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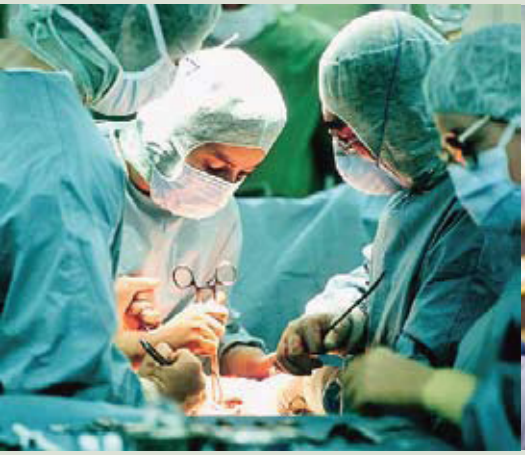


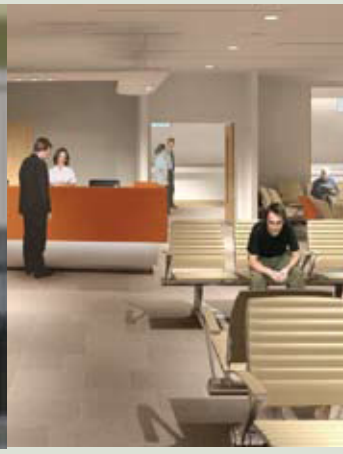

Free Abstracts

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Editorial

Mark Skues, Editor-in-Chief

AFCA / IAAS European Congress of Ambulatory Surgery

The European Congress of Ambulatory Surgery, organized jointly by the Association Française de Chirurgie Ambulatoire and the International Association for Ambulatory Surgery took place on the 28th and 29th January, 2016 at the Hôtel New-York, Marne-la-Vallée, Paris. Thanks are due to the International Organising Committee, the Scientific Committee and the Local Organising Committee of the AFCA for providing an extremely stimulating and interesting meeting demonstrating what is 'state of the art' for Ambulatory Surgery in 2016. Professor Corrinne Vons, as current President of the AFCA, deserves special mention for her seamless diplomacy and good humour in the organization of the meeting.

This edition of the Journal contains the free abstract submissions of international authors who convened from around the world to offer both oral and poster presentations at the Congress, copies of which are included here. Those abstracts that were submitted in French have been translated into English, and are included with a * denoting translation.

Happy reading.

Prospective Evaluation of the Outpatient Care of Appendectomy for Uncomplicated Acute Appendicitis*

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Introduction: Acute appendicitis (AA) is a common surgical emergency, causing few postoperative complications and mainly affecting young adults, making it a potential indication for ambulatory surgery especially in an uncomplicated form (AANC). The aim of this study was to evaluate the feasibility of appendectomy for 12 hour AANC. This was a prospective, single-center cohort of descriptive, non-randomized (NCT01839435). Major patients with AANC were included. Exclusion criteria were pre-operative contraindications (CI) for ambulatory care, organizational CI, admission times (Midnight to 06.00hrs), patient refusal, intraoperative (other diagnosis or complications). The CJP was the success rate of the treatment as outpatients (> 12 ITT / AANC) and per protocol (/ absence of CI in ambulatory). We also studied the rate of consultations, hospitalizations, unscheduled interventions, St Antoine score (prediction of the success of ambulatory care) and the influence of the patient's arrival time (Midnight to 12.00hr vs 12.00hr to Midnight) on the rate of ambulatory success.

Results: From May 2013 to August 2015, 213 patients (mean age 29 years, mean BMI = 23.5 kg/m^2) were included in the study, of whom 42% (n = 90) had no pre-operative CI and 35% (n = 74) had neither pre or intraoperative CI. The ambulatory success rate was 31% (n = 67/213) ITT and 90% (n = 67/74) per protocol. The rate of unscheduled consultations was 12% (n = 8/67), the rate of unplanned hospitalization was 4% (n = 3/67) and the rate of unplanned interventions was 4% (n = 3/67). The rate of ambulatory success was 14% (n = 10/74) and 40% (n = 57/141) in patients arrived between midnight and 12.00hr vs those who arrived between 12h and 0h. Patients with the 5 criteria of scoring St Antoine had a probability of success of outpatient care by 39%. The management of the outpatient AANC is feasible in 35% of cases. You have to offer outpatient consultants ER patients between 12 and 0h.

Optimization of Perioperative Care for Ambulatory Optimization for Left Hemicolectomy*

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Introduction: Ambulatory left hemicolectomy was recently described in ASA 1 and 2 patients. We conducted a prospective study to determine whether an optimized management protocol could afford proposal of such a procedure to a broader patient population.

Material and Methods: Between December 2014 and August 2015, all eligible patients (isolated colonic lesion located on the sigmoid or rectum douglassien supra; moderate comorbidity and / or controlled; lack of social isolation) were included in this study prospectively and consecutively. All patients received the same care protocol. After discharge, patients were followed by a liberal FDI (morning and evening from D1 to D3 and D4 to D10 daily) and were reviewed by the surgeon at Day10 and Day21 or earlier if necessary.

Results: Twenty-nine patients (17 men, 12 women) were included in this study (ASA3, 6 ASA2, 18, ASA1, 5). Six were operated on for cancer and twenty three diverticulitis. Six patients had associated surgery. All patients except one were able to return home the same evening. The mean pain score (ENS) at the output was 1.4 (range 0–3). The average ENS between 0 and 3 was 2.8 (extremes: 1 to 4.4). One patient was seen before 10 days for abdominal pain but examination was normal. None of the patients were re-hospitalized. Simple postoperative were confirmed to Day 10 and Day 21.

Conclusion: Our study confirms the feasibility of a left hemicolectomy for outpatient most fragile patients and / or more complex gestures. Communication between all parties involved and the downstream circuit can guarantee quality and safety.

Ambulatory Surgery Postgraduate Teaching-Training Program in Spain

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Introduction: Ambulatory Surgery training model are based in practice core competency. Clinical competences as knowledges, abilities, and attitudes are necessaries for the health professional activity. Postgraduate ambulatory surgery teaching-training objectives include development of care clinical skills as surgical techniques, anesthesia and analgesia types, postoperative controls and acquaintance of structural and organizational day-surgery characteristics, for instance, waiting list management, selection and inclusion criteria, discharge criteria, and evaluation results.

Material and Methods: Resident presence in our ambulatory surgery unit was stablished in second year of his specialization program. Residents spent in the ambulatory surgery unit a 6 months period. No more than 4 residents per year were admitted. 3 competences were selected to evaluate the medium resident activity, knowledge defined as to be able and to know, abilities defined as to do, and attitudes defined as to be, to be stay, to be when, how to do it? We summarized 3 concepts to obtain the total result, KNOWLEDGES (30%) including Department clinical sessions assistance or presentation, Courses, National scientific meetings, Scientifics papers, ATTITUDES (20%) as Diary presence, Availability, Work team, Relationship with patients-families, and ABILITIES 50% including Consultations under supervision and surgical activity.

Results: 48 Surgery residents were involved in 54.080 ambulatory surgery procedures to 1996 until 2012. Knowledge 28.5% over 30% (learning 5%, teaching 23.5%), Attitudes 19% over 20%, Abilities: 50% were the global results in our unit.

Conclusions: Residents included in our teaching and training model acquire adequate formation to develop their professional activity in day-case surgery programs.

Why are Surgeries Postponed and Cancelled? A New Outpatient Surgery Unit

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Introduction: Will the eligibility criteria be achieved in all proposed outpatient surgery patients? We wanted to know the rate and understand the reasons for postponement and exclusion of patients for outpatient surgery in an outpatient unit, establishing strategies for their reduction.

Material and Methods: Anesthesia preoperative evaluation was made in all patients through medical appointments. This was a descriptive, prospective study with sample – computer records of anesthesia appointments from July 2012 to June 2013. We analyzed the relationship between patients unfit for outpatient surgery and proposed for appointment, with a survey of the reasons and associated diseases. The "unfit" were divided: "provisional" – date of the surgery maintained, assessment dependent on exam results; "postponed" – date of surgery rescheduled for diseases under study/acute medical conditions; "excluded" – with exclusion criteria.

Results: Of the 3129 patients undergoing surgery, 2129 were evaluated through anestesia appointments. Of these, 10.3% were considered "unfit": 50.6% "provisional", 22.6% "postponed" and 26.8% "excluded." The "excluded" accounted for 2.8%. The orthopedics, general surgery and urology are the specialties with the highest rate of patients "unfit" (15%, 14.4% and 9.3%). Most associated diseases: cardiovascular; overweight/obesity.

Conclusion: Identification of the factors that decrease efficiency and quality leads to improvement strategies and increased patient satisfaction. The rate of "unfit" and "excluded" are low compared to other realities. The main reason that justified the "provisional" was the absence of medical exams. The application of the protocols and directed study of diseases in surgical pre operative appointment will reduce it. Acute respiratory infections were the main reason of "postponed". The unpredictability of these situations makes it difficult to improve results. The 1–2 weeks anesthesia appointments advance seems reasonable to reduce patients' postponed "and / or " excluded ". Communication between surgical services and anesthesiology must be optimized and all must be rigorous in applying the eligibility criteria. With this the "provisional" will decrease even more.

Efficacy and Safety of Sublingual Sufentanil for the Management of Acute Pain Following Ambulatory Surgery

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Introduction: Ambulatory surgery, coming to and leaving the hospital on the same day as surgery, is increasingly being adopted. Early discharge demands a rapid recovery and low incidence and intensity of surgery-related side effects, so there remains a clinical need for rapid-acting, potent analgesics that offer predictable offset and good tolerability. A sufentanil sublingual 30mcg tablet (ST), dispensed using a single-dose applicator, is in phase 3 development for treatment of moderate-to-severe acute pain and could offer potential analgesic advantages in ambulatory surgery or other venues requiring non-invasive, acute pain management.

Materials and Methods: The primary objective of this study was to demonstrate the efficacy, safety and tolerability of ST compared to placebo (PT) for the management of acute pain as determined by the time-weighted sum of pain intensity differences to baseline over the 12-hour study period (SPID12). Key secondary endpoints included SPID over the first hour of the study, total pain relief and proportion of patients rating the method of pain management as good or excellent. Safety assessments included adverse events (AEs), vital signs, oxygen saturation and the use of concomitant medications.

Results: A total of 161 (107 ST and 54 PT) patients were randomized and received study drug. Statistically significant SPID12 differences were observed in favor of ST over PT (25.8 vs.13.1; p>0.001), demonstrating superiority for management of acute post- operative pain. AEs in general were mild to moderate in severity with the type and frequency observed, typical of opioids in a post-operative setting. Nausea (29% vs 22%), headache (12% vs 11%) and vomiting (6% vs 2%) were the most common treatment-related AEs for the ST and PT treatment arms, respectively.

Conclusions: Efficacy and tolerability results from this study suggest that sufentanil 30mcg tablets dispensed sublingually via single-dose applicator may offer a viable alternative to IM or IV dosing in an ambulatory surgery population.

Is it Possible Avoiding Rebound Pain After Regional Analgesia? Case Series of Continuous Ambulatory Femoral or Interscalenic Catheter Under Ultrasound Guidance in Developing Country: Institutional Experience in an ASC, Salud SURA. Medellin, Colombia

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Introduction: Continuous analgesia has been shown to improve postoperative functional recuperation after shoulder and knee surgeries. Rebound pain is the main reason for postoperative emergency visits and unplanned admission. A multimodal analgesia based on a regional catheter, offers multiple benefits for patients in ambulatory setting: pain management, opioids sparing technique, with increase patient comfort and improving postoperative outcomes.

Materials and Methods: After institutional review board approval, 52 patients older than 18 years with physical status classification of I to II according of ASA score, scheduled for elective arthroscopic shoulder or knee surgery were included. All patients received standardized anesthesia with preoperative ultrasound-guided interscalenic or femoral block with non-stimulating multiorifice catheter, placement for postoperative analgesia under direct ultrasonographic guidance, an elastomeric pump was used for 50 hours. Multimodal postoperative analgesia regimen included oral NSAIDs and acetaminophen for 5 to 7 days, follow up was done PO day 1, PO day 2, 1 week, 6 months and 1 year after procedures.

