

PARALLEL SESSION 6

THE SCOPE OF MINIMALLY INVASIVE TECHNIQUES

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of surgery in different ambulatory units and patients have a legal right to choose to have their surgery done in any institution they prefer. For this reason there is an increased tendency of patients being operated in ambulatory units not being close to home. Having a good hotel facility seems to become a good argument for getting more patients to a specific unit.

However, organized and formally established hotels for ambulatory surgery patients did not appear in Norway until 1999 and 2000 when the university hospitals in Bergen and Oslo opened their hotels. Since then there has been a rapid increase in hotel establishment with most of the bigger hospitals. Many smaller hospitals have made agreements with a local tourist hotel for using some rooms or a part of the hotel as a hospital hotel.

The organization of these hotels has been to have rooms designed for a patient and an adult accompany in a separate bed. Patients have access to a restaurant or room service as in any other well equipped hotel. The rooms have been spacious; with minibar, bathroom, TV and easy communication with a 24 hrs staffed reception desk. In some places the reception desk have been staffed with medical skilled personnel, in others not. The intention is not to have medical facilities and personnel standby in the hotel, but rather to have good logistics for bringing them rapidly in when needed. The hospitals hotels are mostly run by private hotel organizations on a contract and surveillance of the hospital.

To have an adult escort staying together with them have been a mandatory requirement for ambulatory patients for going to the hospital hotel. Further, the patients should not have ongoing infections, dressings needing special care or other issues known to be in need of professional health care assistance when they are discharged to the hotel.

So far, the experience with this system is good; no mortality has been reported from these hospital hotels and serious problems are very rare. These units have an increasing popularity and their number is expected to increase further. Many places the hotels are also used for other than ambulatory patients: post-delivery women, cancer patients on chemotherapy, elective patients admitted for tests or diagnostic procedures, as well as being used as an all-purpose place to host guests, short-term employees or students at the hospital. There is an ongoing discussion on how running these hotels should be financed, and also if there should be an option to include active medical treatment from health personnel into parts of the hotel.

SELECTION CRITERIA FOR LAPAROSCOPIC DAY SURGERY

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Laparoscopic surgery is the most significant advancement in the field of surgery over the past 15 years. This minimal access approach has been widely embraced and adopted to many common operations. Demonstrated benefits include decreased post-op pain, shorter lengths of inpatient hospitalization, increased patient acceptance, and a more rapid return at work.

Day Surgery procedures, are the most important "revolution" of these last years in surgery. This type of approach, extended to most of all general surgery's interventions, can be adapted, with specific consideration, to the Laparoscopic Surgery.

According with the Quality Health Outcomes Model developed by Mitchell, we have to take care about surgical intervention that we can approach with Laparoscopic model, and, consequently, selection criteria for patients candidates to that intervention.

We made this criteria based on cross-selection of Day Surgery inclusion criteria and Laparoscopic Surgery inclusion criteria.

It is the sequents:

- Good condition of health or in steady state pathologic and therapeutic phase (ASA) first two classes are considered ideal candidates.
- The age (the limit is not absolute).
- The weight, just like traditional surgery, is an important factor and so it has to be carefully evaluated.
- Associated pathologic conditions, like cardiopathy, BPCO, coagulopathies.

With laparoscopic approach, we can made most of general surgery's procedures like inguinal hernia repair, appendectomy, colecistectomy, adhesiolysis, hiatal hernia repair (fundoplication) and obesity surgery (gastric banding).

The aim of the Laparoscopic approach in Day Surgery is not the simple reduction of hospitalization, but is the sensible reduction of patient's discomfort.

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Muchos años han transcurrido desde los inicios de la endoscopia, donde se practicaba con fines exclusivamente diagnósticos, hasta nuestros días.

Actualmente, la relevancia y utilidad clínica de la endoscopia ha experimentado un crecimiento directamente proporcional al avance de las modalidades terapéuticas, por lo que hoy día se ha convertido en una técnica con una doble acepción, diagnóstica y terapéutica.

