One Day Surgery Times

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14th International Congress on Ambulatory Surgery
30th May – 1st June 2022
Bruges, Belgium
IAAS 2022 - https://www.iaascongress2022.com/ - Welcome

ANNOUNCEMENT

Members of The Indian Association of Day Surgery are requested to:

1) **Send their correct & working email ID to: info@daysurgeryindia.org As decided earlier, we are going paperless, all communications will be via email only.**
2) **2019-20 issue of Day Surgery Journal of India, needs articles.**
   If you have any interesting material to share, please send as soon as possible.

COVID – 19

CORONA virus Pandemic is a serious killer.
Please follow safety regulations as issued by the Government agencies, time to time, till the threat dissipates. Please get yourself vaccinated.

Greetings from the Editor,

Almost two long years and still waiting for the Pandemic to eighter turn into an Endemic or the much talked about 3rd wave, which has taken the western world into another disastrous turn!

But, life goes on! We waited, then started with Zoom Meets/Webinars, Hybrid Meets, again lockdown. Restarted, and now, slowly limping back towards normalcy, slowly testing water before treading!

Our National Conference is coming up in Feb.-Mrach'22 as well as IAAS Congress in Belgium. Will they happen? We can only wait and watch. In any case…Zoom hai na! Digital Platform has come to our rescue, time and again. Human touch has definitely reduced, we have re-invented ourselves.

A Historical article, published in the Day Surgery Journal of India, 2005 issue. Thought the changes and its relevance would be of interest to some of us.

Advances in Day Surgery

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Day surgery in the UK enjoyed a brief period of political support in the early 1990's with a National Task Force and the injection of money to develop new units. This did lead to an improvement in day surgery rates but the support was short lived and for many years we have experienced an attitude where managers and politicians believed that there was nothing further to do. In reality there remained a large variation in day surgery performance around the UK that could not be justified on clinical grounds. In 2001 the Audit Commission produced a report on day surgery and stated 'if all trusts could achieve the levels of the best performers 120,000 existing inpatients in England and Wales could be treated as day cases'. Given the problems we face due to having hospitals that are too small for the population we are trying to serve (otherwise known as the 'winter bed crisis') this was a waking up call for hospital managers and politicians.

Over the past 2 years there has been major political support for the development of day surgery within the UK. Indeed it is expected that 75% of the elective surgical workload will take place as a day case within the next few years.

This is important as it will form the majority of the non-emergency work for many anaesthetic and surgical departments. Obviously, this has implications for training of both surgeons and anaesthetists. Anaesthetists in particular have much to offer this population of patients but in many departments, it is not seen as an important area – lacking the drama of ITU, vascular and acute work. Indeed, there is currently a lack of training in this area despite good guidance from the Royal College of Anaesthetists and this is something we are trying to address within the British Association of Day Surgery.

In this article however I will concentrate on the need for anaesthetists and surgeons to work together to revisit their day unit assessment criteria and how they provide post operative pain relief.

Assessment Criteria.

Historically in the UK these have been based on guidelines produced originally in 1985 (updated 1992) by the Royal college of Surgeons. (1) One of the first areas of contention in these is the use of a Body Mass Index (BMI) of 30 as the level where patients become unsuitable for day surgery. (BMI is the patients weight in kilograms divided by their height in metres squared i.e. kg/m2) It is interesting that there are departments still using this level in the UK. For some time now publications have supported the provision of day surgery for obese patients (2-3). In York we have gradually increased this to a level where everyone looks after patients up to a BMI of 37 and those beyond this are looked after by myself and a small group of colleagues who have developed an interest in this area. The real limitation is the weight that our operating trolleys can take and this tends to be around a weight of 150kg.

Recent reviews would support that dantrolene pre-treatment is not necessary in this group of patients (6) and as avoiding trigger factors should be relatively easy then these patients should not be denied day surgery. However they should be identified at pre-assessment and managed by someone who is happy to look after these patients.

Analgesia in day surgery:

We have learned many lessons about analgesia in day patients from Audits performed in York. The major factors to remember are:

The need to educate the clinicians to prescribe analgesia.