Results: The mean operative time was 189 minutes. In the recovery room the VAS was under 3/10, only 4 patients required additional analgesic at home. Any patient had nausea and vomiting. All patients reported high levels of satisfaction with their postoperative regimen of analgesia, without neurologic of infective complication

Conclusions: Routine continuous analgesia for shoulder or knee arthroscopies surgeries, in multimodal treatment could be an effective strategy, reducing rebound postoperative pain and opioid use, avoiding side effects such as nausea and vomiting. Majority of trials reviewed suggest early pain control with single shot, lasting 8 hours for static and maximal 6 hours for dynamic pain. We are really concerned about rebound and chronic pain, by functional consequences, our main strategy for prevention is a continuous regional analgesia ultrasound guided, because in Salud SURA, priority is a centered patient care, with emphasis in multimodal analgesia standardized protocols, with higher patient satisfaction.

Outpatient Surgery (OPS) for Pelvic Organ Prolapse (POP): Preliminary Results of PCAP Study

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Introduction: OPS rate for POP is 4,4% in France (ATIH 2014). Mean length of stay is 4 days. Some publications have shown that OPS is feasible without additional morbidity and with high patient satisfaction rate.

Material and methods: Open prospective study PCAP with ethical approval from CPP SudMed IV N° 2014- A01939-38 Number of patients scheduled: 156 from March 2015 to September 2016. All patients operated for POP were asked to participate. They were divided in two groups: Group 1: eligible for OPS, Group 2 : non eligible. A specific anesthesia /analgesia protocol was designed for the study. Main objective: success rate of OPS for POP Secondary objectives: factors of failure, overall OPS rate, complication rate, patient satisfaction rate, anatomical success. Results at baseline, day after surgery and 1 month are reported here Results at 6 months, 1 and 2 year are not available.

Results: 96/97 patients were included in the study from 17/03/2015 to 28/10/2015 1 patient declined participation. Group 1 : 64/96 (66,7%) were eligible to OPS. The success rate for OPS was 78,1%(50/64). 14/64 patients stayed overnight: 8 urinary retention, 2 nausea-vomiting, 1 subcutaneous emphysema, 1 somnolence, 1 bleeding, 1 scheduling defect. 5/14 failure are considered as preventable There was no post-operative re-admission or emergency consultation in group 1. Patient satisfaction rate was 100% on next-day call and 96% at the 1 month visit. Group 2 : 32/96 (33,3%) were non eligible to OPS: refusal for OPS(3), additional surgery(2), residency > 1h(5), comorbidity(6), No accompanying person at home(16) Success rate of OPS for laparoscopic sacrocolpopexy is 86,7% and 75,5% for vaginal route. Success rate in case of hysterectomy is 75% and 70% in case of concomitant sling.

Conclusion: OPS success rate is 66,7% and overall OPS rate is 50,2%. 35,7 % of failure are considered as preventable. 57% of failure are related to voiding dysfunction in vaginal surgery. Laparoscopic sacrocolpopexy, hysterectomy or sub-urethral sling are not associated with higher failure rate. Patient satisfaction is high at 1 month follow up. As there is no additional morbidity in OPS group, the study is continued.

Day-case Laparoscopic Ventral Rectopexy to the Promontory in 50 Consecutive Patients

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Introduction: Both rectal prolapse and enterocele are indications for ventral laparoscopic rectopexy. Laparoscopic rectopexy offers short term advantages over the open abdominal approach including less abdominal discomfort, faster recovery, shorter hospital stay, and the quasi absence of a scar, as well as being as effective in terms of functional results and recurrence. The relatively minimal patient trauma and short operative duration make it feasible in an ambulatory setting for selected patients.

Material and methods: This is a retrospective study of consecutive patients with laparoscopic ventral rectopexy for full-thickness rectal prolapse or deep enterocele performed in an ambulatory setting in our hospital between November 2011 and March 2015. Patients were selected for day-case surgery on the basis of motivation, favourable social circumstances, and general fitness. Before the operation exteriorized rectal prolapse or deep enterocele was confirmed by dynamic video defecography, and rectosigmoidoscopy, anorectal manometry, endoanal ultrasound, and measurement of radiologic colon transit time tests were made. The laparoscopic anterior rectopexy to the promontory was performed as a day-case procedure with discharge the same day if possible, on a standard analgesia protocol. Patients were contacted by phone the following day.

Results: Fifty patients (48 women) had ambulatory laparoscopic ventral rectopexy. Apart from one case of intraoperative bleeding there were no intraoperative complications. There were 9 cases of immediate post-operative complications necessitating hospitalization of the patient and thus failure of day-case surgery. These complications were mainly due to the general anaesthesia. At one month, 7 patients complained of some kind of constipation or dyschezia. 48/50 patients (96%) were satisfied with ambulatory management, including 8/9 patients who experienced a complication.

Conclusion: We show that full-thickness rectal prolapse or symptomatic deep enterocele using laparoscopic ventral rectopexy and douglassectomy in a day-case surgical setting is effective and safe for patients meeting the social and medical criteria for ambulatory procedures.

Evaluation of a Patient Information Brochure on Postoperative Pain Management for Patients Undergoing Orthopedic Foot Surgery in a Day Surgery Unit

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The shift from hospitalization to day surgery leaves patients with a greater responsibility for postoperative pain management. Knowledge about the hospital's patient education strategies is needed to evaluate whether the patients are able to treat their postoperative pain as recommended. The purpose of this study was to investigate whether a patient information brochure developed by an interdisciplinary team on pain management, used along with verbal information contributed to:

1. Better adherence to the recommended pain management schedule
2. Improved patient satisfactions regarding the information provided
3. Lower pain intensity scores

This quality assurance study used a pre-post test design, and included patients >18 years old who had undergone orthopedic foot surgery in a day surgery unit. Data was collected through systematic telephone follow-up. Adherence to recommended pain management schedule was recorded in the categories: "followed recommendations," "took more than the recommendations," or "less than the recommendations". Patient satisfaction regarding the information provided was rated as dissatisfied, satisfied or very satisfied. Pain intensity was rated as none, low, medium or strong pain. Information brochures with advice on scheduling, dosing and combination of various drugs in relation to expected pain intensity became part of the standardized nursing information in November 2014. Pre-test (N=77) lasted prior to November 2014 and post-test (N=126) from November 2014 to May 2015. Results for adherence to recommended pain management indicated that more patients in the posttest group followed the recommended pain management schedule. Patients in the post-test group reported higher levels of satisfaction with the pre- and postoperative information. The difference in pain intensity between the groups was not significant. An information brochure on postoperative pain management contributed to better adherence to the recommended pain management schedule and higher degree of satisfaction related to information among patients in a day surgery unit. The patient information brochure is an important tool in the department's quality improvement efforts.

Day Surgery Unit Income and Re-admissions. Analysis in a hospital area of Cantabria, North of Spain

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Introduction: We conducted a study of income and readmissions of patients in a DSU (Day Surgery Unit). An internal audit of these quality indicators in the III–IV area of Cantabria, north of Spain, is used from 2013–2014.

Materials and Methods: The source of information employed was that of the Minimal Basic Hospital Admission Data Set. Re-admission has been defined as any admission within the 30 days following release from the hospital The study was conducted on a total of 6.296 patients operated by DSU at that time, 3290 in 2013 and 3006 in 2014. A descriptive analysis has been made with conventional single variable techniques.

Results: We analyzed our unplanned incomes after DSU. They have detected a total of 164 and 116 patients. The causes of income anesthetics reasons would be related to the presence of nausea, vomiting, postoperative pain, anesthetic blockade of the limb, abnormal urination and lack of retraining medium (once the cases of presence of bleeding or social reasons cleared). If we exclude patients admitted for an unspecified medical order, those improper selection as DSU was made or those where could not collect income information, anesthetic causes accounted for 49.4% of cases in 2013 and 32.8% in 2014. Surgical causes have led to 38.7% of income in 2013 and 51.5% in 2014. Income for medical reasons were predominantly patients who had suspended their anticoagulant medication for surgery and needed to restart it the next day, they accounted for 6.3% in 2013 and 5.5% in 2014. The other sources of income were negligible in 2013 and rose to 6.2% in 2014. In our study, the overnight rate was 4.3% in 2013 and 3.6% in 2014. General anesthesia has been provided in 56% of patients. Readmissions were detected in all 6 patients who need re-entry after undergoing ambulatory surgery (0.95%).

Conclusions: It should conduct an internal audit to the quality indicators such as income and readmissions of patients in a DSU. We are applying the initial and ongoing basis in the III–IV area of the Community of Cantabria. With the information obtained will identify the critical points for improvement and implement actions in the area of marketing and management.

Implementation of Outpatient Mastectomies: Evaluation of Care Pathways and Satisfaction Survey*

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After a feasibility study, we decided to offer ambulatory care to patients undergoing mastectomy.

Materials and methods: Evaluation was conducted from January to June 2015. All patients were offered ambulatory care before mastectomy. The course of treatment, in addition to the surgical consultation, included a nurse consultation announcement, a call the next day, a post-operative nurse consultation and a surgical consultation for the announcement of results. An evaluation questionnaire was aimed to analyze the postoperative symptoms and quality of care.

Results: 28.9% patients were programmed (35/121). The conversion rate was 11.4% (4/31). 68.5% had already had an outpatient surgery or chemotherapy day hospital. The average age is 53.7. At the exit: 61.3% had their scars. 54.8% were painful with EVA to 3.41. 93.5% had no apprehension. There was no rehospitalization. The nurse consultation was held on average at 3.9days. 22.5% patients were worried mainly from the modification of body image. This consultation enabled program support care consultations in 32% cases. The consultation with the surgeon was on average at 16.6 days. 41.9% patients were mainly anxious over pending the results were announced. The overall evaluation shows a good perioperative information (9.23) and a significant interest in the nursing consultation (9.13). The overall care was evaluated at 9.43. 100% would do it again in their outpatient mastectomy.

Conclusion: The management of mastectomies as outpatients appears to be reasonable. The rate of between 25% thresholds in the Anglo-Saxon teams . This support is better suited to patients who have had an outpatient course. Nursing peri operative consultations have a key role in the smooth. Discussion areas are better education to pain by introducing nurse education consultation before hospitalization.

Surgical Management of Outpatient Breast Cancer: The 4 Year Experience of a French Cancer Centre*

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Introduction: Breast conserving surgery is performed as an outpatient in 15% cases in the last report of the National Cancer Institute on the treatment of cancer in France. We report our experience of day surgery for breast cancer in a center of fight against cancer since 2011.

Material and Methods: We opened a dedicated structure for outpatient surgery in late 2011 with inpatient unit and operating room. A patient path has been set up: patient selection and preoperative ambulatory proposal to the consultation, call the day before by the secretariat, hospital day with scores output, call the following day by the Ambulatory Surgery Unit, consultation surgical postoperative day 15. Continuity of care is provided by a mobile number to a dedicated on-call doctor contacted at 24 hours and continuously available. Pre and postoperative instructions were specified in the ambulatory passport and phone numbers. A satisfaction survey was provided on discharge.

Results: We operated between October 2011 and May 2015 on 2173 patients for breast cancer as an outpatient. Subtotal mastectomies for cancer represented 57.5% of indications, breast reconstructions 25.3%, lumpectomy for benign disease 14.1%, total mastectomies for cancer 0.4%. The conversion rate was 4.7% (n = 102), in connection with a surgical origin (20.5%), medical (19.6%), a heavier gesture (21.5%), selection criterion not respected (14.7%), organizational issues (5.8%), and unknown nature (17.6%). The operative recovery rate is 0.3% (n = 8) essentially hematoma and the first year (n = 7). Satisfaction surveys report an average rating of 9.1 out of 10. The satisfaction sentinel-node lumpectomy rates ambulatory is 55.1% in 2015.

Conclusion: Our experience confirms that the support for conserving surgery outpatient breast cancer is feasible and well accepted by patients.

Consecutive Breast Cancer Patients Operated in Day Surgery: Quality and Safety Procedure in the French System Health Care

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Introduction: Breast cancer surgery is suitable for outpatient practice. Indeed, this is surgery with short operative time, rather painless, low complication rate and the majority of patients have little comorbidities. Objective was to evaluate the recognized success indicators in day-surgery: rate of conversion into conventional hospitalization, rate of complications and re-hospitalizations the month following surgery.

Material and method: Consecutive cases of breast cancer patients operated in day surgery were prospectively entered into the Institut Curie Day Surgery database between November 2012 and December 2013. Patient characteristics, tumour pathology, pre-operative procedures and type of surgery were collected on 396 consecutive patients. Statistical analysis was performed.