La importancia terapéutica es tal, que permite, en no pocos casos, ser una técnica complementaria o alternativa a la cirugía. Además, es importante considerar que la tasa de éxito de estos procedimientos suele ser alta y la tasa de complicaciones no es elevada. Estos hechos han permitido reducir la morbimortalidad de los pacientes al evitar la práctica quirúrgica, ha disminuido la estancia hospitalaria y, en consecuencia, ha conseguido reducir el coste sanitario. Diversas técnicas se han desarrollado en la endoscopia terapéutica. Entre ellas, cabe destacar los procedimientos más clásicos como la polipectomía de lesiones de diverso tamaño situadas en cualquier tramo intestinal (principalmente a nivel colónico o gástrico), permitiendo, además la toma de biopsias o macrobiopsias para estudio anatomopatológico, cuyo resultado pueden impedir la decisión quirúrgica de lesiones inicialmente sospechosas de malignidad.

Igualmente, el tratamiento con Argon Beam de lesiones angioplásicas ha permitido el control de los pacientes y eludir así la opción quirúrgica, que, en gran parte de los casos, no es definitiva, debido a que suelen aparecer de forma múltiple.

Un avance muy importante, que se ha convertido en una clara alternativa a la cirugía, ha sido el tratamiento endoscópico de los pacientes con hemorragia digestiva alta, una de las causas más frecuentes de urgencia hospitalaria. La endoscopia puede permitir el tratamiento de la lesión causal, ya sea de origen ulceroso (mediante terapia química y mecánica, combinada o no), varicoso (agentes esclerosantes o colocación de bandas), o de otras etiologías.

No menos importante ha sido el avance en las técnicas endoscópicas en el tramo digestivo esofágico. Actualmente es posible la dilatación de estenosis benignas (de origen péptico, cáustico, secundarias a radioterapia o estenosis tras cirugía), dilatación de pacientes con achalasia de cardias, tratamiento endoscópico antirreflujo (mediante distintos procedimientos: Endocinch, Enteryx, Stretta, GateKeeper...), tratamiento de fístulas bronquioesofágicas (inyección de cianocrilato o por coloca-

ción de prótesis) o el tratamiento paliativo de la disfagia tumoral.

La vía bilio-pancreática ha sido una de las principales beneficiadas de los adelantos en la terapéutica endoscópica. La realización de una CPRE puede excluir la existencia de un proceso neoplásico tipo ampuloma y, por tanto, evitar el acto quirúrgico; permite el drenaje de la vía biliar mediante la realización de esfinterotomía y la introducción de un balón de Fogarty o una cesta de Dormia para la extracción de material litiasico y; la colocación de prótesis plásticas para asegurar dicho drenaje o de prótesis metálicas autoexpandibles recubiertas o no en procesos neoplásicos.

Otro aspecto que debemos destacar es el tratamiento endoscópico de las hemorroides internas mediante fotocoagulación o, generalmente, colocación de bandas elásticas, que se constituye en una técnica sencilla, segura, barata y con una tasa de éxito superior al 90-95%, evitando la realización de cirugía.

Un campo muy importante a considerar, como se ha mencionado en distintos apartados con anterioridad, es el tratamiento paliativo de los tumores digestivos mediante la colocación de prótesis plásticas o metálicas autoexpandibles, según el caso. Hasta hace poco tiempo, el tratamiento de estos pacientes se realizaba mediante tratamiento quimioradioterápico, de escasa-nula eficacia, o mediante cirugía, asociada a una no desdeñable tasa de morbimortalidad. El tratamiento endoscópico mediante la colocación de prótesis en pacientes con tumores esofágicos, obstrucción neoplásica en la salida gastroduodenal, tumores que impiden el drenaje biliar o neoplásicas colónicas no quirúrgicas ha supuesto un considerable cambio en el manejo terapéutico de estos pacientes. Estos procedimientos logran evitar una cirugía en pacientes, que debido a sus características, se consideraría de alto riesgo, permitiendo una mejora de la calidad de vida en un grupo de individuos con una esperanza de vida muy limitada. Además, en el caso de las neoplasias colónicas que producen cuadros obstructivos posibilitan una descompresión colónica temporal, como puente a la cirugía, evitando la colostomía y una segunda intervención reconstructiva.

