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Abstracts

Intravenous regional anaesthesia: evaluation of four different additives to lidocaine

L Muño, C Gomez, JP Ortega, C Pardillos, S Rasal, A Bueno, A Urieta

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Introduction: Intravenous regional anaesthesia is a simple technique that may be useful in patients scheduled to undergo ambulatory hand and forearm surgery. The aim of this study was to evaluate differences in onset of the block and analgesia after releasing the tourniquet between an opioid, nonsteroidal anti-inflammatory drugs and another local anaesthetic. *Patients and Methods*: One hundred and twenty patients (ASA I or II) scheduled for forearm surgery were randomly assigned to one of the four following groups: group I, 30 ml lidocaine 0.75% + 5 ml saline; group II, 30 ml lidocaine 0.75% + 5 ml bupivacaine 0.25%; group III, 30 ml lidocaine 0.75% + ketorolac 30 mg + 4 ml saline; group IV, 30 ml lidocaine 0.75% + fentanyl 100 μg + 3 ml saline. After application of routine monitoring, a double tourniquet was positioned on the upper operative arm. Onset was determined by the appearance of paresthesias, while the sensory block was evaluated by the disappearance of temperature sensation. Furthermore, the time to complete motor blockade of the fingers was assessed. After releasing the tourniquet, the reappearance of muscle activity and temperature sensation as well as the appearance of spontaneous pain were assessed. *Results*: There were no differences among groups in demographic variables, distribution of surgical procedures, length of surgery, or tourniquet times. After releasing the tourniquet, the occurrence of spontaneous pain was slowest in the ketorolac group (group III) and faster in group IV. There were no significant differences between groups in other clinical variables. *Conclusion*: The addition of 30 mg ketorolac to local anaesthetic resulted in a significant longer pain-free period after releasing the tourniquet. The addition of an opioid to local anaesthetic did not provide a faster onset of the block or a longer pain-free period after releasing the tourniquet.

Outpatient oftalmological surgery at the Hospital General de Baza between 1995 and 1997

JL García Serrano, EJ Martín Ruiz, T Mylonopoulos, L Bustamante, MD Lara, A Alarcón

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The good results of outpatient surgery have had an important impact on our service. We conducted the following descriptive study of 684 operations of outpatient surgery carried out at the Unit of Ophthalmology from April 1995 to May 1997. Of all our operations, 73.27% were done on an outpatient basis in 1995, 91.35% in 1996 and 94.51% in 1997. Of the operations, 96.78% were carried out under local anaesthesia and the remaining 3.22% under general anaesthesia. The mean length of stay was 0.19 days. One out of 10 patients remained in hospital because of complications or social reasons, the length of stay in this group being 2.0 days. Today, in our service, outpatient surgery represents 94% of operations; mainly under local anaesthesia, the cataract being the dominant surgery, of which 9.2% do not leave the hospital on the day of surgery. For this, the global length of hospital stay of our patients is less than 1 day.

Laringeal microsurgery as an outpatient procedure

V Tortosa, T Pérez, V Gisbert, C Díaz, MªD Sánchez-Alcón, T Seijas

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We believe that ambulatory anaesthesiology in endolaryngeal microsurgery is a sure technique when correctly performed. We studied 61 patients operated on at our hospital with this technique, excluding big tumours in which we anticipated respiratory problems. No problem was found and only 3% were hospitalised for problems in extubation. No patient was readmitted to hospital in the following days because of problems.

First year experience in a day surgery unit in a medical care centre under public ownership

A Jiménez, C García-Algora, JM Remartínez, C Murillo, JM Abenia, J Cuartero, M González

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The practice of ambulatory surgery means a substantial change in the attitude of surgeons. This change means its implementation in many countries has not been easy. Between September 1995 and June 1996, 620 consecutive patients (35% women) of median age 47 years were treated with major ambulatory surgery procedures. The distribution for the different specialities was: general surgery, 45.2%; orthopaedic surgery, 21.6%; urology, 16.4%; otorhinolaryngology, 8.9%; ophthalmology, 4.4%; and vascular surgery, 3.5%. Data were stored on a personal computer and analysed with the Stat View 4.4 program. Most operations were performed for: hernia, 148 cases; removal of metal, 55 cases; subcutaneous tumour, 45 cases; laryngeal lesion, 39 cases; pilonidal disease, 36 cases; hydrocoele, 36 cases; cataract, 27 cases; varicose vein, 22 cases; and arthroscopy, 19 cases. With a mean surgical time of 40 min, the most common procedures were: hernioplasty, 91 cases; herniorrhaphy, 76 cases; excision of tumours, 71 cases; surgical metal extraction, 54 cases; hydrocoele repair, 40 cases; laryngeal microsurgery, 39 cases. Local anaesthesia was done in

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37.5% of patients, spinal in 30%, general in 18.5%, retrobulbar in 4.5%, epidural in 4% and others in 5.5%. Hospital admission was necessary in 5% of patients and readmission in 1.4%. Twelve percent of patients developed some minor complications: urinary retention, 17 cases; wound infection, 11 cases; vomiting, 11 cases; and inadequate pain control, 8 cases. The satisfactory results show that the Day Surgery Unit provides a high quality treatment despite little experience.