Results: 396 consecutive patients were included. The mean age was 54 years [25–84], 69% of them had a pre-operative tracking in radiology and 60% a preoperative radioisotope injection in nuclear medicine. Rate of conversion into conventional surgery was 9.8% 95% CI [6.9 to 12.7]. Rate of post-operative surgery complication was 3.7% 95% CI [1.8 to 5.6], rate of re-hospitalization in the month following surgery was 1.2% IC 95% [0.1 to 2.3]. Concerning surgery, we performed 208 tumorectomies with sentinel node (52,5%), 103 tumorectomies (26%), 218 sentinel lymph nodes (55%) and 41 axillary dissection (10%).

Conclusion: This study shows a low complication rate (3.7%) and re-hospitalizations within the month after the surgery (1.2%). However, the conversion rate is high (9.8%) and seems to be one of the areas of improvement to be considered. We found 62% of the conversions because of a drainage which could be avoided or could be maintained by anticipating the come back home with a drain.

Hemithyroidectomy: A Day Case Procedure in the UK?

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Introduction: A consensus of British Association of Endocrine and Thyroid Surgeons suggested the feasibility of thyroid surgery as a day case. It was however suggested that this should be balanced against the risks and careful selection of patients. The aims of our study were to support or oppose the consensus based on our experience of hemithyroidectomy as a day case procedure. Our intentions were to find the effects of age of patients, ASA grade and operating time on postoperative length of stay.

Material and Method: We collected retrospective data of patients who underwent hemithyroidectomy as a day case from Feb, 2013 to Feb, 2015. Operating time, postoperative length of stay, ASA grade and readmission were analyzed along with demographic data of patients. Correlation was determined between age of patients, operating time and length of stay. Correlation coefficient and scatter plot were obtained using SPSS.

Results: A total of 76 patients (67 Female and 9 Male) underwent hemithyroidectomy who were deemed fit for day surgery during that time. Mean age was 47.17 with 15.10 SD. Mean operating time was 62.93 minutes with 15.09 SD. Mean postoperative length of stay was 18.14 hours with 2.33 SD. Mean postoperative length of stay was slightly shorter in ASA 3, 17.25 hours, compared to 18.24 and 18.16 hours for ASA 1 and 2 respectively. There was no readmission for any complication. There was very weak negative correlation between operating time and length of stay with correlation coefficient of 0.092 and $p > 0.01$. When compared between age and postoperative length of stay, there was very weak positive correlation with correlation coefficient of 0.10 and $p > 0.01$.

Conclusion: Hemithyroidectomy can be safely performed as a day case. Age of the patient, ASA grade and operating time do not contribute towards length of hospital stay.

Reference: HE Doran, J England, F Palazzo Questionable safety of thyroid surgery with same day discharge. *Annals of the Royal College of Surgeons of England* 2012;94(8):543–7.

Why Build an Infrastructure Designed Specifically for Ambulatory Surgery?

Brian Oosterhoff

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Introduction: Although day surgery is fast becoming the new standard, most European countries continue building hospitals based on inpatient accommodation. In order for ambulatory surgery to be successful, we must rethink hospital design. Day surgery requires its own specifically built environment to make it as simple and safe as possible.

Material and Method: Throughout the continent is a vast variety in the number of hospital beds per capita that is inconsistent with most health quality indicators, as OECD data indicates. The European Observatory on Health Systems and Policies edited 10 key recommendations in making day surgery happen, pointing out the significance of a specific approach that differs from inpatient processes. Four of these recommendations are highlighted. The added values and cost-effectiveness of a freestanding facility are demonstrated by the data of a McKinsey survey. During this talk I will underline the relevance of the concept, illustrated with practical examples of our freestanding, compact facility. Yearly, we perform more than 3000 increasingly invasive surgical procedures in a wide range of specialties. Our unit has no beds. Upon admission, patients are prepared on a versatile operating table. This avoids time-consuming and unsafe patient transfers.

Results: An open-space design of the recovery room and the operating theater provides a safe and reassuring overview while preserving patient privacy. A freestanding design facilitates setting up specific clinical pathways maximizing the predictability of the outcomes. Conclusion: The Kodak story demonstrates how dangerous it can be for a business to resist innovation. Ambulatory surgery is about innovation of care, it's not about beds. If your hospital is saturated with beds, overwhelmed by numerous assignments and requires expansion, a study of local needs may well lead to the setting up of a freestanding center for your healthy surgical patients. These patients do not need a hospital bed and will be thankful to save time and money. Moreover, their general health will not be put at unnecessary risk.

Patients with Special Needs Requiring Day Case Dental Surgery: A Service Improvement Project

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Introduction: Adults with learning disabilities are a particularly vulnerable group. Areas of healthcare recently identified as requiring improvement include the provision of understandable information to this patient group and their inclusion in decisions about their care. To this end, a service improvement project was established. We identified three key parallel aims in our approach; to develop a care pathway for patients with learning disabilities requiring day case dental surgery, to design a leaflet providing information about the proposed admission, and to conduct a satisfaction questionnaire for completion by the attending carers.

Methods: The care pathway was designed to cover relevant aspects of the Mental Capacity Act 2005, the Best Interests process, and a locally developed strategy for the peri-operative management of adults with special needs requiring dental surgery. It also encouraged the inclusion of any other necessary medical procedures whilst the patient was anaesthetised. The information leaflet for carers included guidance on reducing patient anxiety prior to admission and discussion surrounding the possible anaesthetic induction techniques employed and the potential use of appropriate restraint. It also emphasised that conventional discharge criteria would be adapted where necessary and safe to allow discharge at the earliest opportunity. The satisfaction questionnaire was designed to capture the entire patient experience from referral to treatment and discharge. The questions included closed, ranking and free text formats to optimise feedback.

Results: We collected feedback from 12 sequential attending carers. All of those surveyed received information leaflets. With the exception of one case, this literature was rated favourably. The quality of the clinical care from admission to discharge was generally ranked very highly.

Conclusion: We can report that the service was very well received by the majority of the carers surveyed. The feedback has been helpful in extending the service to patients with special needs requiring anaesthesia for other scheduled operations and procedures.

The Effect of Lidocaine Infusion on Postoperative Intravenous Opioid Administration in Patients Undergoing Thyroidectomy In the Ambulatory Setting

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Background: Opioids are associated with respiratory depression, postoperative nausea and vomiting, and immune suppression. Adjuncts to treat pain, limit narcotic use, and fast-track the surgical process may serve as a suitable option to reduce the unwanted effects of opioids. Lidocaine, given as an infusion, may reduce the use of longer acting narcotics in the ambulatory setting. This study examines the effect of intraoperative lidocaine (Lido) infusion on intravenous opioid administration in the postoperative period in patients undergoing thyroidectomy in the ambulatory setting.

Methods: After obtaining IRB approval, a retrospective review was performed for 52 patients who had thyroid surgery under general anesthesia over 18 months. The data was extracted from our electronic medical record. Patients undergoing neck dissection were excluded. Patients were placed into two categories: those who received Lido as part of their anesthetic plan and those who did not (No Lido). All patients received a general anesthetic including fentanyl, acetaminophen and at least two prophylactic antiemetics intraoperatively. Patients were recovered in our PACU and 23 hours observation unit. Age and duration of surgery were evaluated by a t-test and categorical data were evaluated by Fisher's exact test. P-values >0.05 were considered statistically significant.

Results: Age, gender, Body Mass Index, ASA and surgery duration were similar for both groups. 17/22(77%) of the No Lido patients received postoperative fentanyl versus 22/30(71%) of the Lido group (p=0.608) and 5/22 (23%) of the No Lido group received hydromorphone as compared to 0/30 (0%) of the Lido group (p= 0.010).

Conclusions: Patients receiving Lido required less hydromorphone in the postoperative period in this study. Our practice consists of first treating pain with a short-acting opioid. Hydromorphone is used as a pain rescue when the short acting opioid is no longer effective in the PACU. Lidocaine may be a useful adjunct in reducing intravenous opioid administration in the postoperative period for patients undergoing thyroidectomy. Future studies are needed to explore this possible benefit.

Educational Visit Abroad as a Foundation for Organizing a Day Surgery Unit

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Starting a day surgery unit "from scratch" can be quite a challange. You can't rely on somebody you know, because nobody knows things you should know. So, after a lot of time spent trying to find the way, I turned to the British Association of Day Surgery and got all the help I needed. My journey started in Norwich, where I spent a week learning about organizing a day surgery unit in my country. The only organized day surgery unit in my country until then, was doing adult day surgery, and they didn't have enough information needed for organizing pediatric day surgery unit. After Norwich I visited Great Ormond Street Hospital in London, and also got a lot of information there. After returning to my country I was confident and satisfied I got enough ideas about what kind of project I should present to my superiors and management in my hospital. A couple of weeks later, IAAS held a workshop in my home town, which I attended, and after that I started to work intensively in making things happen. I had a great deal of problems. Nobody was interested in changing things, nobody wanted to follow any guidelines. I spend a lot of time talking to different kind of people, on different functions (including the Head of the Hospital) and my coworkers, I gave a lot of lectures on the subject and didn't succeed. I decided to change the Hospital and started to work in another Children's Hospital (in the same city) which was until then strictly pediatric hospital (they didn't have any surgery). The Head of the Hospital was very enthusiastic about the project and believed that we need to have pediatric surgery unit for our patients. That was 5 months ago. On October 19th we officially opened our Day Surgery Unit based on IAAS guidelines. The time spent abroad made a difference. We were able to get some idea and vision on how day surgery should be organized. The IAAS workshop also helped a lot. We would like our story to be an example on how International society helps, well established organizations can make a difference, and that despite a lot of problems on your hands- you can make it happen.

Exchange of Experiences between Day Surgery Units

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One of the most important things in life is the contact between people, especially between people with common goals. All over the world doctors, nurses and hospital managers are working to establish the best day surgery care for their patients. All are working in their own environment, with specific problems of their own patients and with their managing possibilities. All are working in their own local facilities. All have to work together with local practices of general practitioners and local home care. All have to work in their own facilities with specific administration, specific local practical possibilities. All have to work with colleagues in a team. Therefore teaching and training of surgeons, anaesthetists and nurses is an important issue to be dealt with. Lean thinking is increasingly applied to day surgery units : lean is focused on reducing waste, waste in time, waste in material, waste in efficacy and so on. Some units are believers and also far more advanced in using the lean principles. All these have nothing to do with surgical techniques or anaesthesiological practices in performing day surgery: the evolution of the techniques of both specialities we have seen during the last decades is so important that the principle of day care has become the number one issue in the Health Care Politics. And this is not only because of the certain economic gain. You must be a good and experienced surgeon to work in a day surgery unit; the same stands for the anaesthesiologist, the nurse and even the man or the woman who is responsible for the administrative part. Day Surgery is an organisational concept and needs people, specifically trained in this matter: you need specialists in surgery, in anaesthesiology, in nursing, in management but with a graduate in day care surgery. Continuous learning is important: to see how other people are doing the same thing. So we organised an exchange between nurses of day surgery centers. And that is where this presentation is about.

Use of Lean and Six Sigma Methodologies in the Day-Surgery Unit of a French Comprehensive Cancer Center, in Order to Improve the Process of Patient's Return to Home

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Introduction: As part of day surgery, patients should be a major player in their management, in particular to prepare discharge. A satisfaction study conducted by a Hospital showed the need to improve the process of patient's return to home. The objective of this study was to validate that Lean Six Sigma (LSS) methodology with the help of an external company was well adapted to solve this problem within a tight timeline.

Material and method: The Hospital led this project with the support of a LSS expert coming from a Medical Device(MD) company. A multidisciplinary team has been set. A process mapping has been performed (from Chung score completion to day-after call (DAC)). Then, to identify steps that generate the most patient dissatisfaction, a questionnaire has been developed and administered to patients. The top 5 issues have been identified and an action plan addressed for each road block.

Results: Project started on 18/06 and the action plan was kicked off by 30/07. Process mapping identified 28 steps. Survey included 24 patients' feedback. 5 prioritized topics: 1. signage 2. information/help of patient when they go by taxi 3. delay of patient's discharge validation by doctors 4. operative report explanation 5. DAC process if patient not reachable Actions implemented: signage improvement, new taxi booking process, new indicator of discharge validation delay, improvments of patient's information on operating report, modification of day-after call process including a call to a close relation if the patient cannot be reached after 2 trials.