Por último es importante resaltar el papel que están teniendo técnicas de reciente instauración como la Ecoendoscopia, que permite, entre otras indicaciones, la punción de lesiones no filiadas y la posibilidad de realizar abordajes transhepáticos para la canulación de la vía biliar en pacientes con CPRE no efectiva. Otras, más novedosas, como la mucosectomía permite el abordaje de distintas lesiones, como el esófago de Barrett, lesión precancerosa del adenocarcinoma esofágico.

Como conclusión, podemos afirmar que el avance de la terapéutica endoscópica ha permitido reducir el número de intervenciones quirúrgicas y la tasa de complicaciones, con un porcentaje de éxito elevado.

BODY CONTOURING IN DAY SURGERY**Bartholomeusz H.***Plastic Surgery, Australia*

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Procedures for contouring various areas of the body have been performed by Plastic Surgeons for many decades. Traditionally these procedures have involved general anaesthesia and inpatient hospital stays for many days. Over the last six years I have performed a wide range of these extensive procedures in my own day hospital facility.

This paper discusses the holistic approach to patient care that enables these procedures to be performed safely in a day surgery setting.

Discussion includes the pre-operative education of the patient as it relates to alleviation of patient anxiety for the procedure. Anaesthetic and surgical intra-operative details are outlined and the post-operative care of the patient is given special attention.

Pictorial representation of various procedures serves to highlight the wide range of operations that can be safely performed. I therefore encourage all surgeons in this field to consider choosing ambulatory surgery centres for these procedures.

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LAPAROSCOPIC FUNDOPLICATION AND SURGERY FOR MORBID OBESITY PERFORMED AS DAY SURGERY?**Funch-Jensen P.***Dept. of Surgical Gastroenterology L, Aarhus University Hospital, DK-8000 Aarhus C, Denmark.*

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Surgery for gastroesophageal reflux and morbid obesity has increased during the last decade. Especially obesity surgery has almost increased explosively due to the "obesity epidemic" in the Western World.

This fact makes it particularly important to consider the procedures as subject for day surgery, due to the significant impact on costs.

The prevailing condition for accomplishment of the procedures on day surgery basis is sufficient pain control. Furthermore, as ambulatory surgery often will imply that postoperative complications arise at home, considerations of – especially pro-

cedure specific – complications are important as well.

LAPAROSCOPIC FUNDOPLICATION

Gastroesophageal reflux disease (GORD) is one of the most common GI disorders. The treatment comprises three steps: general advice, pharmacotherapy, and surgery. For patients with chronic disorder (around half of the patients) the options are lifelong pharmacotherapy or surgery. Drug therapy is very efficient in GORD. However, in younger patients, and in patients who fail to respond to medical therapy, surgery may be the treatment of choice. Furthermore, cost benefit studies have proven surgery to be advantageous over pharmacotherapy.

Antireflux surgery can be performed equally well via the laparoscopic route as compared to open surgery, and today open procedures are only made in cases where laparoscopic procedure is not possible.

In a consecutive series of 30 patients we aimed to perform laparoscopic fundoplication on day case basis. The procedure was either a Nissen plasty (with division of the short gastrics) or a Toupet procedure (without division of the short gastric vessels). The patients were thoroughly informed about the procedure, and instructed about dismissal from the clinic no later than 5 o'clock p.m.

The patients were scheduled with starting time no later than 11 o'clock a.m. Mean operating time was 90 minutes (range 40 – 140 minutes). No pre-operative complications were observed, and none were converted into open surgery.