Design and structure of ambulatory surgical units

C Sánchez-Cabezudo Díaz-Guerra, JL Porrero Carro

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The arrival of ambulatory surgery to the National Health System constitutes a new way of surgical attention, in which the main beneficiary is the user, and requires the organisation of spaces and the creation of new areas of care. The objectives of this modality of surgical care are to improve the diagnostic and therapeutic processes as well as to reduce the cost. For creating an Ambulatory Surgical Unit, we have to make exhaustive and good planning, analysing the following: the population around and its request, the need of staff and instruments, and the architectural structure we are going to build. Also, we have to design the different areas of the unit, their physical characteristics and functions: Consultation Area, Reception Room, Waiting Room, Wardrobe Room, Pre-anaesthetic Area, Surgical Area, Post-anaesthetic Recuperation I Area, Post-anaesthetic Recuperation II Area.

Considerations over the off-work period after inguinal herniorraphy

A Martín Duce, F Arrieta, E Tobaruela, JM Mugüerza, R Villeta, M Diez, A Gutierrez, F Noguerales, J Granell

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The time of work cessation after an inguinal herniorraphy does not have any influence in the failure rate of a given technique. In the decision of returning to work, several clinical factors have been traditionally considered, such as the type of hernia or the degree of physical activity required by the job. Nowadays, it is considered that a period between 2 and 4 weeks off work is adequate for most patients. With the purpose of evaluating the opinions concerning this matter, we have conducted a nationwide audit with 187 participating surgeons and 201 general practitioners. Both groups conclude that a 4-week off-work period is adequate in an ideal patient. Nevertheless, the physical degree of laboural activity, the presence of bilateral hernia, the use of a prosthetic mesh, and the will of the patient in reducing this period have influence in the advice of more than 50% of the physicians of both groups. As none of the factors quoted have influence on the failure rate of a herniorraphy, the authors suggest that more thorough information could be useful for both surgeons and general practitioners.

Ambulatory surgery of PTFE (gore-tex) vascular prosthesis for hemodialisys

D Pacheco, JR Polo, R Vázquez, J Sanabia, JA Rueda, José A Alcazar

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In order to analyse the results obtained in prosthetic vascular access for dialysis, performed in an ambulatory surgical setting, all the operations done between January 1992 and April 1995 were retrospectively revised. Two hundred and seventy-six prosthetic vascular accesses with polytetrafluoroethylene grafts were performed. Two hundred and forty-six out of the 276 operations were done as outpatient cases, so that the substitution index was 89%. The kinds of accesses were as follows: 184 (74.8%) upper arm grafts; 28 (11.3%) loop forearm grafts; 27 (10.9%) straight forearm grafts; 7 (2.8%) brachiojugular grafts; and 1 (0.4%) femoro-femoral graft. All operations were performed under local anaesthesia without pharmacological pre-medication. There were no postoperative deaths. Early complications were as follows: postoperative bleeding controlled spontaneously with local pressure, 2 (0.8%); early peri-prosthetic infection, 2 (0.8%); early thrombosis successfully treated with rescue surgery within the first 48 h, also in an ambulatory setting, 3 (1.2%). Three patients needed hospital admission (1.2%), one due to threatening arrhythmia and two because of severe hyperglycaemia and ketoacidosis in diabetic patients. There was no increase in morbidity when the patients travelled for long distances from the hospital to their home immediately after the operation. After considering these results, we can state that prosthetic vascular access can be performed in all patients under local anaesthesia and in an ambulatory surgical setting without an increase in morbidity.

Indications of long-term central venous catheter. A 290-case experience

AT Calderón Duque, S Alonso Lera, JL Gómez Muñoz, L Rabadán, J Alvarez Fernández-Represa

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Introduction: We assessed the outcome of long-term central venous catheters used in cancer patients from October 1988 to June 95. *Patients and Methods*: Two hundred and ninety catheters were inserted in 275 cancer patients. In 178 cases, a reservoir was also implanted. In this series, 161 patients were males and 114 females with age ranging between 18 and 84 years. The most frequently used approach was percutaneous puncture of the left subclavian vein. *Results*: The mean operative time was 43 min for catheter with reservoir vs. 34 min for Hickman® catheters. The overall morbidity rate was 9.7%, with 7.3% for the catheter with reservoir group and 13.9% for the Hickman® group. *Conclusions*: Long-term central venous catheters with reservoir were associated with a lower morbidity compared with Hickman® catheters. On the other hand, catheters without reservoir allow the administration of larger volumes of fluids and highly concentrated substances especially, if it remains in place less than 6 months.

Gynaecological outpatient unit. Our experience

P Deulofeu, LL Casanova, A Avecilla, P Sánchez, J Codina, L Díaz, C Utrera

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After our first year of satisfactory experience in this kind of surgery, we have been following the same orientation for 2.5 years. We have extended the indications, increased our surgical activity, starting a program of 'afternoon surgery', reduced hospitalisation and avoided waiting lists.