Conclusion: Key success factors: involvement of management, multidisciplinary team, patient centric, data driven methodology, visual tools. LSS methodology and the support of an external expert demonstrated their efficacy in solving organizational concerns within a hospital in a short timeline. All the actions implemented aimed to improve the quality of the process and patient's flow. Positive qualitative feedbacks have already been collected. The satisfaction questionnaire will now periodically monitor satisfaction level as part of a continuous process.

Day Surgery Unit Income and Re-admissions. Analysis in a Hospital area of Cantabria, North of Spain

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Introduction: We conducted a study of income and readmissions of patients in a DSU (Day Surgery Unit). An internal audit of these quality indicators in the III–IV area of Cantabria, north of Spain, is used from 2013–2014.

Materials and Methods The source of information employed was that of the Minimal Basic Hospital Admission Data Set. Re-admission has been defined as any admission within the 30 days following release from the hospital The study was conducted on a total of 6.296 patients operated by DSU at that time, 3290 in 2013 and 3006 in 2014. A descriptive analysis has been made with conventional single variable techniques.

Results: We analyzed our unplanned incomes after DSU. They have detected a total of 164 and 116 patients. The causes of income anesthetics reasons would be related to the presence of nausea, vomiting, postoperative pain, anesthetic blockade of the limb, abnormal urination and lack of retraining medium (once the cases of presence of bleeding or social reasons cleared). If we exclude patients admitted for an unspecified medical order, those improper selection as DSU was made or those where could not collect income information, anesthetic causes accounted for 49.4% of cases in 2013 and 32.8% in 2014. Surgical causes have led to 38.7% of income in 2013 and 51.5% in 2014. Income for medical reasons were predominantly patients who had suspended their anticoagulant medication for surgery and needed to restart it the next day, they accounted for 6.3% in 2013 and 5.5% in 2014. The other sources of income were negligible in 2013 and rose to 6.2% in 2014. In our study, the overnight rate was 4.3% in 2013 and 3.6% in 2014. General anesthesia has been provided in 56% of patients. Readmissions were detected in all 6 patients who need re-entry after undergoing ambulatory surgery (0.95%).

Conclusions: It should conduct an internal audit to the quality indicators such as income and readmissions of patients in a DSU. We are applying the initial and ongoing basis in the III□IV area of the Community of Cantabria. With the information obtained will identify the critical points for improvement and implement actions in the area of marketing and management.

Together For Safety Assurance

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The "Together For Safety Assurance" project designed by nursing teams of the departments nursing consultation, outpatient surgery and recovery aims to involve the nursing team and patients who require outpatient surgery in the promotion of the safety assurance culture in a hospital environment.

Main Goals: Increasing the knowledge of the patients before surgery and on the surgery day. Understand for patient about the outpatient surgery way since the day of nursing consultation until preparing to be back home. Empowerment of the patient for the first step of the surgery safe checklist;

Methodology: Retrospective study of quantitative and qualitative methodology. The deadline for the development of the first stage will involve two months between November 2015 and January 2016.

Sample: All patients subjected to thyroid surgery, who should have had anesthesiology and nursing consultations before surgery and fulfils all requirements for outpatien surgery.

Activities: Apply a guide which contains all the relevant information to patients on safety procedures. The patient will know the patient way and all the recommendations for outpatient surgery before the surgeryand participate with their correct answers for the surgery checklist in the surgical operating room, they should know what happens in the clinical recovery, and how it is been prepared homecoming.

Evaluation: Nursing Consultation, Physical preparation and Safe Surgery Checklists, Knowledge for family of the patient's length of internment in recovery unit; Nursing Phone call Consultation after 30 days of surgery.

Main Data: All patients proposed had anestesiology and nursing consultation; 75% of patients fulfill the recommendations of preoperative physical preparation; 75% of patients had no doubts about the outpatient surgery way; 100% of patients participated in the safe surgery checklist; 75% of family indicated at least two significant factors on the time in recovery unit; all patients had the nursing team consultation by phone call 30 days after surgery.

Main Outcomes: Promotional movie disclosure of outpatient surgery; Nursing brochure; Patient's empowerment for the partnership care.

Ambulatory Thyroid Surgery with Prolonged Recovery: Safety and Outcome Evaluation

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Objective: The main barriers for short stay thyroidectomy are haemorrhage, bilateral recurrent laryngeal nerve palsy causing respiratory compromise and hypocalcaemia. The aim of this study is to clarify the principles for safe thyroid ambulatory surgery with prolonged recovery (> 24 hours) and evaluate outcome in one year period.

Patients and Methods: Retrospective analyses of medical records of 375 consecutive patients undergoing ambulatory thyroidectomy in an academic hospital, from October 2014 to October 2015. Patient inclusion criteria, operative and pathologic data, complications and readmission rates were reviewed.

Results: The operations performed were: 330 total thyroidectomies, 10 total thyroidectomies with modified neck dissection, 23 lobectomies, and 12 totalizations of thyroidectomy. Morbidity (8,3%) consisted of hematoma in 5, recurrent laryngeal nerve palsy in 3, and transient hypocalcemia in 13 patients. The mean nodule size, size of the thyroid gland and the rate of malignancy were not associated to higher morbility. Patients scheduled for ambulatory surgery were transferred to inpatient care in 2,7% of cases due to complications, and 2% due to delayed administrative discharge.

Conclusion: Current results demonstrate that thyroidectomy can be carried out safely and effectively as a 23 hour stay procedure.

Laparoscopic Cholecystectomy Without Overnight Stay: Is it Safe?

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Introduction: Laparoscopic cholecystectomy is the gold standard procedure for the treatment of lithiasic gallbladder pathology and acute cholecystitis. Whether or not it should be done as ambulatory surgery without overnight stay is still being discussed. The aim of this study is to evaluate the efficacy and safety of laparoscopic cholecystectomy in an outpatient basis with no overnight stay

Materials and Methods: Retrospective study of interventions performed between June 2009 and December 2014,in the Ambulatory Surgery Unit of our institution. Data regarding patient´s demography, peri and postoperative complications, surgical time, re-admission rates was collected.

Results: A total of 275 patients were subject to laparoscopic cholecystectomy in the ambulatory unit without overnight stay. Two patients had intra-operative complication, which needed conversion to laparotomy. The mean time for the procedure was 64 minutes. Same day admission was 7% and readmission was 0.36%(1 patient). There was no mortality

Discussion / Conclusions: Ambulatory laparoscopic cholecystectomy has low admission rates, postoperative complications or re-interventions which shows that it is a safe procedure when performed in ambulatory without overnight stay.

Impact of Anaesthetic Outcomes on Paediatric Day-Case Tonsillectomies

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We wished to identify potential anaesthetic reasons for unplanned admissions, possible areas to improve outcomes and to improve services.

Methods: A retrospective study of all case notes and discharge letters of paediatric day case tonsillectomies between august 2013 to august 2014. We collected data for prescribed analgesics (NSAIDs), anti-emetics, PONV scores, pain scores and the reasons for overnight stay.

Results: 28.9% patients stayed overnight. The reasons for the overnight stays were Pain (25%), vomiting (18.75%), overnight observation (18.75%), parental request (6.25%), fever (6.25%) and unknown (18.75%). 73.2% patients received anti-emetics and 86.25% patients received non-steroidal anti-inflammatory analgesics. Pain and PONV scores were recorded in 86.95%patients in recovery and were satisfactory. A few patients complained of pain and vomiting in the ward but did not receive any treatment.

Children's surgery should be performed as day case whenever possible. [1] Pain and vomiting were the leading reasons for the unplanned stay. SIGN guideline recommends routine use of dexamethasone and anti-emetics to prevent post-operative nausea and vomiting and NSAIDs are recommended as a part of analgesia to prevent PONV. [2] We suggested regular prescription of analgesics along with PRN prescription, prescription of more than one anti-emetics and use of NSAIDs when not contraindicated.

References:

Standards for children's surgery, Children's Surgical Forum 2013

Management of sore throat and indications for tonsillectomy. A national clinical guideline April 2010. SIGN - 2.4 post-operative care, SIGN 7.5.3 prevention of PONV.

D.I.E.S (Diabetes in Elective Surgery)

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Introduction: Diabetes is the epidemic of the 21st century and the biggest challenge confronting Australia's health system. People with diabetes have an increased risk of developing multi-organ dysfunction and infections. This rise will impact quality of care, surgical admission rates, patient safety, length of stay and cost implications. The Average Length of Stay (ALOS) for patients in our institution is 3.3 days compared to 5.8 days for patients with diabetes.

Methods: We engaged and communicated with the The Ambulatory Procedure Centre, Outpatient clinic, Endocrine team, Anaesthetists, Surgeons, Nurses, General Practitioners (GP's) and Allied Health. We designed and customised information brochures and guidelines to meet client needs. We planned optimisation of glycaemic control prior to surgery through identification of patients with HbA1c > 9%. We targeted the issue through GP flyers, posters, information brochures to patients and spot HbA1c checks in the pre-admission clinic. Patients with HbA1c > 9% would receive automatic referral to Diabetes centre and surgery delayed until glycaemic control improves. Where urgent elective surgery cannot be delayed, diabetes stabilisation would commence as soon as possible.

Results: For patients with diabetes we predict reduction in incidence of infections, hyperglycaemia and hypoglycaemia whilst in hospital, readmission to hospital after surgery, ALOS and increased patient satisfaction, optimal pre-surgery glycaemic control, improved budget and finances. Follow-up for outpatient diabetes stabilisation through the diabetes service is also arranged prior to discharge.

Conclusion: Understanding that the populations at high risk for diabetes require specific types of treatment and care. We hope our new implementation of pathways, signage, brochures, and new assessment tools will enable better outcomes for our patients with diabetes requiring elective surgery. Our vision with this project is to enhance the patient's experience and outcome. Through a multidisciplinary input we aim to implement a safe quality improvement project with positive results for our patients, staff and hospitals.

Who is Dissatisfied with Varicose Vein Ambulatory Surgery and Why?

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Introduction: The aim of this study is to evaluate overall satisfaction of patients scheduled for varicose vein ambulatory surgery and analyze clinical and demographic factors that might influence the final result.

Methods: A group of 292 patients submitted to vein surgery between December 2014 and October 2015 were retrospectively evaluated. Archived medical records were reviewed and telephone interview attempt of all patients was conducted. Patients were excluded from the study after 3 failed telephone attempts.

Results: A total of 253 from 292 (86.6%) patients were included in our retrospective study, with a female:male ratio of 2.4:1 and a mean age of 50.9 ± 11.1 years-old (mean ± SD). Ninety-five percent of the patients were symptomatic, 10.7% had active or healed venous ulcers. Almost half the patients were submitted to bilateral varicose vein surgery (44.3%). The majority was submitted to stripping of the great saphenous vein (67.6%). All patients had recommendation to use compression stockings and 59% maintained stocking treatment at the time of the interview. Thirty one patients went to emergency room in the first month, from whom 18 during the first week after surgery. Eighty seven percent of patients reported to be very satisfied or satisfied with medical care and surgery outcomes, 7.5% were not satisfied.

Conclusion: The majority of patients in this study are satisfied or very satisfied with their surgical outcome. Major factors related to dissatisfaction were female gender, cosmetic result and persistence of pain or edema attributable to discontinuation of the recommended use of compressive stockings.

Voiding Related Delays in Discharge: A Completed Audit

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Introduction: Voiding related delays in discharges occur frequently in day surgery patients and result in overnight stays, undue burden on staff, and frustrated patients. We conducted a retrospective study to identify such delays in the Milton Keynes hospital daysurgery unit and sought to improve this by introducing a safe voiding discharge protocol.

Objective: To identify whether our implemented discharge protocol has led to more efficient but safe patient discharges.

Methods: We designed and implemented a voiding discharge protocol for general surgical patients undergoing day surgery. This was based on a retrospective cohort study evaluating outcomes in 616 patients between October 2014 and February 2015. Data was initially analysed to assess which patients required an overnight stay, then further investigated to assess the incidence of POUR in high and low risk groups. High risk patients are defined as males over 50, those who have had inguinal hernia repair or anorectal surgery and those with prostatic pathology. An algorithm was then developed to guide discharge in low risk groups. We have audited the implementation and use of this protocol and present our findings.

Results: Our study identified an incidence of POUR of only 2.6% of the total general surgical day case surgeries evaluated(n=153). The low risk group had an incidence of 1.28% whilst the high risk group had an incidence of 4%. Following the implementation of our protocol, our audit has so far revealed that out of 86 patients evaluated, admission to discharge times have decreased significantly from an average of 397 minutes to 170 minutes (P=0.05) for all low risk patients. Furthermore there have been no re-admissions.