Sixteen out of 30 patients could be dismissed on the same day. The remaining fourteen patients were sent home the day after surgery, except one patient who stayed in hospital until day 4. This patient had continuing pain, and a hematoma was found in the Teres ligament at diagnostic laparoscopy the day after surgery.

Out of 30 patients 18 had the surgical procedure finished before noon. Out of these patients 16 could be sent home on the day of surgery, whereas two of these patients were dismissed on day two.

The patients were followed for the next two weeks by means of a diary where the patients every day gave information on dysphagia, pain, fatigue, and mobilization.

The data on day by day median pain (scale 0 – 3) appears from the table below:

It is concluded that laparoscopic fundoplication can be performed on day surgery basis, but that the procedure should be done early with a minimum of 5 hours recovery in the Clinic.

Albeit it is possible to do, other factors should be kept in mind as well. Postoperative paraesophageal herniation is a serious complication that may occur in up to 5 % of the patients, usually within the first days after surgery. Most often this complication occurs when the patient vomits. This

fact makes it important to omit drugs promoting vomiting, e.g. morphine. One way of omitting morphine is to establish an epidural catheter; this regimen makes it more difficult to do the operation as day surgery. The risk of serious postoperative complications is probably the reason that ambulatory fundoplication is not yet widely distributed.

OBESITY SURGERY

There are many different procedures for morbid obesity. The most common techniques are gastric bypass and application of an adjustable gastric band.

The first procedure has been most widespread in USA, whereas banding has been more employed in Europe and Australia. Probably banding will find its area of indication in patients with BMI < 50, and gastric bypass in patients with BMI > 50.

Both procedures can be done laparoscopic, although bypass surgery is still done open in a number of Centers. Bypass surgery comprises the construction of two anastomoses. This renders a risk for anastomosis insufficiency: On the first postoperative days due to construction failure, and on day 4-10 due to ischemia with secondary burst of the anastomosis. This fact is probably responsible for the only sporadic use of gastric bypass on ambulatory basis. Personally I have no experience on gastric bypass as a day surgical procedure.

Gastric banding could ideally be done as an ambulatory procedure, and this is well described in the literature.

In my department we only have experience with banding in 124 patients. Our regimen has been the use of epidural analgesia in the first 100 cases. In a series of patients we have subsequently demonstrated that this is unnecessary, and our current status is now to do the procedure and send the patients on the hotel facility of the hospital. At the same time we register pain, fatigue, PONV, and mobilization. Our plan is to commence banding procedures on day surgery basis from September this year, provided that our current data collection – in accordance with the literature – prove satisfactory.

In conclusion: Surgery for gastroesophageal reflux disease can be performed on ambulatory basis, provided that special attention is directed towards early procedure specific complications.

Gastric banding for obesity can ideally be carried out as a day surgical procedure, whereas laparoscopic gastric bypass on ambulatory basis still is investigational.

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BIOSURGERY AS A NEW TOOL IN AMBULATORY SURGERY

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External Shockwave Therapy (ESWT) was developed after IWW from different European Scientific Centers, being the first representative technique lithotripsy. With biological experimentation it was evident that many mammals tissue reacted to those physical force and today there is consensus that shockwave induce a concatenation of biological response from different tissues ending in a newest repair capability. Main indications for this type of treatment includes Non-union or Delayed union, Tendinosis (Rotator cuff intra-substance tears, rotator cuff calcified tendinosis, tennis elbow, Achilles tendinosis, Patellar (" jumper-knee "), Fasciitis Plantaris), and latest reports indicate that researchers have found important advances in Osteochondritis / Avascular Bone Necrosis. Because an important characteristic of SW, induces "neo-vascularization with muscularized neo-vessels", today it is investigated and applied in cases of myocardial infarction and initial results are promising.

