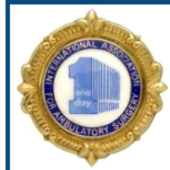
International Association for Ambulatory Surgery

NEWSLETTER

Number 3/13, November 2013

News from the President

I am pleased to report I have had a busy schedule since taking over as your President. I have visited Timisoara for a combined Executive Meeting and training event of which you will read more later in the Newsletter. I would like to take this opportunity to thank our Romanian colleagues, and Dr Florentina Cadariu in particular, for their hospitality and attendance at what was an important event for our organisation. My next trip was to Santiago de Compestela where I spoke at the close of the joint National Congress of our Spanish and Portuguese colleagues. Once again I would like to thank them for their hospitality.
I am really keen to hear more from colleagues around the world on what they are doing through their day surgery units. We sometimes hear of advances in our own countries but fail to publicise them further afield – an example was a unit in the UK that started performing laparoscopic nephrectomy as day cases several years ago – how many of us are managing this? We certainly can't in my own unit but the fact that we know it can be achieved does spur us on to be bolder in our approach. If you have information on new procedures or new technologies being used in day surgery then please write to me at President@iaas-med.com or consider submitting an article to our Journal.

Ian Jackson, President

International News

Training Workshop – Timisoara Romania

The IAAS Training Workshop "Day Surgery: Making it Happen – Overcoming Barriers" was held in Timisoara on September 15-16, 2013. Twenty-six participants, 20 surgeons, 3 anaesthetists, 3

doctors, 22 from Romania (Timişoara, Bucureşti, Cluj, Novaci), 2 from Hungary (Budapest), 2 from Serbia (Belgrade) took part in the Day Safe Educational Course with a dedicated session on Overcoming Barriers.
The course in Timisoara was the first step in preparing surgeons and anaesthetists, especially the younger ones, to practice ambulatory surgery through learning from experienced clinicians from the EU.
The discussions with participants were very interesting; the Romanian participants could learn about the steps made by the EU colleagues in forming and developing day surgery in their country. This way, EU physicians were able to learn and understand the favourable and unfavourable aspects of implementing day surgery in Romania and Eastern Europe.

Florentina Cadariu, local Training Workshop Coordinator

Honours and Awards

Beverly Philip M.D., IAAS Executive Committee Member and co-editor in chief of Ambulatory Surgery, has been elected Vice-President for Scientific Affairs of the American Society for Anesthesiology (ASA). As the new Chief Science Officer, she will have responsibility for all of ASA's educational and scientific activities, including research and publications, educational offerings and meetings, and clinical and subspecialty activities. Earlier this year, Beverly was honoured as the James H. Nicoll Memorial Lecturer at the 10th IAAS International Congress in Budapest. Her keynote address - The path of Ambulatory Surgery: Roots, Trees and Stars – is available to view on our website.

Spanish Association of Major Ambulatory Surgery - ASECMA

On September 26-28, the XI Spanish National Congress and the II Iberian Congress on Day Surgery was held in Santiago de Compostela. ASECMA was the host of both congresses along with the Portuguese Day Surgery Association (APCA). The general title was "The Day Surgery way, where we are and where we are going". During the 3 day congress, more than 300 day managers, nurses, anaesthesiologists and surgeons participated in round tables, conferences, face to face procedures and workshops. Over 100 abstracts were presented. The quality of the presentations was very high. Paulo Lemos, IAAS Past President opened the conference with a talk on "How to evaluate the quality

in day surgery" and Ian Jackson, current IAAS President, closed with a talk on "Patient Safety – How IT can support".
The ASECMA is developing a national registration of DSU called "DUCMA PROYECT". For more information: www.proyectoducma.com
Next events 2014:
Troya (Portugal) 18-20 May .3rd Iberian Congress - 8th APCA Congress
Las Palmas 2-3 October. 10th National Symposia of ASECMA
IAAS 11th World Congress, Barcelona 2015 May 10-12 .
ASECMA will be the host of the next IAAS International Congress. National and International Committees as Scientific program are in progress according to IAAS Executive Committee rules.
For more information: www.asecma.org; www.inspiranetwork.com; fax +34915470507

Fernando Docobo, ASECMA

Country report: Surgery in Germany – where and what data?

Using the new OECD definitions, an attempt is made to locate inpatient and ambulatory surgery in various surgical units (table 1). Basis for statistics are number of cases and not number of accounted procedures because procedure-based statistics result in numbers 2 to 3 times higher than case-based statistics and reflect only requested billing. As no statistics are collected in "surgery records" any more, almost all statistical data nowadays originate from accounting records.
For inpatient treatment, accounting is usually based upon DRG accountings. But for the ambulatory sector no DRGs in Germany exist yet. The fee schedules include: 1. EBM, a unitary fee schedule for Social Health Insurance SHI; 2. GOÄ, a fee schedule for privately insured people; 3. UV-GOÄ, a fee schedule for the Statutory Accident Insurance DGUV; and 4. private contracts (Selektivverträge) of individual sickness funds of SHI.
For years the German Association for Ambulatory Surgery (BAO) did not succeed in getting data on ambulatory surgery from the EBM, although they reflect the greatest part of ambulatory surgery (table 1). With the help of IAAS and its immediate-past president, Carlo Castoro, the German Ministry of Health could be convinced that these data are necessary for the IAAS survey on surgical statistics. We recommend using IAAS influence when it is difficult to get national statistical data.