Conclusions: Following our successful retrospective cohort study which proved that the incidence of POUR in patients undergoing day surgery was much lower than expected, we developed a local protocol to enable more efficient patient discharges whilst ensuring patient safety. Our protocol has shown to significantly reduce time spent in the day surgery unit therefore saving bed-hours and avoiding patient inconvenience. We plan to continue collecting data and ensure compliance with the protocol.

Day-case Robotic-Assisted Ventral Rectopexy is Significantly More Costly and Time Consuming than Day-case Laparoscopic Ventral Rectopexy: A Prospective Study

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Introduction: Ventral rectopexy to the promontory has become one of the most advocated surgical treatments for patients with full-thickness rectal prolapse and deep enterocele. Despite its challenges, laparoscopic ventral rectopexy with or without robotic assistance for selected patients can be performed with relatively minimal patient trauma thus creating the potential for same-day discharge. The aim of this prospective case-controlled study was to assess the feasibility, safety, and cost of day-case robotic-assisted laparoscopic ventral rectopexy compared with a routine day-case laparoscopic ventral rectopexy.

Material and methods: Between February 28th 2014 and February 3rd 2015, 19 consecutive patients underwent day-case laparoscopic ventral rectopexy for total rectal prolapse or deep enterocele in our institution. Patients were selected for day-case surgery on the basis of motivation, favourable social circumstances, and general fitness. One out of two patients underwent the robotic-assisted procedure (n=9). Demographics, technical results and costs were compared between both groups.

Results: Patients from both groups were comparable in terms of demographics and technical results. Patients operated on with the robot had significantly less pain (p=0.045). Robotic-assisted laparoscopic rectopexy showed longer median operative time (94 min vs 52.5 min, p>0.001) and higher costs (9,088 vs 3,729 euros per procedure, p>0.001) than laparoscopic rectopexy.

Conclusion: Day-case robotic-assisted laparoscopic ventral rectopexy is feasible and safe, but results in increased operative time and higher costs than classical laparoscopic ventral rectopexy for full-thickness rectal prolapse and enterocele. We found no arguments to support the routine use of robotic assistance in rectopexy operations.

Quality of Life Assessment Using the EuraHS-QoL scale in Ambulatory Inguinal Hernia Repair

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Introduction: The purpose of this paper is the assessment of the quality of life in the pre and postoperative period in patients who underwent inguinal hernia repair in an ambulatory surgery unit.

Methods: Between January 2014 and April 2015, 164 patients underwent inguinal hernia repair in an ambulatory setting. A re-evaluation appointment 6 or more months after surgery was completed in 102 patients (111 hernia repairs). 62 patients unavailable, unreachable or that missed the re-evaluation appointment were excluded. To assess quality of life in the pre and postoperative period the EuraHS-QoL 9 questions questionnaire regarding homolateral pain, activity restrictions due to pain/discomfort and cosmetic discomfort was applied. Responses are scored from 0 to 10, where 0 corresponds to the best condition and 10 corresponds to the worse. Stratifications of scored responses(0, 1–3, 4–7, 8–10) and differential scores in pre and postoperative period for each questionnaire (negative, null, 1–45, 46–90) were performed and analysed.

Results: Study group comprises 98 male and 13 female with an average age of 55.62 years (27–95). In all questionnaires the total of 0 responses increased from 35.3% to 71.7% and the total "8–10" decreased from 18.5 % to 1.1%. For Rutkow-Robbins (67) and Lichtenstein (37) repairs the total of 0 responses increased from 33.7% to 70.3%, and from 36.9 to 72.97%, respectively. The "8 to 10" responses decreased from 22,9% to 1,0% and from 12,3% to 0,9%, respectively. The differential scores of pre and postoperative period for each questionnaire were 7% negative, 8% null and 82% positive (65% for 1 to 45 scores and in 17% for 46 to 90). The differential score average was 17,2 with the maximum score of 62 and the minimum of -15. The Rutkow Robbins's differential scores were 6% negative, 9% null and 85% positive (60% for 1 to 45 scores and 25% for 46 to 90). The Lichtenstein's differential scores were 11% negative, 8% null and 81% positive (76% for 1 to 45 scores and 5% for 46 to 90).

Conclusion: Hernia surgery in an ambulatory setting improves patient quality of life. No difference was detected between the two surgical techniques employed.

Bariatric Ambulatory Surgery with Extended Recovery – Is it Safe?

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Introduction: Bariatric surgery is an option for the treatment of morbid obesity in patients who meet criteria. Is this concept applicable in ambulatory setting as a 23 hour stay procedure?

Material & Method: Retrospective analysis of medical records of patients submitted to bariatric ambulatory surgery with extended recovery, from April 2014 to October 2015. Patient inclusion criteria, multidisciplinary assessment protocol, operative data, complications and readmission rate results were reviewed.

Results: A total of 159 consecutive patients were included in this study, 119 (74.8%) underwent a vertical sleeve gastrectomy procedure, 39 patients (24.5%) underwent a gastric band-related operation and 1 patient (0.01%) underwent a calibration of a previous Roux en Y gastric bypass. Morbidity occurred in 7 cases (4.4%), with no mortality to be registered.

Conclusion: Current results reveal conformity with the results published in the literature. When conducted in high volume center with designed protocols, bariatic outpatient surgery appears to be viable and safe option.

Evaluation of a Patient Information Brochure on Postoperative Pain Management for Patients Undergoing Orthopedic Foot Surgery in a Day Surgery Unit

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The shift from hospitalization to day surgery leaves patients with a greater responsibility for postoperative pain management. Knowledge about the hospital's patient education strategies is needed to evaluate whether the patients are able to treat their postoperative pain as recommended. The purpose of this study was to investigate whether a patient information brochure developed by an interdisciplinary team on pain management, used along with verbal information contributed to:

1. Better adherence to the recommended pain management schedule
2. Improved patient satisfactions regarding the information provided
3. Lower pain intensity scores

This quality assurance study used a pre□post test design, and included patients >18 years old who had undergone orthopedic foot surgery in a day surgery unit. Data was collected through systematic telephone follow□up. Adherence to recommended pain management schedule was recorded in the categories: "followed recommendations," "took more than the recommendations," or "less than the recommendations". Patient satisfaction regarding the information provided was rated as dissatisfied, satisfied or very satisfied. Pain intensity was rated as none, low, medium or strong pain. Information brochures with advice on scheduling, dosing and combination of various drugs in relation to expected pain intensity became part of the standardized nursing information in November 2014. Pretest (N=77) lasted prior to Nov. 2014 and posttest (N=126) from Nov. 2014 to May 2015. Results for adherence to recommended pain management indicated that more patients in the posttest group followed the recommended pain management schedule. Patients in the posttest group reported higher levels of satisfaction with the pre□ and postoperative information. The difference in pain intensity between the groups was not significant. An information brochure on postoperative pain management contributed to better adherence to the recommended pain management schedule and higher degree of satisfaction related to information among patients in a day surgery unit. The patient information brochure is an important tool in the department`s quality improvement efforts.

Teaching-training Day Surgery in the Undergraduate Period

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Introduction: Changes in student requirements and increased student numbers mean that less time per student for patient contact is available. Medical students and recent medical graduates in surgical specialities should be aware of the differences between impatient and ambulatory surgery. Medical teaching in undergraduate and postgraduate levels is based on the premise that learning is better if students are involved in the day-to-day care of patients. Pregraduate stay in a Day Surgery Unit (DSU) must be included in medical studies core. Main objectives were Ambulatory Surgery circuits knowledge, Patients and surgical procedures selection criteria, Postoperative controls.

Material & Method: During 1 month medical students are introduced in our Ambulatory Surgery Unit (ASU). All medical students would be present in ASU along 4 years. In our unit the student distribution is 3rd COURSE Basis of surgery, 4th COURSE Surgical systems pathology 1, 5th COURSE Surgical systems pathology, 6th COURSE Clinical report graduate. Students have to elaborate a PRACTICE NOTEBOOK DOCUMENT including types of surgical-anesthetic procedures, description of their active participation and a brief report about clinical personal lived cases. Finally they must present a Personal report about developed practice (REFLEXION REPORT). They were evaluated by a clinical tutor with a maximum total score of 10

Results: 180 medicine undergraduates spent one month within a period of four years in our Day Surgery Unit 3rd COURSE Basis of surgery (90 DSU pupils: Anaesthesia ETN, Ophthalmic, General Surgery) medium practice notebook: 9/10 points. 4th COURSE Surgical systems pathology (30 DSU pupils: General Surgery) medium practice notebook: 9.5/10 points. 5th COURSE Surgical systems pathology (30 DSU pupils: Orthopedic and General Surgery) MEDIUM PRACTICE NOTEBOOK: 8.5/10 points, 6th COURSE Clinical report graduate (30 DSU pupils: General Surgery) medium practice notebook: 9/10 points. Total medium practice notebook: 9/10 points.

Conclusion: In our experience Ambulatory Surgery pregraduate teaching and training has an adequate impact in our student's learning.

New Information Channels in Laparoscopic Cholecystectomy Day Case Surgery

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Introduction: Quick communication between patients and ambulatory surgery units is especially necessary in day case surgery. Patient participation is an elementary factor in out-patient surgery thus a fluent communication with patients is essential for the success of surgical procedure. In these days mobile technologies allows us to create new channels for transmit relevant information in relation with perioperative period. Day case laparoscopic cholecystectomy is a safe and cost-effective surgical procedure. The authors have developed a new App for mobiles as an innovative channel that contributes to offer complete, comprehensible, and clear information for patients. Hence new technologies could increase the improvement of standards of quality and safety and patient satisfaction. Our goal is the development of a mobile application which includes necessary perioperative information about ambulatory laparoscopic cholecystectomy as an optional, free, and quick communication channel in an ambulatory surgical program.

Material and methods: An ambulatory surgery App has been developed at the Ambulatory Surgery Unit of Duques del Infantado Hospital (Virgen de Rocío University Hospital (Seville, Spain) in agreement with the Andalusian Regional Health Ministry.

Results: Anesthetists and surgeons highly experienced in ambulatory surgery cholecystectomy collected all necessary information for the perioperative period in this surgical procedure. Information was structured in a compatible mobile model and was incorporated in a new section of the Official Software Application of the Andalusian Public Health System. We worked in agreement with the Andalusian Regional Health Ministry. Actually Andalusian population have a free access into Salud Responde App for mobile devices with internet connection to resolve their doubts about laparoscopic cholecystectomy.

Conclusions: Developing mobile Apps as an information way could have a strong impact on a population who have an easy access to new technologies.

Hemorrhoidal Artery Ligation and Recto Anal Repair (HAL-RAR) – Is it Advantageous?

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Surgical methods of treatment of advanced hemorrhoidal disease include the classical hemorrhoidectomy (Milligan-Morgan and Ferguson), stapled hemorrhoidectomy (de Longo) and hemorrhoidal artery ligation and recto anal repair (HAL-RAR). The HAL-RAR, described in 1995 by Morinaga et al., is based on selective ligation of hemorrhoidal arteries guided by Doppler, with or without mucopexy. This technique has the advantage of preservation of hemorrhoidal plexuses and overlaying mucosa. Recent literature has demonstrated levels of efficacy and complications similar to the previous techniques. The aim of the study is to evaluate the grade of pain, early complications and early recurrences of this technique performed in an outpatient basis. We conducted a retrospective study between December of 2014 and October of 2015 in the Ambulatory Surgery Unit of our institution. We evaluated the degree of hemorrhoidal disease, pain in the immediate postoperative period, at the first 24 hours, a week after the procedure and in the first follow-up visit. We also evaluated early complications and early recurrences. A total of 21 patients, most with grade III hemorrhoids (67%) reported, in the majority of cases (81%), no pain in the immediate postoperative period, and 3 cases of severe pain. Not only at the first 24 hours but also a week after the procedure, patients reported mostly no or mild pain, with only one case of severe pain in the first 24 hours. In the first follow-up visit we reported just one case of severe pain. Seven patients had discrete blood losses mainly in the first 24 hours, one had an episode of urinary retention at the third day after surgery and one an episode of profuse diarrhea and fever two days after surgery. We have register of four recurrences (19%) in the first months of follow-up. Although this is a small group of patients and a short time of follow up, hemorrhoidal artery ligation demonstrated both in the postoperative period and after surgery, mainly mild level pain and no register of serious postoperative complications, which indicates that it is a safe and effective procedure, with the advantage of preservation of the anorectal canal structures.