SW mechanism induce, at first stage, "membrane porous" during nanoseconds while diffusion and osmosis occurs, then you can find cellular colorants or cytostatic drugs into the cells about minutes ; secondly, this "tremor" of the cell's membrane release growth factors, many of them remains in a "latent form" in and out of cells. In the lab, currently it is possible to identify the "TGF superfamily cascade", VEGF, iNOS, and surprisingly in many species there is a development of stem-cells, which final end and function it is going to be orientated to solve the affliction treated. So for instances, in non-union cases we can see that after a short period of time (6 – 8 weeks) besides a subsidence of pain, patients relate more comfort and confidence in function and x-rays or CT-Scan show initial phases of consolidation that normally involves all the non-union area, using 4000 impacts / 0,33 mJ/mm². The same single dosis, induces resorption of Calcified Shoulder Tendinosis in the Shoulder, about 7 of 10 times during the next 8 to 12 weeks.

Histological survey depict this neo-vascularization as a main-corner in the subsequent chain-of-events, revealing that associated to this finding, appears new cells with better biochemical properties, controlling apoptosis and repairing debris areas. All of this it is reflected by clinical healing in our out-patients and imagenologic studies done reveals the healing processes.

Because disease's locations and range&dosis of SW, we need to apply this particular kind of treat-

ment under Ambulatory Surgery indications ; a sedated patient, in ambulatory OR under Anesthesiologist surveillance, represents the safest way to treat patients. SW has no report of complications when properly administered to, but many times aged or damaged people requires a deep transitory care to be able to receive this new technology.

To date, we work with 2 Orthopaedic Devices (Orthospec/Medispec) and one Dornier Compact Alpha; our experiences includes 750 treatments & observations done, following ISMST / ISF indications, in order to get a coherent experience.

It will be show actual indications, numbers and cases available, histological correlations and new trends in Orthopaedic Shockwaves solved with concourse of Ambulatory Surgery.

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PARALLEL SESSION 7

OFFICE-BASED SURGERY

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OFFICE BASED SURGERY - "DESIGN AND STANDARDS. ACCREDITATION GUIDELINES"

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Office based surgery in specifically designed and constructed facilities attached to medical practitioners' consulting rooms has not developed in Australia up to the present time, although there is potential for approximately 25% of all procedures, mostly minor operations/procedures, to be carried out in these facilities.

In 2001 the Australian Day Surgery Council prepared Guidelines for the Accreditation of Office Based Surgery Facilities. It is essential that high standards of quality and safety are provided and some of the most important recommendations in the Guidelines will be emphasised.

The design of these facilities should be simple with emphasis on safety, quality, function and cost efficiency. A model design based on an existing facility in Sydney will be presented followed by illustrations of its features.

The patient and financial advantages of office based surgery will be discussed with comparative cost data for ambulatory surgery centres and acute bed hospitals.

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OFFICE-BASED SURGERY: CHOICE OF PATIENTS, ANESTHESIA AND PROCEDURES

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SUGGESTED REFERENCE

American Society of Anesthesiologists' informational manual:

"Office-Based Anesthesia:

Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment".

<http://www.ASAhq.org/publicationsAndServices/physician.htm#office>

I. Administration and Facility.

II. Clinical Care

SELECTED SECTIONS (EDITED)

Procedure Selection

Procedure selection defines the types of surgical procedures that can be performed under office-based anesthesia. A review of existing state regulations and professional recommendations reveals a wide variation as to how much the state or regulating body assumes the responsibility for defining the complexity of case that can be performed, and how much is left to the practitioner to define for him/herself. For example, the regulations governing office-based anesthesia in some states have defined the level of surgical complexity based on the extent to which sedation or anesthesia is required. This ranges from Level 1 surgery, such as excision of moles, warts and cysts requiring minimal preoperative tranquilization, to Level 3 surgery, which includes procedures that would reasonably require general anesthesia or major conduction anesthesia. In other states, health care practitioners themselves establish written policies governing the specific surgical procedures that may be performed in their office. Some procedures have specific physiologic needs that the anesthesiologist should be aware of. These