereafter, on rescue, a combination of paracetamol 1000 and 60 mg of codeine.

RESULTS: Two patients were admitted to in-hospital care owing to social conditions. A total of 110 (out of 159) felt pain (69%) but only 100 (63%) accepted treatment.

In general, orthopedic patients needed more analgesics than gynecologic patients. Having received post-operative treatment with lornoxicam 8 mg, 47 patients (30%) needed the rescue treatment. Thereafter only eight patients (5%) claimed additional analgesic treatment.

Nurses rated this regime as acceptable or good in 151 cases and insufficient in 2145 patients rated pain management as acceptable or good and four rated it bad. At discharge VAS score was below two in all patients. Opioids were not used.

DISCUSSION: Post-operative pain management is one of the most important items to control. In this study, we found it of importance that the informing staff also cared for the patient during or after surgery. Lornoxicam was effective in pain management and reduced the number of patients in need of treatment to 63%. After an additional dose of 8 mg only 30% remained in pain after 15 min of observation. Of these only 5% remained insufficiently controlled even after a paracetamol and codeine supplement. These patients were offered the PCM/codeine combination again, with success. It is worth mentioning that no patients needed opioids. In conclusion, lornoxicam is effective in post-operative pain control together with oral paracetamol in combination with codeine. In this respect, continuity and proper pre-operative information is very important.

**P37c**

**Developing the emerging surgical facility: freestanding ambulatory and short-stay centers**

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A step-by-step methodology for establishing new surgical programs in a variety of settings. Members of the panel will include, at a minimum, experts in: operations and management; planning and development; and clinical/medical services. Issues to be addressed include: feasibility determination; financial considerations; regulatory conditions; medical staff development; facility planning and design; organizational/business configurations. Global private healthcare investment will nearly triple in the next 10 years. As more countries' health care financing policies shift their emphasis toward private sector alternatives for health care delivery, those in the ambulatory surgery community must be prepared to lead the development of those surgical settings most likely to be both responsive to and predictive of these trends. ASC/short-stay surgical settings offer an alternative to a public healthcare system quandary by providing access, high quality and customer service in a resource-eficient manner.

**P38c**

**Development strategies for the creation of a turn-key free standing ambulatory surgery unit; a case study within the environment of merger and acquisition**

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The development of a free standing ambulatory surgery center is identified as a complex, labor intensive and costly endeavor. The unique matrix of regulatory compliance coupled with the identification of the community needs within a framework of fiscal responsibility promotes the need for immediate action. This presentation encourages the utilization of established consultants that address the clinical, fiscal and administrative responsibilities in the creation of an ambulatory surgery center. An examination of empirical studies and a retrospective analysis of existing centers in New York state serve as the framework that identifies the pathway that reduces the timeline for the development of an ambulatory surgery center from the existing 3 years marker to a 9 months project. The successful implementations of specific strategies are benchmarked within the arena of the state as well as utilization of certain the national markers. The identification and maintenance of clinical standards that serve to identify the service are stressed as paramount factors in the development of the specialties within the scope of a multispecialty center. Various fiscal methodologies and the identification of the organizational structure are identified as successful mechanisms for the center's owners and investors that serve to promote and generate income for the project. The broad range utilization of management consultants that incorporate design, building, funding, clinical expertise and administrative excellence is seen as a cost effective mechanism for the successful transition from conception to utilization of the free standing ambulatory surgery center. This methodology can be applicable in developing countries as well as within the existing complex of healthcare delivery.

**P39c**

**Development of an overnight stay facility within the day unit — the first years experience**

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A significant number of patients are excluded from management as day cases on social grounds, most commonly because they have no career at home or need to travel a long distance to the hospital. This problem has been addressed by other institutions in various ways including hospital based hotels and developing partnerships with local hotels.

The David Beevers Unit is a large day unit treating approximately 9000 patients per year, with three theatres hystercscopy, urodynamics and lithotripsy suites and also accepts patients having angiography and some medical procedures. The ward area is large with 12 beds, six each for men and women and 14 trolley/chair spaces. The normal working hours are 07:30–21:00. We have opened 12 beds as a low dependency overnight facility for five nights per week, this is staffed by one nurse and a health care assistant. Patients have to meet a set of strict criteria to be considered suitable these include, a low level of dependency; ability to sell medicate; arrangements for discharge the next morning and not requiring routine review by medical staff prior to discharge. The majority of patients are booked from clinic or at their pre-assessment visit but there is the facility to organize overnight stay on the day if a bed is available. Any patient whose medical condition deteriorates is transferred to another ward.