Characterization of PACU Based on the Perception of the Nursing Professionals in Colombia

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Introduction: The post-anesthesia care unit (PACU) is a vulnerable site for perioperative adverse events. The aim of the study was to describe the perception of professional nursing staff about the operation of the PACU.

Material and method: Study with sequential mixed approach: a descriptive cross-sectional quantitative phase used a survey, which was applied to nursing professionals who work in a PACU. The evaluated aspects were staff characteristics, infrastructure and PACU processes; a second qualitative descriptive-interpretive phase used in-depth interviewing with nurses involved in the care of an adverse event in PACU. Absolute and relative frequencies, median and IQR were reported. Comparison between levels of complexity was made, considering significant $p>0.05$. The qualitative analysis was based on grounded theory.

Results: 154 surveys were collected and 18 in-depth interviews were conducted. 27% of respondents consider the quality of information at handing over the patient as poor, being more frequent in relation to postoperative management plan (45%). Shortcomings in the training of auxiliary nurses were reported, specifically in the management of airway problems, cardiovascular complications and emergency management. The burden of administrative tasks makes available less than 40% of working time in patient care. Work overload, insufficient nursing staff and communication problems between doctors and nurses were persistently mentioned. A 21.4% do not use scores as a criterion for PACU discharge, and among those who use it, 16 % do not record it. No difference between levels of complexity of the facility was found ($p > 0.05$).

Conclusions: The PACU is perceived as a place of care and attention with deficiencies in the handover of patients, auxiliary training in handling critical situations, and lack of time for patient care. Overwork, an insufficient staff of nursing, communication problems and lack of adherence to guidelines are common and may predispose to adverse events.

Prospective Study of Systematic Ambulatory Surgery in 146 Consecutive Patients with Symptomatic Haemorrhoidal Disease in a Single Institution

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Introduction: Haemorrhoidal disease represents a favourable condition for ambulatory management of patients who need an operation because of youg age around 50, rare associated severe comorbidities, short operation time, and well-known, preventable, exceptionally life-threatening acute complications. The aim of this prospective study was to assess the feasibility of systematic day-case management of consecutive patients needing an operation for symptomatic haemorrhoidal disease in a single institution.

Material and methods: Between January 2013 and September 2015, 146 consecutive patients underwent day-case haemorrhoidal artery ligation with mucopexy (HAL-RAR, n=105), haemorrhoidectomy (MM, n=37) or haemorrhoidopexy (Longo, n=4) in our institution. Causes of ambulatory surgery failure were recorded and analyzed.

Results: Hundred and thirteen patients (70.8%) could leave the ambulatory unit on the same day. Ambulatory management was successful in 88 (80.8%) HAL-RAR patients, 21 (56.7%) MM patients, and 0 Longo patients. Thirty three patients had to stay in hospital and represent failure of day-case surgery management. Causes for ambulatory failure in these patients were, in decreasing order, uncontrolled pain (n=7), too late operation in the afternoon as ambulatory unit closes at 07.00 pm (n=6), patient "last minute" discharge refusal with no clear medical or social reasons (n=5), drowsiness due to general anaesthesia (n=5), frail patients (n=4), social condition mainly because of absence of "last minute" accompanying person (n=3), urinary retention (n=2) and bleeding (n=1).

Conclusion: Ambulatory surgical management of patients with symptomatic haemorrhoids is feasible in more than 70% of cases. This rate can probably be increased with better management of pain and anaesthesia type, systematic operation as first case in the morning, creation of an ambulatory unit that closes later than 07.00 pm, and better social management particularly in single, frail patients.

Accreditation of an Outpatient Unit – What do Professionals Think?

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Introduction: It is believed that everyone who has credit, deserve and inspires confidence. The accreditation process aims to continuous quality improvement in healthcare facilities and excellence of care. Our goal was to know the perception of nurses and doctors in the outpatient surgery unit in respect of an accreditation process.

Material and Methods: Descriptive prospective study, questionnaire applied from May to July 2015. 20 questions, three alternative answers: ?yes?; ?no?; ?do not know?. Convenience sample, n = 81, 56 doctors and 25 nurses. Descriptive analysis of the variables: professional category, genre, age, length of service and professional experience in ambulatory surgery. Chi-square test to analyze the independence between the professional category, length of service and professional experience and the questions asked. SPSS Statistics (V21, IBM SPSS, Chicago, IL), with p >0.05 considered statistically significant.

Results: 63% female, 37% male. Averages: age - 41.3±11.1 years, length of service - 16.9±10.8 years, professional experience - 2.96±1.55 years Most never participated in an accreditation process, in spite of all respondents already have "heard" the concept. Almost all respondents (97.5%) think it is a process of qualifying services and definition of professional skills (77.8%). 82.7% agree that it is a process of improvement of services, security for patients (84%) and quality improvement (86.4%). Although 50.6% agree that accreditation is a bureaucratic process and 81.5% which is a demanding and costly process, 67.9% of professionals would like to work in an accredited service. The professional category, length of service and experience in outpatient surgery did not influence the overall perception of professionals (p> 0.05).

Conclusion: Being seen as a bureaucratized and demanding process, professionals recognize improvements in the safety and quality for what they would like to work in an accredited service. Professionals' opinion meet the concept that organizations' differential is in people.

Pec Block, a New Tool: Combine Ideal Outcomes for Surgeon, Anesthesiologist and Patient

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Introduction: Postoperative pain is a primary complaint for a prolonged convalescence, functional delayed recovery and hospital readmission, a multimodal analgesia techniques and benefits in ambulatory surgery are more evident, with dynamic pain like new marker in patient satisfaction. Pecs I block is recognized as a technique to pain control, likewise as opioid sparse, avoiding adverse effects such as nausea, vomiting and constipation, further decreasing length of hospital stay and perioperative care costs.

Materials and methods: We report 10 patients for breast augmentation surgery. All received multimodal anesthesia in a standardized technique, including Pecs I block after anesthetic induction. Bilateral infraclavicular Pecs I block was performed "in-plane? from medial to lateral approach, under ultrasound guidance. 10–15 mL of 0.25 % bupivacaine was deposited. Figure 1. Perioperative standardized multimodal analgesia with ketorolac 60mg IV intraoperative, and celecoxib 200mg PO every 12 h for 5 days postoperatively. When the reported VAS is 4 or greater, a loading dose of 3 mg of morphine was administered through slow IV route.

Results: The visualization of the spread of local anesthetic between the muscle layers was possible in all patients; the mean age of patients was 26 +/- 3 years, the mean operating time 60 +/-° 10min. In the PACU visual analogue scale (VAS) pain core was less than 2. Any patient required rescue analgesics, without nausea or vomiting. All reported high levels of satisfaction; their postoperative VAS score dynamic pain was 2–3/10 during 48 hours follow up

Conclusion: PEC I block is effective strategy for multimodal analgesic management for breast augmentation surgery, with proper handling of dynamic/static pain and opioid consumption. Pecs I block under ultrasound-guided technique, plus oral celecoxib 200mg every 12hs for 5 days, provides excellent postoperative analgesia avoiding the use of opioids and decreasing side effects such as nausea and vomiting, directly contributing to better control of dynamic pain, that is so markedly affected in this specific group of patients, improving quickly return to their daily activities.

An Audit of Compliance with National and Local Guidelines on Pre-operative Medical Assessment for Day Case Cataract Surgery in a UK Eye Hospital

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Introduction: The use of small-incision phacoemulsification has allowed cataract surgery to be performed under local anaesthesia in patients with multiple co-morbidities, without requiring anaesthetist to be present during the procedure. In this situation, anaesthetic guidelines regarding pre-operative identification of patients who may not be medically fit for surgery are particularly important. An audit was conducted in a UK specialist eye infirmary to assess the level of adherence to local and national guidelines on pre-operative medical assessment for cataract surgery.

Method: Medical notes were reviewed retrospectively for all cataract surgeries performed on a random day every alternative weeks between February to May 2014. Assessment of medical parameters and outcomes (e.g. deferred listing, cancellation) at both pre-operative assessment and on day of surgery were recorded.

Results: 102 cases were reviewed. In pre-assessment, pulse rate and blood pressure were recorded for all patients. 50% of diabetic patients did not have their BM recorded. 36% of patients on warfarin did not have their INR recorded. 94% of patients did not have their oxygen saturation recorded, including patients with known respiratory disease. Medical parameters were all well recorded on the day of surgery. 5% of patients did not proceed to be listed for surgery at pre-assessment -60% were deferred listing following local guideline ?STOP' criteria whilst 40% were not. 3% of patients were cancelled on the day of surgery, all in adherence with local guidelines.

Conclusion: The audit revealed several areas where compliance with local and national guidelines was unsatisfactory, particularly in the recording of pre-assessment medical parameters. This audit was presented to the ophthalmology department and remedial actions were put in place, including the implementation of a new pre-operative assessment checklist.

We Don't Know What We Do Until We Question it

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Introduction: Qualitative studies focused on the patient experience, from the conceptual and methodological point of view, are fundamental tools for the evaluation of satisfaction in health care, contributing to humanization and improvement. This study aims to assess the comments or suggestions recorded by patients in open-ended questions on a satisfaction survey in outpatient surgery.

Materials and methods: Sample collected in a total of 3979 patients operated on an outpatient basis from January to September 2015. A qualitative-quantitative and descriptive study, based on the analysis of open-ended question responses in the satisfaction survey, sent by post-mail, to patients that underwent outpatient surgery. It was made a quantitative and descriptive analysis of the frequency of responses and their distribution by socio-demographic variables and it was applied the Bardin method of content analysis in three categories: process, structure and results.

Results: 1104 (27.75%) patients answered the satisfaction survey and 234 registered their opinion in the open-ended question field. The majority of comments were made by females (n = 126; 53.85%), age group above 56 years old (n=131; 55.98%), married (n=150; 64.1%), employees (n=97; 41.45%) and retired (n=93; 39.74%). It was verified a similar number of responses in the group of basic education and high school plus college education. The procedural indicators, related to communication and interpersonal relationship, were the most reported: sympathy, humanization, competency and professionalism (48.72%). The negative indicators most frequently mentioned were of structural nature: signage, equipment noise and catering (24.79%) and those related to the procedural process: waiting times for scheduling the consult and surgery, and the preoperative period (41.03%).

Conclusions: In this study, we conclude that some of the structural and procedural aspects did not meet the patients' expectations, so, their correction are required to improve satisfaction and provided care.

Continuous In Situ Diffusion of Ropivacaine for Ambulatory Congenital Hand Disorders Surgery in Young Children

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Pediatric ambulatory surgery presents a specific set of challenges to the anesthesiologist. As in adult ambulatory surgery, we report 4 ambulatory surgical procedures involving osseous correction for two young children with congenital hand disorder. The whole procedure was performed under general anesthesia and axillary block under ultrasound guidance with ropivacaine 2%, a tourniquet was applied on the upper limb. The elastomeric pump consisting of 60 mL of ropivacaine 2% and 60mL of isotonic saline permitted the continuous infusion of the operative site. The diffusion flow was 2 ml/h for a period of 48 hours. The surgeon and parents determined POCIS score at the 7th-24th-48h postoperative hours. The first patient aged 12 months and weighing 12kg had at his left hand a radial club hand (stage 1) and a five-fingered hand at both sides. For the left hand one was carried a capsular release of the lateral side of the wrist and stabilized by intramedullary pinning. Then a pollicization was performed on the left hand at the age of 15 months and on the right hand at the age of 18 months. POCIS score was 0 at the seventh postoperative hour and 1 at the 24th and 48th postoperative hour. The second patient aged 16 months and weighing 17kg had a congenital syndactyly of the second and third left fingers with a bony fusion of the middle phalanx. One was carried an osteotomy of the middle phalanges and a skin plasty to separate the two fingers. A Y-shaped catheter was set up to deliver a saline solution with ropivacaine for the two fingers. POCIS score was 0 at the 7th, 24th and 48th postoperative hour. We recommend this technique for controlling postoperative analgesia after congenital hand surgery and in general for children requiring osseous procedures. For our patients and after clear information given to the parents, the use of such a device has allowed an ambulatory surgery when most of time several days of hospitalization are required. This has had the beneficial effect of limiting parental stress and has provided greater comfort to the child during the postoperative period.

Pain managment with Continuous in situ Diffusion of Ropivacaine Following Mini-invasive Locking Plate Fixation for Distal Radius Fracture

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Objective: The aim of this comparative and prospective study is to evaluate the results of pain managment with the association of 2 techniques for the treatment of radius distal fracture with volar locking plate : a mini invasive pronator-sparing technique which can avoid hematomae and then necessity to drain, and in situ continuous diffusion of Ropivacaine.