Table 1: Data on surgical cases in various surgical units and sources for statistics 2011

Inpatient cases	
Most hospitals, so-called DRG-hospitals. DRG statistics	6.962.712
Surgical cases in hospitals of Statutory Accident Insurance (DGUV). No statistics	**?**
Total inpatient cases	**6.962.712**
Ambulatory cases	
Day cases (hospital KG 2 statistics)	1.864.222
Outpatient cases (statistics of EBM = doctors' fee scale)	**3.921.978**
Day cases (hospital) and outpatient cases of privately insured people (no statistics available. Estimation on the basis of 10 % of population)	578.620
Cosmetic surgery (private, estimated)	500.000
Outpatient cases paid for by private contracts of SHI. No statistics available	**?**
Outpatient cases of Statutory Accident Insurance (DGUV). No statistics available	?
Total of day cases (hospitals) and outpatient (day clinics)	**6.864.820**
Total surgical cases (inpatient, day cases, outpatient)	**13.827.532**
Percent ambulatory surgery	50 %

Jost Brökelmann, BAO
German Association for Ambulatory Surgery – BAO

Hot Topics in Day Surgery

Ambulatory Surgery and Anaesthesia striving for optimal safe and effective practice; *Preventive Multi-modal pain and PONV management – not lack of evidence but sometimes forgotten?*

Postoperative nausea and vomiting is still not uncommonly seen and it is a joint commitment to implement practices in order to reduce its occurrence. The Apfel PONV risk score[1] has long been

available and it is helpful identifying patients at risk. Multimodal prophylaxis and preventive manoeuvres should be instituted accordingly. The classical paper published in NEJM[2] already in 2004 evaluating the effects of 1, 2 or 3 drug prophylaxis provides simple but safe and effective advice for multi-modal PONV prevention. Apfel et al[3] have also provided a simple identifier for post discharge nausea and vomiting that can help to provide patients at risk for PDNS with take home medication in order to reduce occurrence and severity. They identified five independent predictors (odds ratio; 95% CI): female gender (1.54; 1.22 to 1.94), age less than 50 yr (2.17; 1.75 to 2.69), history of nausea and/or vomiting after previous anaesthesia (1.50; 1.19 to 1.88), opioid administration in the postanaesthesia care unit (1.93; 1.53 to 2.43), and nausea in the postanaesthesia care unit (3.14; 2.44-4.04). Thus, not only PONV prophylaxis but also a preventive multi-modal analgesia concept is strongly recommended in order to reduce postoperative pain. The safety and effectiveness of opioid sparing multi-modal pain management has recently been reviewed [4]. Structured procedural specific preventive PONV and pain should be a basic part of the ambulatory surgical perioperative care.
Single i.v. dose of dexamethasone has been shown seemingly effective as one of the cornerstones in triple PONV prophylaxis[5] and De Olivera et al recently made an update meta analysis supporting its benefit[6]. Increasing the dose provides additional benefit in having analgesic effects. A meta-analysis published in Anesthesiology 2011[7] concluded that dexamethasone at doses more than 0.1 mg/kg is an effective adjunct in multimodal strategies to reduce postoperative pain and opioid consumption after surgery. The benefits are seemingly outweighing the potential risks. The increase in blood glucose associated with the administration of dexamethasone has also recently been addressed and "re-assessed" by Professor Sessler and his group in US[8]. Treatment of intraoperative hyperglycaemia should account for the hyperglycaemic surgical stress response trend depending on the stage of surgery as well as the added effects of steroid administration. Denying steroid prophylaxis for postoperative nausea and vomiting for fear of hyperglycaemic response *should be reconsidered* given the limited effect of steroids on intraoperative blood glucose concentrations. The preoperative administration of the drug produces less variation of effects on pain outcomes.
De Olivera's group has also recently published an updated Meta Analysis on low dose metoclopramide, an old, cheap and well-establish drug[9]. They concluded that metoclopramide 10 mg i.v. is effective to prevent PONV in patients having surgical procedures under general anaesthesia. Metoclopramide seems to be a reasonable agent to prevent PONV. Nutall et al recently published a paper in Anesthesiology[10] supporting the safe use of low dose droperidol for PONV prophylaxis. They conclude that low-dose droperidol does not increase the incidence of polymorphic ventricular tachycardia or death when used to treat postoperative nausea and vomiting in the surgical population. There are obviously several safe and effective drugs that can be used, combined more or less on a complete regular basis to combat of the occurrence of postoperative nausea and vomiting. Thus, it seems a reassuring number of available drugs and evidence for their safe and effective use is available. However, there is not always consistent and structured adherence to evidence medicine. Frank et al found in a study in Germany that these simple and safe basic guidelines are not fully implemented – adhered to, suggesting *there is room for improvement[11]*. This was also the conclusion made by over past president Professor Paulo Lemos in his presentation during the European Anaesthesiology Society meeting in Barcelona June 2nd 2013.

