Symposium Report
Outpatient anaesthesia

Introduction
Between 40 and 50% of all surgical procedures may be performed on an outpatient basis. It is imperative for the anaesthetist to provide the best anaesthetic care for outpatients to facilitate their return to daily living and care. The symposium was divided into four parts: Which patients? Which procedures? Which anaesthetic technique? and What are the particular problems in paediatric outpatients and in recovery room?

Dr. Duncan described the types of patients and the different procedures which were suitable for outpatient surgery. Age and prolonged duration of outcome do not have a bearing upon outcome. Furthermore, an increased complication rate with ASA III patients has not been demonstrated. Different types of specific procedures are acceptable for outpatient surgery, and are constrained only by the need for an uncomplicated postoperative course.

Dr. Chung discussed the best anaesthetic techniques for ambulatory patients. Clear fluids are allowed until three hours before the scheduled time of surgery. Propofol is now playing an important role as an outpatient general anaesthetic agent. We should be aware that conscious sedation has the highest overall complication rate in outpatient surgery and regional or local anaesthesia the lowest.

Dr. Hannallah discussed the selection of patients for paediatric outpatient surgery. Special consideration should be given to children with running noses and heart murmurs. All ex-premature infants less than 50 wk post-conceptual age should be admitted to hospital so that they may be monitored after surgery for possible apnoea, bradycardia, and oxygen saturation.

Dr. Wetchler discussed the problems of pain, nausea and vomiting, and post-intubation croup in the recovery room. The anaesthetist must assume an active role in recovery room problem solving and in the discharge of outpatients, or we will find more of our patients than necessary facing unanticipated hospitalization following an outpatient procedure.

Outpatient anaesthesia will play an ever-important role in the decade of the nineties. Our commitment will be to "zero defect" outpatient anaesthesia to 'facilitate the patients' return to their daily living and function, and increase satisfaction with their anaesthetic.

Key words
OUTPATIENT ANAESTHESIA

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douleur, nausée et vomissement et du croupe post intubation en salle de réveil. L’anesthésiste doit assumer un rôle actif vis-à-vis des problèmes en salle de réveil et pour congéder les patients externes sinon on devra faire face à une augmentation de l’hospitalisation non-anticipée.

L’anesthésie en externe jouera un rôle de plus en plus important dans les années 90. Notre but ultime sera d’atteindre le moins d’hospitalisation non prévue possible et de faciliter le retour des patients à leur travail et fonction journalière tout en augmentant leur satisfaction de l’anesthésie.

Day surgical anaesthesia: Which patients? Which procedures?

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It has been estimated that between 40 and 50% of all surgical procedures may be done without overnight postoperative hospitalization. The safety with which care can be provided in modern outpatient facilities, combined with cost savings inherent in providing ambulatory as opposed to inpatient services, has resulted in a growing number of procedures being mandated to be done on this basis.

In spite of the widespread development of ambulatory care services there has been relatively little critical evaluation of their outcome. Appropriate randomization of subjects between inpatient and outpatient facilities has not occurred, and many descriptive articles cover a prolonged period during which many changes occurred in both anaesthetic and surgical techniques. Large series of patients from both Canada and the USA point to the safety of the provision of care on an ambulatory basis. However, the exuberance to reduce hospital costs has resulted in this system of care being invoked for patients beyond those carefully selected in the early development of day surgical programs.

A measure of failure in a day surgical program is the need to retain an unscheduled patient in the hospital. The frequency with which this happens has been reported variously at 1% in children and 0.28–2.44% in adults – the latter ten-fold variation in complications was most likely related to patient selection and the year of service. The usual reasons for unscheduled admissions relate to persistent pain, nausea and vomiting, syncope, or surgical bleeding. Mortality related to an anaesthetic or surgical problem is distinctly unusual, with emergency or life-threatening complications estimated to occur in less than 0.007% of cases. As to morbidity necessitating admission it has been suggested that surgery is most often at fault: in the large series from Vancouver, admissions occurred for surgical reasons in 0.22%, and for anaesthetic reasons in 0.07%. It should not be forgotten that the patient may also be a direct cause, because the lack of an appropriately supportive social environment may necessitate hospitalization and be perceived as failure of the day surgery system.

Which patients?
The acceptability of patients to a given ambulatory facility will often depend upon the infrastructure in that medical community. The dedication of day surgery units to safety and cost-effectiveness often implies community support resources, the absence of which would preclude ambulatory services. It is impossible, therefore, to generalize completely the recommendations of other units to your own. For example, if responsible home support is lacking, or if transportation distances to obtain postoperative medical assistance are excessive, inpatient care is recommended. Similarly, if the patient is either unable or unwilling to comply with postoperative instructions, acceptance to the day surgical program should be denied.

The descriptive studies referenced have demonstrated several factors that do not have any bearing on outcome. For example, when outcomes are assessed by recovery times or incidence of unscheduled admissions, age does not have a bearing upon outcome (except for premature babies). Similarly, prolonged anaesthesia does not seem to be a factor, although late recoveries may pose problems for day-surgery staffing. Finally, although most peer-reviewed series have included predominantly ASA I and II subjects, an increased complication rate with ASA III subjects has not been demonstrated. Indeed, with modern drugs and surgical techniques, patients with well-controlled systemic disease are more likely to experience complications related to the surgical procedure than from concurrent medical problems.

There are several types of patients who should not be offered the option of ambulatory care. These include:
1. Non-optimal management of medical disease (ASA III and IV)
2. Malignant hyperthermia