In the first year of operation 699 patients have used the facility, with an overall bed occupancy of 26%. The cost of providing this service is considerably less than for an inpatient bed.

This arrangement provides a cost effective solution for these patients and releases a valuable resource for inpatient use.

**P40c**

**Can the American model for the emerging surgical facility be adapted to the global environment?**

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The combination of the managed care revolution that has swept across the U.S. in the past decade (to varying degrees of support) and a drive toward innovation and entrepreneurship has made plausible and successful the challenge to the hospital hegemony over surgery. The Emerging Surgical Facility (''ESF''), which may include ambulatory surgery services, among others, and which may permit overnight or short-stays, i.e., postsurgical recovery care, has become the site of millions of safe and effective U.S. surgeries. The question is then raised whether, in those national health systems where scepticism regarding control over the intoduction of new private health care

delivery sites, the ESFs can take hold and survive. This session will allow participants to consider whether and how new surgical facility consepts can be championed in their own countries, whether in their respective surgical practices, their hospitals, their communities or their health systems. Analysis will be prevented comparing potential impacts between the U.S. and selected national health systems of EFSs.

**P41c**

**The marginalization of the availability and delivery of healthcare specific to the reproductive health needs of an inner city population; The role of the free standing ambulatory surgery center**

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The number of women requesting reproductive health services in New York City account for 10% of the national figure. Forty percent of the women requesting reproductive health services in New York City reside in the borough of Brooklyn. The demise, through merger and acquisition, of the community-based hospitals in the borough of Brooklyn has had a significant impact on the availability of reproductive health services. An examination of the availability of services in the borough and the accessibility of these services are examined through existing empirical and analytical data as well as survey, interview and observation. The evolution of services is traced through public policy and the political environment in an attempt to identify the current status of need versus services. Recommendations for future policy implementation is identified and explored through a practical operational perspective. Specific methodologies surrounding privatization of municipal programs, the formation of a coalition of providers and development of political coalitions is identified as a mechanism to address the issue of adequate access to care. These specific mechanisms for the development of the availability and delivery of healthcare can be utilized as a model and successful methodology in the ambulatory environment.

**P42c**

**Diversifying the procedures profile of the ambulatory surgery center with short-stay capability: Controversy or Expectation?**

Arthur E. Casey[a], Joni M. Steinman[b]

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[b]*Managing Principal, AUSMS Helathcare Consultants, Post Office Box 16948, San Diego 92176, CA, USA*

The presenters will review the shift of more complex types of surgical procedures to ambulatory surgery centers (''ASC'') from the early 1990s to 2000, with a specific focus on total joint replacements. The presentation will derive its database from both an outcomes analysis and an economic analysis, comparing a traditional inpatient setting with an ASC/short-stay setting. Discussion will cover key factors that must exist at the ASC in order to perform these complex surgeries including surgeon experience, or expertise and recovery staff capabilities. Appropriate patient selection and general recovery period will be examined.
CONCLUSION: Advances in anesthesia, surgical technique, pre- and post-operative evaluation and therapies and pain control methods make it possible to safely perform a new cohort of surgical procedures in an ASC setting with short-stay capability, with concamitant economic savings to the patient and his payor.

**P43c**

**Impact of Managed Care on the Ambulatory Surgery Center ("ASC")**

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The presenters will evaluate recent trends in managed care policy as implemented by private and public health plans and insurers on freestanding ambulatory surgery/short-stay centers. Since managed care precepts are being 'exported' to nations worldwide, including those with publically-financed health care delivery systems, this presentation is aimed at discussing how a continuum of surgical services can be created by bringing private-sector surgery providers into more direct collaboration with public-sector officials and managers. An analysis of the 'pros and cons' of managed care on both outcomes and quality of care in a traditional inpatient environment and an ASC/short-stay setting will be reviewed. Issues pertaining to the efficient use of resources when managed care policies are prevalent, whether in the private or public sectors, together with issues related to access to alternative surgery sites will be examined.

**P44c**

**Additional care for cancer patients**

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The aim of the project is to give cancer patients additional coaching and support by a form of care additional to hospital care. The care consists of a massage that is administered by hapto-therapists.
APPROACH: Making inventories of information, interest and motivation of the staff, introducing care in a phased plan.
WARD PROCEDURE: Before the patient is admitted to the ward for chemical therapy he/she is presented a leaflet on additional care during the interview. During the first therapy session the nurse will inquire after the patient's interest in the additional care, and if so, an appointment with the therapist is made. The care is always initiated in the hospital.
RESULTS: After half a year an evaluation was made by surveying and interviewing patients, nursing staff and doctors. Its findings were very positive. In December 2000 scientific research was completed in which a comparison was made with a similar class of patients in another two hospitals. In one of the hospitals no extra care was administered, in another extra care was given by a beautician. The findings were that massage diminishes the complaints during chemical therapy more than in the other hospitals.
CONCLUSION: The additional care provides a positive influence on the quality of life. By massaging/touching the patients are coached through their disease, it provides relaxation creating physical and mental well being enabling the patient to better cope with the side effects of chemical therapy. The interventions are, massage; relaxation; visualization and breathing exercises and hapto-therapeutical physical touch.