[1] Apfel CC, Läärä E, Koivuranta M et al (1999) A simplified risk score for predicting postoperative nausea and vomiting: conclusions from cross-validations between two centers. Anesthesiology 91:693–700.

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[3] Apfel CC, Philip BK, Cakmakkaya OS, Shilling A, Shi YY, Leslie JB, Allard M, Turan A, Windle P, Odom-Forren J, Hooper VD, Radke OC, Ruiz J, Kovac A. Who is at risk for postdischarge nausea and vomiting after ambulatory surgery? Anesthesiology. 2012 Sep;117(3):475-86.

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[6] De Oliveira GS Jr, Castro-Alves LJ, Ahmad S, Kendall MC, McCarthy RJ. Dexamethasone to prevent postoperative nausea and vomiting: an updated meta-analysis of randomized controlled trials. Anesth Analg. 2013 Jan;116(1):58-74.

[7] De Oliveira GS Jr, Almeida MD, Benzon HT, McCarthy RJ. Perioperative single dose systemic dexamethasone for postoperative pain: a meta-analysis of randomized controlled trials. Anesthesiology. 2011 Sep;115(3):575-88.

[8] Abdelmalak BB, Bonilla AM, Yang D, Chowdary HT, Gottlieb A, Lyden SP, Sessler DI. The hyperglycemic response to major noncardiac surgery and the added effect of steroid administration in patients with and without diabetes. Anesth Analg. 2013 May;116(5):1116-22.

[9] De Oliveira GS Jr, Castro-Alves LJ, Chang R, Yaghmour E, McCarthy RJ. Systemic metoclopramide to prevent postoperative nausea and vomiting: a meta-analysis without Fujii's studies. Br J Anaesth. 2012 Nov;109(5):688-97.
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[11] Franck M, Radtke FM, Baumeyer A, Kranke P, Wernecke KD, Spies CD. Adherence to treatment guidelines for postoperative nausea and vomiting. How well does knowledge transfer result in improved clinical care?. Anaesthesist. 2010 Jun;59(6):524-8.

Jan Jakobsson, MD, PhD, Adj. Professor Anesthesia & Intensive Care
Karolinska institutet, Stockholm, Sweden

Day Surgery: Making it Happen

Training Workshops and Training Needs Assessment

The IAAS has organised 2 more training workshops in Eastern Europe open to surgeons, anesthetists, nurses and managers on organizational models and best practices of day surgery. Course content will draw on the experience of leading Day Surgery and Day Services throughout Europe and North America with the aim to provide evidence-based solutions adaptable to the different local situations.

Workshop dates and venues

November 22-24 — Kolarovo, Slovakia
December 5-7 — Belgrade, Serbia

For more information, click here

Help the IAAS identify the training needs in Ambulatory Surgery. Please take a few minutes to complete the short survey found on our website. The IAAS invites everyone interested in Day Surgery to take our survey. It will assist us in providing an exciting and useful program for future workshops.
To take our survey, click here

These workshops arise from the IAAS 2013 WORK PLAN EASTERN EUROPEAN YEAR, which has received funding, in the form of an operating grant, from the European Union, in the framework of the Health Programme.

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Ambulatory Surgery – Volume 19.4

Survey on incidence of surgical procedures and percentage of ambulatory surgery in 6 European countries.
JD Brökelmann & C. Toftgaard
Day surgery laparoscopic cholecystectomy: comparative analysis in two consecutive periods in a cohort of 1132 patients
F. Docobo Durántez, M. Arance García, A. Navas Cuéllar, J. Mena Robles,J.M. Suárez Grau, F.J. Padillo Ruiz
Patient Perspectives of Noise During Minimal Sedation Procedures
K. Sanniec & M. Gellis
Anterior-Apical Mesh Repair System in an ambulatory setting
D.Sinhal, J.Iyer, M.Mous, R.Muller, A.Rane

Newsletter and Journal survey

Did you enjoy this newsletter? What do you think about our Journal Ambulatory Surgery?
Please let us know by taking our short survey. Thank you!
For the Newsletter: **http://tinyurl.com/oobo6sr**
For Ambulatory Surgery: **http://tinyurl.com/oqm73vv**

Carlo Castoro, Newsletter Editor-in-Chief
Email: editor.iaasnewsletter@iaas-med.com
Paulo Lemos Portugal, Beverly Philip USA, Ian Jackson UK, Co-Editors
International Association for Ambulatory Surgery IAAS
President: Ian Jackson
IAAS registered address: Tichelrei, 1 B-9000 GENT (Belgium)
Email: iaas@iaas-med.com
IAAS registered Number 0458.707.654
Internet: www.iaas-med.com