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12th International Congress on Ambulatory Surgery,
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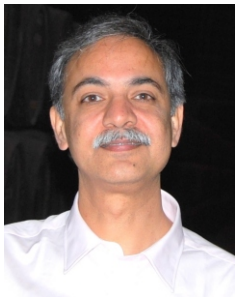
Register soon on: www.iaascongress2017.com



Adult Day Case Anesthesia- Present Day Scenario

Mangeshikar Tillottama
Consultant Anaesthesiologist.

(Continued from previous issue...)

As the sub-spatiality of ambulatory anesthesia has expanded to include the total complex care of a broad spectrum of surgical patients, practitioners have been challenged to improve their peri-operative pain management techniques. 77% of patients still experience pain peri-operatively. In outpatients, 80% of patients experienced pain after discharge, with 82% of those patients reporting their pain was moderate, severe or extreme.
Discharge criteria:

·- Awake, alert, oriented, responsive (Or return to baseline).
·- Minimal pain.
·- No active bleeding.
·- Vital signs stable (not likely to need pharmacologic intervention).
·- Minimal nausea.
·- No vomiting.
·- If non depolarizing neuromuscular blocking agent used, patient can perform 5 second head lift.
·- Oxygen saturation of 94% on room air (3 mins or longer) OR return of oxygen saturation to baseline or higher.

In order to be eligible to bypass phase 1 recovery (PACU), the patient must meet all of the above criteria, and in the judgment of the anesthesiologist, be capable of transfer to the step down unit, with apt care and facility for patient management at that location.

Summary:

Today, there is a continued trend to expand the indications for ambulatory surgery. Because outpatient anesthesia is a break from our traditional training, we are constantly being confronted with the need for change in our clinical practice patterns. We have recognized that the needs of the surgical outpatient may be very different from the inpatient and are now trying to adapt our practice patterns to meet the psychological and pharmacologic requirements of the compacted peri-operative management, the outpatient receives.

Daycare Surgery for Breast cancer

Bose SM
Former Prof. & Head of Surgery, PGI, Chandigarh,
Former President: Association of Surgeons of India. Indian Association of Surgical Gastroentrology.

Medical science has made spectacular progress during the last quarter of century by undertaking a number of novel steps; daycare surgery is one of them.

Shorter hospitalisation has been recommended for minimising nosocomial infection, to cut down the expenditure and also to have a large patient turnover in the hospital or nursing homes. I have been exposed and practicing short hospitalization for quite sometime now but did not have the chance of undertaking daycare surgery (hospitalization for less than 20 hours) for major procedures.

I have spent 37 years in PGI, a premier government institute with great rush of patients; the trend over here has always been to investigate the patient completely, to get his pre-anaesthesia check up carried out through the out-patient department, and when everything is cleared for surgery, then to admit the patient and undertake surgery the very next day. An attempt was made to keep the post-operative hospitalisation to bare minimum. Daycare surgery procedures were restricted to minor operations undertaken under local anaesthesia only. There was natural hesitation to undertake daycare surgical procedures involving major operations or operations under general or spinal anaesthesia; the major reason for not opting for daycare surgery was lack of domiciliary medical support system, non-availability of satisfactory emergency medical care, unhygienic environment in the house, inability of the relations to understand and carry out basic medical jobs like proper administration of prescribed medicines, etc. We, therefore, always hesitated from such

practices. The patient and his relations were probably more hesitant than the doctors.

I must also admit that the hesitation was also because of lack of commitment and initiative on our part for daycare procedures as all of us were full time government employees and also, on the part of the patient, as the bed rent was not substantial.

But, once I superannuated from PGI and went into practice, my perspective changed gradually. It is said that necessity is the mother of invention and same thing happened with me also. The patients that I started getting in my practice were obviously of better financial quality and more literate. The problem of unhygienic conditions, inability of administering the medicines as per instructions was no more there. But, I must admit that money was a major deciding factor, now my patient has to shell out a hefty sum of money for each day of his or her stay in the corporate hospital or the nursing home, ranging from Rs. 2000 to Rs. 6000 per day; and this prompted me to take initiative and I started having the hospitalization period much smaller than what I used to have in PGI. I also found out that majority of the patients would abide by my advice, after all the room rent pinches them more than me.

My Protocol: How I do it?

Cancer breast is a topic of my interest and I manage a reasonable number of cases. I started sending selected patients to their homes in less than 20 hours after surgery. The protocol is more or less fixed to support both the patient and the surgical team. The patient gets his needful investigations and pre-anaesthesia check up carried out through the outpatient.

The patient is given all the necessary instructions, is asked to have bath (including head bath) everyday for 3 to 5 days prior to surgery with an antiseptic soap, to take a laxative in the previous night, if need be. The patient takes her regular daily medicines (for hypertension, cardiac ailments, bronchial asthma, etc.) in the morning between 6 am and 7 am with a cup of tea or milk and then is completely off oral intake till the operation time. 40 mg of Pantaprozol, 0.5 mg of Alprazolam and any other medicine prescribed as premedication are also taken.

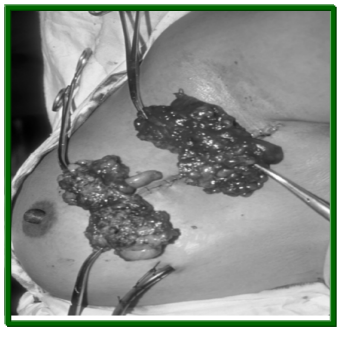
The patient reports to the hospital at about 11 in the morning, rests in the pre-operative room, intravenous infusion is started and the patient is shifted to the OT at about 1 pm. Operative procedure, modified radical mastectomy or breast conservation surgery, is carried out.

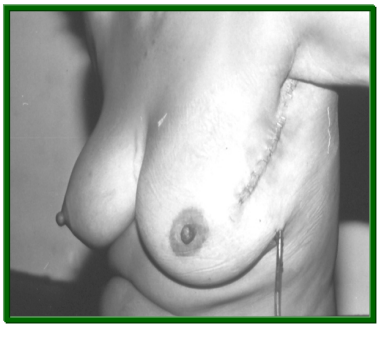
I use diathermy very liberally right after making epidermal skin incision by the scalpel and try to obtain very satisfactory haemostasis so that the blood loss is very less. Two drains are usually put in cases of MRM, one under the upper flap and the other one in the axilla, both brought out through separate stab wounds. The segmental mastectomy site is not drained, the dead space is filled up by rotating local breast tissue and the axilla is drained. I try to close the lower part of the axilla by stitching the axillary fascia to the chest wall and this decreases the axillary drainage.

Gentle handling of the tissue and good aseptic measures are meticulously followed. The entire surgical procedure takes about 70 to 90 minutes; patient is allowed to recover fully from anaesthesia before shifting to postoperative observation area. Profofol, Norcuron, Butrum, Midazolam, Pantaprozole, Perinorm are the few drugs that my anaesthetist colleague uses routinely during the operative procedure. I usually prefer an IV dose of third generation chephalosporin at the time of induction and another dose at about 10 pm at night.

The patient is shifted to her room after three or four hours stay in the postoperative area. The infusion drip is removed at about 8 pm, having received about 2.5 L of IV fluid in total, the cannula is retained. The patient is allowed oral fluids (water, tea, juice, soup) 4 to 5 hours after completion of surgery, can take a few biscuits or bread piece in the night for dinner.

Completion of Breast Conservation Surgery:





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