**P45c**

**Day surgery in the medical centre Alkmaar information about the last 5 years**

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*Medical Centre Alkmaar, the Netherlands*

The Medical Centre Alkmaar is a large regional hospital in the north–west of the Netherlands. The day hospital consists of a ward

with 37 beds and four operating theatres including their own recovery room. On a yearly basis there are 8500 patients treated. The Paster presentation will contain information in relation to,

- development;
- organization;
- nursing.

**P46c**
**Patient morbidity following oral day surgery-use of a nurse-led post-operative telephone questionnaire**

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INTRODUCTION: Patient morbidity following oral day case surgery is variable, but patients are known to experience sometimes quite severe post-operative pain, swelling and impaired oral function. Often these significant sequel of surgery have resolved by the time patients attend for clinical review.
METHOD: In this study 60 consecutive patients attending for oral surgery under day case anaesthesia were telephoned 24 h post-surgery by the day case nurse coordinating their ambulatory care on the day of surgery.
Using a standard questionnaire, ten specific questions were asked relating to the patients' general well-being, post-operative pain experience, effectiveness of discharge medication and the occurrence of complications.
In this manner it was hoped to characterize the nature and severity of problems encountered, from the patients' perspective, during their first 24 h post-surgery.
RESULTS AND CONCLUSIONS: The detailed results of the 60 patient questionnaire will be summarized, together with the number and severity of commonly reported complications.
The suggestions for the future expanded role of nurse-led telephone consultations within ambulatory care packages will be discussed.

**P47c**
**EUS guided cytoponction**

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The endoscopes ultrasonography (EUS) is a technique of recent diffusion (since 1990). Two types of instruments have been developed, one is using a mechanical rotating probe, the other is using a linear probe. The linear EUS permits the realization of guided cytoponction (fine needle aspiration FNA).
The indications of EUS FNA are mainly represented by the positive diagnosis of a solid or cystic pancreatic or mediastinal tumors and the lymph probe staging, in order to adapt the medical or surgical treatment.
The examination requires preferably general anaesthesia (upper way) in order to improve the tolerance and the efficacy, but may be performed ambulatory. Rectal procedure is undergone without sedation.The fluid collected is spread on slides for pathological interpretation. Complications are few, mild acute pancreatitis (in 5% cases). No dissemination along the ponction site has been reported.
EUS FNA represents a major tool for improving tumor diagnosis or staging and, therefore, to tend to select patients for the optimal treatment.

**P48c**
**Recidivated thyroid neoplasia with Hurthle cells — case report**

M Pavkov, M Cornian, R Lighezan, N Tudose

*Timisoara*

Thyroid neoplasia with Hurthle cells represents a rare form of thyroid neoplasia and is characterized by a particular biological behavior. The cells of the tumor are of Hurthle type in a percent that lies over 50%.
We present the case of a female patient, age 58, having oncotic adenoma that recidivated 4 years after undergoing bilateral subtotal thyroidectomy. The surgical procedure consisted of ambulatory tumor ablation followed by multiple morpho-pathological examinations, hematoxiline-eosine; van Gieson; AgNor coloration; immunoreaction for thyreoglobulin LSAB; electronic microscopy.
Surgical treatment represents the main therapeutic measure and it has to be performed in accordance with oncologic principles, lobectomy in benign forms; total thyroidectomy in malign forms; excision in healthy tissue in recidivations. The main malignancy criteria consists of angioinvasivity and of capsular invasion. The malign potential is higher than in other differentiated thyroid carcinoma.

**P49c**
**Ambulantes Praxisoperationskonzept in Winterthur 1998/1999**

B Grob

*Winterthur*

Wir stellen das ambulante Potential der Region Winterthur mit Ca. 250 000 Einwohner vor, und zeigen auf, was und in welcher Grössenordnung von 15 ambulanten Praxisoperationssälen bearbeitet werden kann. Wir zeigen ein neues Prinzip einer mobilen Anästhesie-Equipe, und auch den hohen Qualitätsstandard, der eingehalten werden kann.