Methods: In the group 1 (11 patients), there was no catheter but a suction drain for 3 of them. In the group 2 (23 patients operated by another surgeon), an in situ catheter is placed in the surgical site for a continuous diffusion (flow 5 mL/h) of 270 mL of Ropivacaine 2% with an elastomeric pump. The catheter was removed by a nurse at home 48 hours after surgery. Pain was evaluated with pain Visual Analog Scale (VAS) at Day 1, Day 2, Day 3, Day 7 and Day 30 with a comparative t student test ($p>0,05$). A radiological examination was performed at Day 30. The type of hospitalization was noticed.

Results: In Group 2 ,VAS at Day 1 / Day 2 was significally lower than in Group 1 : 4,8 / 3,5 vs 6,6 / 5,6 ($p>0,05$). There were no difference of the results of VAS at Day 3, Day 7 and Day 30. No radiological sign of chondrotoxicity was observed at Day 30. There were 6 patients operated in one day surgery in Group 1 (55%) and 20 patients in one day surgery in Group 2 (87%).

Conclusion: The association of the mini invasive technique with an in situ diffusion of ropivacaine is an effective procedure to control post operative pain after treatment of distal radius fracture and then could authorize one day surgery.

Wide Awake Sonographically Assisted Percutaneous Trigger Finger Release: A Prospective Study of 99 Digits

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The WALANT (wide awake local anesthesia no tourniquet) technique for percutaneous trigger finger release has become increasingly popular. The aim of this prospective study about 99 fingers is evaluate the feasability and outcome of this technique and to propose a classification of the results. 89 patients has been operated under local anesthesia, with a simple 19G needle ultrasonographycally with a high frequency probe and at the end of the procedure, an intrasheath steroid injection. According to Quinnell classification, 68 fingers (including the thumb) was classified type 3 and 31 type 4. Criterias of exclusion were children, Quinnell 1 and 2, and diabetes / rheumatoid deseases, or history / trauma / surgery of the flexor tendon. Pain was evaluated with the Visual Analogic Scale (VAS : 0 if no pain to 10 if extremly intense). At one month follow up, the results were noted as excellent, adverse event, complication and failure. There was no lost sight patients. The mean VAS was 1,45 (extreme 0 to 5). 87 fingers presented an excellent result. 12 fingers had an adverse event (3 with a Dupuytren's brid on the scar, 3 with a slight swelling of the digit, 1 with a transitory paresthesia of the fingertip, and 5 with a small lack of flexion of the digit). No one had a complication (no sign of infection, no tendon rupture and no nervous section) or a failure i.e. with recurrence of the triggering. The WALANT technique with ultrasonography allows the surgeon to perform an effective, painless percutaneous trigger finger release safely and quickly.

A New Fast Track Approach for Patients with Carpal Tunnel Syndrome

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Carpal tunnel syndrome is commonly treated by a mini-open or endoscopic procedure. It has been desmonstrated previously that an ultrasound guidance permits assessment of a precise anatomical diagnosis in the carpal tunnel, avoiding nervous lesions, and controlling the complete release of the median nerve. The aim of this study is to evaluate the feasibility and the avantages of this technic with wide awake approachfor anesthesia and thus to validate an original ultra fast track procedure for patient who suffer of a carpal tunnel syndrome.

Method: In a prospective study, 350 people (55 men and 295 women, mean age 62years old) were treated betwen with an ultrasound-guided percutaneous procedure by two operators. All carpal tunnel syndromes had been diagnosed by an electrophysiological examination. The procedure has been performed for all patients with a modified wide awake protocol of anesthesia (local anesthesia with epinephrine, associated with a median nerve blockade at the wrist) and without tourniquet. None received any sedation. The procedure was performed with a Kemis knife. The progression of the knife was controlled with the ultrasound probe. A picture of the knife through the retinaculum was taken as evidence of the complete release. All the patients went directly to the nursing ward and were allowed to leave this unit after 15 min.

Results: All the patients had a good clinical result. There was no nervous injury. All the clinical parameters were the same compared to traditional carpal tunnel relase. None of the patients complained about refllex sympathetic dysrophy. The mean duration time to leave was 32 min (15–68).

Conclusion: The study emphasises that ultrasound guided carpal tunnel release is a safe method. Moreover, this surgery may be done without a tourniquet and with limited anesthesia. Patients may have an immediate functional recovery of the hand that allows them to spend a very short time in the day surgery ward. This study has pointed out the possibility to reduce drastically the cost of the carpal tunnel syndrom with the use of an ultra fast track procedure allowed by ultra sound guided surgery with wide awake plus approach.

A Bidirectional Day Surgery Application in Andalusia

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An application (APP) for mobile phones to improve ambulatory surgery has been developed for use in the public hospitals of Andalusia. It is used before surgery and after discharge. Before surgery it gives instructions about pre-surgery diet, fasting period, medication and other requirements. After discharge, patients are informed about their expected recovery, pain relief, medication and other issues. Development of this application has been a challenge due of the number of surgery types, patient conditions and different operative systems for mobile telephones. This 'App' has been developed by 'Salud Responde' (Health Answers), the service that provides multichannel access to the Andalusia Public Health System 24 hours a day. This application, at the moment, has strong limitations because communication is only in one direction. Patients cannot communicate their doubts, possible changes in their condition or report problems with the surgery date. A new application is being developed to overcome these shortcomings; the goal is minimise peri-operative complications and late cancellations. With this communication App, in the preoperative period patients will have full communication and will be able, also, to fill an online preoperative questionnaire. A dedicated staff could provide individual recommendation for patient preparation and if necessary, for example, conciliation of medication. In the postoperative period, professionals will be able to follow patients in the first 24 hours, and patients will be able to report on their situation and ask for advise or help if needed. They will be asked to answer a satisfaction and quality of results survey, providing the patient point of view to the Day Surgery Unit and Health System, giving them an opportunity to improve. This application will be used in Andalusia where more than 200,000 day surgeries are performed each year. FEDER funds have been obtain for this project to be developed in four years.

Dimensions with Major Impact on Patient Satisfaction in Ambulatory Surgery

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Introduction: Understanding patients' experiences and perspectives is critical to improve performance and quality of patient care. Patient satisfaction is an important part of quality of care, however, it is a complex concept that is influenced by multiple factors. The purpose of this study is to assess the dimensions with major impact on patient satisfaction in ambulatory surgery.

Materials and methods: All patients (3.979) operated on an ambulatory basis from January to September 2015 were selected to participate. A satisfaction questionnaire was delivered to all patients that underwent ambulatory surgery and sent back to the institution by post-mail. The questionnaire consisted of 13 multiple-choice items, in a 5 point Likert scale, divided into 8 dimensions, concerning preoperative information, waiting time, quality of care, empathy, comfort, privacy and postoperative information. A quantitative and descriptive analysis of the obtained answers were made and it was applied the Pearson correlation to assess which dimensions are the most relevant for global patient satisfaction.

Results: The satisfaction survey was answered by 27.75% of patients from the total sample. The majority of responses were female (54,59%) patients and age group between 56–75 (58,58%) years old. Waiting time, preoperative information and quality of care were the dimensions with the most negative evaluation. Empathy and postoperative information were the dimensions with most positive assessment. The global satisfaction was classified with 5 in the scale by more than 80% of the patients.

Conclusions: Unlike the administrative perspective that focuses much attention on perioperative waiting times, our study shows that the behavioral perspectives as empathy towards the patient and the definition of a post-operative plan are the dimensions with the greatest impact on satisfaction and patient comfort in health care. The data analysis allows us to intervene in the chain of patient care, improving his experience during the ambulatory unit stay.

Anal surgeries as Day Case in India

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Aim: Retrospective analysis of 1176 benign anal surgical cases, performed as day case, at One Day Surgery Centre, India's First Multi-speciality, stand alone, dedicated Day Surgery Centre, in Mumbai, a metropolitan city, with an aim to creating a prototype DSC. Introduction: Day Care Surgery, as it is popularly known in India, is in its initial stages. There is a definite interest in establishing and propagating Day Surgery over the past 9 years.

Material: Data collected from May 2007 to April 2015, were analysed retrospectively, of Benign Anal diseases performed at the Centre. Surgically treated patients were categorised as Haemorrhoids: 734 cases, Fistula-in-ano: 128 cases, Chronic Fissure-in-ano: 61 cases, Peri-anal abscess: 176, Ano-rectal Polyps: 9 and Pilonidal Sinus cases: 68. Mean average hospital stay was 6 hours.

Method: Both centres are ISO 9001-2000 compliant, created specifically for Day Surgery. Case selection and criteria for patient preparation and discharge were followed as per recommendation of The Indian Association of Day Surgery. Pre□operative counselling was performed during the first consultation. The discharge process was strictly monitored and criteria are followed. Complications were explained to the patient along with post procedure instructions. Readmissions were carefully noted.

Conclusion: Results revealed a marked trend towards better acceptance in towards Day Surgery, with more willingness to go home on the same day of the procedure. Marketing and meticulous implementation of Protocols as a safeguard, providing a high standard of patient care, eventual will lead to acceptance increasing acceptance. Readmission in Day Surgery cases were nil.

Patient Standing in the Operating Room: An Experience in Ambulatory Surgery*

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Introduction: The project is based on the following reflection: Because patients undergoing ambulatory surgery go on the day of their intervention walk in the outpatient settings, why do they not do so until the operating table? Valid patients are accompanied by foot, in an outfit respecting their privacy, to the operating table. The main objective of the study is to evaluate the satisfaction of patients undergoing this new transfer mode.

Material and Methods: This is an observational study. The satisfaction survey was conducted via questionnaires hand delivered by nurses to patients before discharge. These questionnaires relate to respect for their privacy, the adequacy of this new mode of transfer with their health and their desire for future intervention. A survey of adverse events and accidents is carried out continuously (falls, identitovigilance errors, transfer mode errors?). Results: The evaluation was performed on the first 5 months of operation (from October 2014 to February 2015). Our population includes 27% of the patients of our outpatient surgical structure (872 patients standing on 3261). The response rate was 77%.

Results: 98% of patients (658 of 673) believed that transfer mode is suited to their condition. -97% of patients (653 of 673) were satisfied with the respect for their privacy. 84% of patients (568 of 673) would choose this mode of transfer for a next intervention. No adverse event or accident has been identified

Conclusion: Improving satisfaction and preserve the autonomy of patients improve their feelings, especially in terms of dignity. A space for free expression in our questionnaire was available and many patients reported a decrease in their stress by this new transfer mode. This project aims to be extended to the whole of our facility for patients in the context of early perioperative rehabilitation programs.

Implementation of Outpatient Mastectomies: Evaluation of Care Pathways and Satisfaction Survey*

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After a feasibility study, we decided to offer to the patients to be operated on as outpatients in case of mastectomies.

Materials and methods: Evaluation conducted from January to June 2015. All patients before having a mastectomy were offered ambulatory care. The course of treatment in addition to the surgical consultation, included a nurse consultation announcement, a call the next day, a post-operative nurse consultation and a surgical consultation for the announcement of results. An evaluation questionnaire was aimed to analyze the postoperative symptoms and quality of care.

Results: 28.9% patients were programmed (35/121). The conversion rate was 11.4% (4/31). 68.5% had already had an outpatient surgery or chemotherapy day hospital. The average age is 53.7. At the exit: 61.3% had their scars. 54.8% were painful with EVA to 3.41. 93.5% had no apprehension. There was no rehospitalization. The nurse consultation was held on average 3.9 J. 22.5% patients were anguished mainly from the modification of body image. This consultation enabled to program support care consultations in 32% cases. The consultation with the surgeon was in average 16.6 J. 41.9% patients were mainly anxious over pending the results were announced. The overall evaluation shows a good perioperative information (9.23) and a significant interest in the nursing consultation (9.13). The overall care was evaluated at 9.43. 100% would do it again in their outpatient mastectomy.

Conclusion: The management mastectomies as outpatients, appears to be reasonable. The rate of between 25% thresholds in the Anglo-Saxon teams . This support is better suited to patients who have had an outpatient course. Nurse peri operative consultations have a key role in the smooth. Must be discussed, better education to pain, by introducing nurse education consultation before hospitalization.

Dental Operations Outpatient Surgery Under Procedural Sedation*

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Summary: Sedation procedural combined with local anesthesia allows the realization of most of Dental interventions outpatient surgery. It has three advantages: saving time, simplifying the surgical procedure and a high degree of patient satisfaction.