Educate the patient (and their carer) to actually take the analgesics provided.

Provide the patient with details about what to do if they are still in pain.

Furthermore, after some operations advice about over the counter analgesics should be given for when they run out of the analgesia supplied.

Table 1 presents a summary of some of our data for patients who reported moderate or severe pain when they were contacted at 24 hours after discharge from hospital. In 1992 it can be seen that in this group only 67% had been given analgesia to take home. Clinicians felt that the procedures they were having were not painful and so we had to educate our colleagues that it is important to ensure that patients are given pain killers to take following discharge. This programme has been largely successful as you can see that 98% of our patients were prescribed analgesia to take home in 1994 and 2000.

When we asked this group of patients who are reporting moderate or severe pain did they take the tablets given to them we found that in 1992 9% reported not taking them and another 22% used tablets they already had at home. This problem was addressed by the nursing staff educating both patients and their carers on how and when to take their pain killers. We also reinforced this by providing written information to remind them. Further audits in 1994 and 2000 confirmed that this approach has improved this problem. It is interesting to note that despite patients reporting experiencing moderate or severe pain that large number report that they were able to control their pain using the tablets provided. This number has again improved with education since 1992. The results fit with the findings of Table 2 which looks at the reported degree of pain felt by our patients. This has shown improvement between 1992 and 2000 and this has been achieved despite a change in case mix to larger more painful procedures.

Table 1. Results from patients reporting moderate or severe pain after discharge.

Supplied with tablets	**1992**	**1994**	**2000**
Yes	67%	98%	98%
Control with tablets			
Yes	53%	84%	80%
No	4%	4%	6%
Some of the time	12%	8%	9%
Used own	22%	3%	2%
Not taken	9%	1%	2%

The secret of pain relief in day surgery is to use a multimodal approach to analgesia during their stay and in the postoperative period. This requires the use of NSAIDs, Paracetamol, Codeine, short acting opioids (fentanyl) and the liberal use of local anaesthetics.

However, no one has all the answers to analgesia following day surgery and as we increase the complexity of procedures being performed then we have to look to new methods. One new technique being used around the world is the continuous or patient controlled infusion of local anaesthetic into the area that has been operated on. (7) This has been made possible by the development of reliable disposable pump systems that can be connected to fine catheters (often epidural catheters) which are left inside the patients wound. Indeed some authors are now leaving the catheter inside joints (8) for the first 24 hours after discharge. This technique is popular in some parts of Sweden and Australia but is also beginning to be used in the UK.

I would like this opportunity to repeat what I hope has been a theme in this article-success in day surgery is down to teamwork. The team includes the surgeon, the anaesthetist, the nursing staff and any support staff you may have. Time spent building a good team who understand the needs of the day surgery patient and their carers can pay large dividends in the long-term. Day surgery can only succeed if we provide a quality service for our patients. This is what our British Association of Day Surgery promotes – please take time to look at the website www.bads.co.uk. There you will find lots of useful information about day surgery and even a discussion area where you can ask questions. Don't be afraid to join in.

The Publications area allows you to download our booklets already mentioned in my article plus others on discharge criteria, day case laparoscopic cholecystectomy and skill mix and nursing establishment for day surgery units.

Finally, I would like to thank the Editor for the kind invitation to contribute to the first issue of The Indian Journal of Day Surgery. I wish you success with this new venture and look forward to hearing how things progress.

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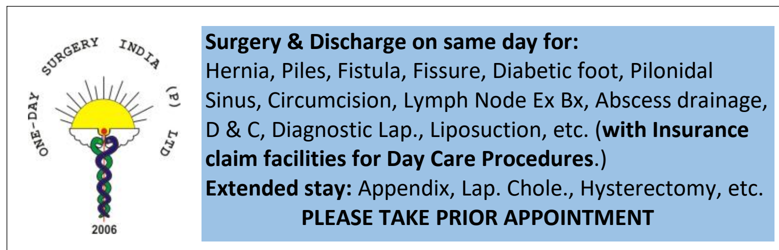

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