Introduction: Procedural sedation (also called conscious sedation) is described in many therapeutic procedures. We wanted to adapt to data of oral surgery for which only local anesthesia is possible for surgical reasons or convenience, but where general anesthesia seems heavy and burdened with too many side effects.

Technique: It is available for operational extraction of third molars, as well as many other operations typically achievable in ambulatory surgery. We've included 92 patients to date. The induction and maintenance of anesthesia are by TCI mode (intravenous anesthesia with target concentration) of propofol and remifentanil and continuously adapted to low doses. The operation is carried out after a local anesthetic lidocaine with adrenaline, with suction and careful hemostasis. Empathetic verbal contact is maintained throughout the procedure. Discussion: This technique has several advantages, without compromising on safety. It facilitates the surgeon's work compared to local anesthesia: improved collaboration, reduced stress thus bleeding, absence of predatory reflex when local anesthesia; but also compared with general anesthesia: patient engagement that sets itself the position of his head and opening his jaw function that asks the surgeon. It allows saving time in all phases of hospitalization.

Conclusion: Procedural sedation allows operations in the best conditions for the majority of patients in most outpatient oral surgery indications. It requires high collaboration between the anesthesiologist and the surgeon. In these conditions, patient satisfaction is unanimous.

Optimization Turnover of Ambulatory Surgery Unit (PCU) of a Center Against Cancer After Analysis of Postoperative Monitoring Periods*

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Optimization of the turnover of an ambulatory surgery unit (PCU) of a center of fight against cancer after analysis of monitoring periods postoperative.

Introduction: Our institution has opened an integrated UCA 5 seats in 2011. In addition, we occasionally use a room immediately adjacent to the UCA.Y are practiced acts of breast cancer surgery and plastic, central venous access site and endoscopies, procedures performed under general anesthesia or sedation. Until 2014, the turnover was 1 patient / site / day. A first analysis of postoperative monitoring times in April 2014 (Breast surgery vs others) helped to highlight significant time losses, mainly of organizational origin. After presenting the results to the teams, it was defined 2 circuits, after consulting ananesthésie, short (AC) and long (AL) as the estimated duration of postoperative monitoring (according to the procedure and comorbidities, information transcribed on the operating program). The goal is to channel 2 patients AC per day by wheelchair.

Methods: Analysis of postoperative monitoring times (getting Aldrete score = 10, PACU length of stay, validation output UCA (Chung score), exit UCA / arrival in SSPI) in September 2014 in 52 AC and 85 G, occupying registration chairs of the UCA since January 2015.

Results: obtaining Aldrete score = 10: 33 min vs 48 min AC AL; AC output SSPI 1:14 vs 1:50 AL; AC output validation UCA 1:06 vs 1:28 AL, output UCA / arrival SSPI 3:26 vs. AC 4:17 AL. - 30 double rotations 6/30/15 vs 120 loans contiguity beds (21%).

Conclusion: It is possible to channel 2 AC patients in the same chair (one first thing in the program, the other in early afternoon). For as the percentage of double rotation remains low. It is explained by the rise of breast activity with preoperative trails and the many constraints of an integrated block. To improve this, we are considering the creation of a room off the street (before start of concept).

Continuous Surveillance Of 707 Varicose Vein Operations Under Tumescent Local Ambulatory Anaesthesia Using Innovative Computer Software "PATIENT MONITORING"*

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The use of tumescent local anesthesia for ambulatory surgery is varices yet widespread. We evaluated the feasibility and short-term results of this technique, with monitoring carried out using innovative software. This two-centre prospective study of 603 patients and 707 interventions was conducted between 1 January and 31 December 2014. All patients underwent varicose vein surgey under local tumescent anesthesia with or without sedation and with a valid email was included. The collection of post-operative data was performed using software sending questionnaires to patients from Day 0 to 7 and Day 15 and 30 on their pain, bleeding, functional ability and satisfaction. The population consisted of 72.8% women, mean age 51 years and BMI of 24.4. 24.2% had recurrent veins. The mean clinical severity score was 4.5 / 30 and preoperative pain on a visual analog scale was 2.53. Local anesthesia without sedation was achieved in 79% of cases. Twenty phlebectomies were performed on average. The additional procedures were: ligation (15%), stripping (19%), radio frequency (26%), Laser (3%), sclerosis foam (3%), embolization (0.4%), perforator ligation (0, 3%) and recovery crossectomy (0.7%). No intra-operative complications occurred. At Day 0 and Day 1, the response rate was 66% and 57%. The mean VAS was 1.73 and 1.24. The activity was considered normal or subnormal in 85% and 93% of cases. 99.6% of patients said they were satisfied or very satisfied at D0.

At 30 days, there were 0.1% infection, 0.3% of superficial thrombophlebitis, no deep vein thrombosis, no hematoma, no lymphorrhoea, and 0.1% neurological complications. The surgery of varicose veins under local tumescent anesthesia with or without sedation can be done without risk. It gives excellent immediate results in terms of pain, functional recovery and satisfaction. The computer assessment tool used is a method of medical data that is extremely useful and reliable.

3578 Ambulatory surgery in thyroid practice*

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Aim: To report and assess the results of the lobo isthmectomy performed in digestive surgery.

Methods: From 2009 to 2014, 41 patients underwent lobo isthmectomy thyroid. With same day discharge offered to all patients with no suspicion of cancer, no coagulation abnormality, an ASA score<= II, and after information provision and informed consent. No drainage was left.

Results: The average length of stay was 8 hours. A hematoma was identified in the first six post-operative hours, requiring drainage. There were no other complications or readmissions. All patients were satisfied, but two of them would have preferred to retrospectively spend a night in the hospital. 96% of patients would advise this method of care to a friend.

Conclusion: This thyroid surgery may be considered a safe and feasible ambulatory procedure for the majority of patients.

Outpatient Robotic Radical Prostatectomy: A Future Surgery?*

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Introduction: To assess the feasibility of robot-assisted radical prostatectomy (PRA) with duration of stay in hospital under twelve hours and determine patient satisfaction.

Material and Methods: From March to October 2015, 7 patients with localized prostate cancer were selected to benefit from robotic prostatectomy as an outpatient. Patients were selected for their good condition and favourable environmental factors. All those operated upon volunteered for an outpatient procedure. The surgery had been validated by an oncology consultation meeting and conducted transperitoneally. Sedation and analgesia were performed using a target controlled infusion of propofol. The post surgical evaluation criteria were the VAS scale for pain, blood loss, score Chung and patient satisfaction survey. Results: The mean age of patients was 62 years (57–72). The average distance between home and the hospital wass 30.5 kilometers (5 to 56). The average duration of general anesthesia was 161 minutes (140–203). No perioperative incidents were noted. The blood loss was 130.6 ml on average (75–220 ml). The patients stayed less than 12 hours in the unit of care through rehabilitation adapted with Chung score of 9 or 10 before returning home. The mean VAS score was 0.4 (0–2) on discharge, with no readmissions. Removal of the drainage blade was performed on the second day (D1–D2) and removal of the urinary catheter at day 7 (D6–D8). Finally, the satisfaction score of operated patients shows that 96% (92 to 100) were very satisfied with the care.

Conclusion: This first series of radical robotic prostatectomy performed in France in hospital less than 12 hours shows interest in minimally invasive surgery in the treatment of selected patients for outpatient care.

Intravenous Analgesia For Some Painful Ambulatory Surgery Procedures*

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Introduction: Postoperative pain is still the weak link. The return home is the question, is known in some surgeries, particularly orthopedic and colo-rectal, that there is a level of pain that can be moderate or severe for the first two post-operative days. The implementation of invasive analgesia at home by elastomeric pump was started from the results obtained during the telephone contact first 24–48 hours after surgery. Use of invasive analgesic techniques at home allows control of postoperative pain and improves the level of patient satisfaction.

Objectives: To assess the analgesic efficacy with elastomeric pumps for continuous intravenous infusion at home for colorectal surgical and orthopedic surgery patients and also rate their satisfaction.

Material and Methods: Service Coordination involved CA., HaD and Pharmacy. Forecast elastomer dispositive. Prospective observational study from 2010 to 2014, 1370 patients. Evaluate the carrying out the elastomeric device every year. Quirurgique assess the most favored technique. Quantified by the visual analog scale of pain intensity in the first 24 and 48 hours after surgery at home. Assess the level of patient satisfaction.

Results: There was an annual increase in devices implemented at home?. Most favored surgery had the hallux valgus. Pain in the postoperative 24 hours was between 0–3 lightly. For 48 hours the pain is decanted to moderate. Patients showed a high degree of satisfaction.

Conclusion: Our study demonstrates that the use of endovenous elastomeric pump, continuous infusion, as a method of postoperative analgesia in case of procedures with moderate-to-severe pain home, is effective hang the first 24-48 hours. We must improve surgical coloproctologique because the Roman pain two days and in this case, we need a second device to be good. The degree of patient satisfaction with this device, was excellent.

Feasibility of Thyroid Lobectomy as an Outpatient. A Retrospective Study of 130 Patients*

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Introduction: The increase in outpatient surgical activity is a goal of health policy in France. Practicing total thyroidectomy as an outpatient remains contentious but can hemithyroidectomies be possible? In theory, thyroid lobectomies do not require bilateral dissection so the bleeding risk is lower. The aim of our study is to evaluate our practices in terms of indication, risk and success of outpatient surgery for hémithyroidectomies.

Materials and Methods: This is a retrospective study of two non-university centers between January 2009 and December 2013. The medical indications against the hemithyroidectomies ambulatory were: ASA > 2, taking anticoagulant, risk aggregation, the presence of a thyroiditis, and gesture associate (parathyroidectomy contralateral side or dissection). A demographic analysis was performed and the search was made for complications, unanticipated admission rate and unplanned hospitalization.

Results: 130/294 (44%) were performed on an outpatient hemithyroidectomies. 64% of the causes of non-ambulatory programming were for reasons other than medical. The average age of ambulatory patients was 44 years, with a clear predominance of women. 8/130 (6%) ambulatory hémithyroidectomies had a tabulation. Only two hospitalizations were converted into conventional without any recovery. All patients were satisfied or very satisfied with the treatment as an outpatient.

Conclusion: The practice of ambulatory hémithyroidectomies seems feasible and safe. Expanding the indications of over 50 patients, tabulations, central neck dissection, ipsilateral to parathyroidectomy and toxic adenoma; does not contain, a priori, any risk.

Evaluation of Spinal Anesthesia in Outpatient Surgery and Urology Comparison Between Chloroprocaine and Bupivacaine*

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Introduction: Spinal anesthesia in urological outpatient surgery is currently still controversial with the risk of lengthening the duration of hospitalization and the risk of urinary retention. The objective of this study was to analyze the length of stay in the Ambulatory Surgery Unit and complications of patients operated under spinal anesthesia, depending on the local anesthetic used (Bupivacaine or Chloroprocaine).

Methods: This single-center retrospective study included all patients operated in urology outpatient department under spinal anesthesia between December 2011 and May 2015. The cohort was divided into two groups according to the type of local anesthetic used: Bupivacaine (B) and Chloroprocaine (C). Quantitative variables were compared by student t test (normality checked by Kolmogorov-Smirnov) and qualitative variables by Chi2 test. A p value <0.05 was considered statistically significant.

Results: 75 patients were enrolled, with 71 (95%) discharged home on the same day. The fialures of discharge were: one patient at home (N = 1), caillotage bladder (N = 1), JJ probe intolerance (N = 1), delay of urination in Recovery (N = 1). The average duration of action was 27 ± 19 min, the SSPI 55 ± 31 min, that of living in the UCA 36 ± 91min. 45 patients (60%) received bupivacaine and 30 patients (40%) Chloroprocaine. The average length of stay in the PACU was significantly reduced in group C (47 ± 24 min vs. 61 ± 34 min, p = 0.04). One patient had a delay in urination in Group B that was not significantly different. There were no other significant differences for the other criteria studied except that the average age was higher in group C (p = 0.02).

Conclusion: Spinal anesthesia in urological outpatient surgery does not seem to compromise discharge and did not induce urinary retention, particularly with chloroprocaine. The use of chloroprocaine appears to decrease the length of stay in PACU compared to bupivacaine. Spinal anaesthesia is popular with patients, and has a place in urological outpatient surgery.

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The same declaration signed by all the authors must also be posted to the appropriate Editor-in-Chief.

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