



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

SAMBA's Future to Be Ruled By Committee

By Frances Chung, M.D.
2003-04 SAMBA President

The main mission of SAMBA is to advance the study of ambulatory anesthesiology, contribute to its growth and influence, encourage specialization in the field of ambulatory anesthesiology and encourage high ethical and professional standards by fostering and encouraging research, education and scientific progress in the specialty.

In order to elevate the quality of patient care in ambulatory anesthesiology, evidence-based outcomes research is necessary. SAMBA, the leader in ambulatory anesthesiology education and research, is pleased to announce the Society's second Outcomes Research Award. SAMBA is making \$150,000 available over a two-year period for the award.

This is the second time that SAMBA will present a grant to fund outcomes research in ambulatory anesthesiology. The recipient of the Society's first Outcomes Research Award is Lee A. Fleisher, M.D., Baltimore, Maryland, for his research on "Outcomes in Ambulatory Anesthesia Related to Location of Care."

The Outcomes Research Award will catalyze high-quality research in ambulatory anesthesia, thus elevating the quality of our patient's care. Preferred outcomes-oriented research topics are the investigations that will potentially yield results applicable to many patients who undergo ambulatory anesthesia.

Physicians who wish to receive a complete copy of the request for proposal and an application for the Outcomes Research Award should contact the SAMBA Office or download the information from the Society's Web site at <www.sambahq.org>. The application submission deadline is January 15, 2004.

Visit

<www.sambahq.org> to
learn about SAMBA's
E-newsletter
'SAMBA Talks'

With the continuing proliferation of Internet technology, electronic communication is a very important link in our busy daily lives. The Subcommittee on E-newsletter, under the leadership of Chair Mary Denise Daley, M.D., and Vice-Chair Gareth S. Kantor, M.B., have done a great job with the monthly SAMBA E-newsletter "SAMBA Talks." The subcommittee's tasks include reviewing the literature on a regular basis, liaising with the SAMBA leadership and other SAMBA committees to ensure the timely dissemination of information related to events within the Society and directing the interactive "Professional Discussion" section in "SAMBA Talks." The committee members are: Dr. Daley, chair; Dr. Kantor, vice-chair; Juan Carlos



Frances Chung, M.D.

Duarte, M.D.; Daniel T. Goulson, M.D.; Suhas V. Kalghatgi, M.B.; J. Lance Lichtor, M.D.; Alonso Mesa, M.D.; Melinda L. Mingus, M.D.; Terri G. Monk, M.D.; Brian M. Parker, M.D.; and Beverly K. Philip, M.D.

These dedicated SAMBA members work extremely hard to bring you up-to-date information every month, and SAMBA is very grateful for their contributions.

In other wonderful news, our Spanish electronic version of "SAMBA Talks" is now available online thanks to the great translation effort by Dr. Duarte.

SAMBA is looking at new ways to better serve its members. If you have any suggestions or comments, please send me an e-mail at <frances.chung@uhn.on.ca>. Your suggestions or comments are always welcome. 

SAMBA Learning to Speak New Languages

SAMBA has made enormous overall strides, and its international presence continues to grow. SAMBA is working toward expansion of high-quality ambulatory anesthesiology practice worldwide. One of the steps in this process is disseminating the current literature, which may not be accessible to ambulatory anesthesiology practitioners in many countries. Such dissemination is now being accomplished by the availability of *Ambulatory Anesthesia* as well as the Web-based newsletter "SAMBA Talks." The next step is to provide this information in other languages, and we have begun this process with the completion of our Spanish version of the E-newsletter.

The efforts of SAMBA members who give their valuable time to fulfill the Society's mission cannot be overstated. I believe they serve SAMBA and compliment those who help out because they consider the ability to serve as a reward. Furthermore we value the input of all our members who share their views. I hope, however, that many more members get involved in expanding SAMBA. One of the signs of a healthy organization is

that a large number of its members share their views, critical or complimentary, to further the organization's mission.

In this issue, **Babatunde O. Ogunnaike, M.D.**, Dallas, Texas, reviews the session on preoperative screening presented last May at the SAMBA 18th Annual Meeting in Boston, Massachusetts. **Stephen A. Cohen, M.D.**, Boston, provides us with an overview of the session on discharge issues after ambulatory surgery. **Brian M. Parker, M.D.**, Cleveland, Ohio, summarizes the panel discussing the current status of day surgery in the United Kingdom.

Kumar G. Belani, M.D., Minneapolis, Minnesota, presents us with information on prevention of retinopathy of prematurity by avoiding hyperoxia and repeated episodes of hypoxia-hyperoxia in infants weighing less than 1,500 grams.

I encourage all members to attend this year's SAMBA Mid Year Meeting on Friday, October 10, in San Francisco, California, just prior to the American Society of Anesthesiologists Annual Meeting. 



Girish P. Joshi, M.D.

Be sure to attend the SAMBA Mid Year Meeting in San Francisco, California, on October 10!



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SAMBA

Subcommittee on Publications

Chair and Editor
 Girish P. Joshi, M.D.

- Kumar G. Belani, M.D.
- James B. Mayfield, M.D.
- Babatunde O. Ogunnaike, M.D.
- Brian M. Parker, M.D.
- Mary Ann Vann, M.D.
- Janet M. VanVlymen, M.D.
- Suntheralingam Yogendran, M.D.

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SAMBA Past President Happy to Witness Growing Society

By Lydia A. Conlay, M.D., Ph.D.
Immediate Past President

It has indeed been a pleasure and an honor to serve as SAMBA President. It has been a busy and productive year with a number of changes that I will detail below.

First and absolutely foremost, membership increased by 5 percent over the previous year, reversing a three-year negative trend. How nice that SAMBA is growing again! We owe our thanks to Yung-Fong Sung, M.D., Atlanta, Georgia, Chair of the Committee on Membership.

Second, SAMBA joined with the Federated Ambulatory Surgery Association and the International Association for Ambulatory Surgery to present the 5th International Congress on Ambulatory Surgery on May 8-11,

cess. The committees on Annual Meeting and Mid Winter Meeting combined to provide for better coordination for the meetings and to mentor future meeting chairs.

A number of administrative policies also were introduced. First, a process was initiated to establish a confidentiality policy regarding personal information provided by members to SAMBA. A decision was made to accept advertising (and thus advertising revenue) in *Ambulatory Anesthesia* and the SAMBA E-newsletter "SAMBA Talks." A move was instituted to change the name of the Committee on Affiliations to the Committee on Affiliations/Liaisons to better describe its functions. A Committee on Electronic Communications was established to formalize the structure in support of the SAMBA E-newslet-

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2003, in Boston, Massachusetts. This exciting mega-meeting contained a wide variety of speakers, spectacular exhibits and many attendees from around the world. The effort was chaired on behalf of SAMBA by Rebecca S. Twersky, M.D., Brooklyn, New York, and Barbara S. Gold, M.D., Minneapolis, Minnesota, and SAMBA no doubt owes them a significant debt of thanks for their hard work.

The Committee on Annual Meeting was revised this year to include members who had previously planned annual meetings for the Society. Chaired by Walter G. Maurer, M.D., Novelty, Ohio, this group conducted a comprehensive strategic review of the meetings aided by an electronic membership survey by J. Lance Lichter, M.D., Iowa City, Iowa. The resultant report provided a comprehensive analysis of past meetings and a blueprint for success for future suc-

cess, which is available monthly as a benefit for all members. In addition, a new Web site was designed and was implemented on May 31, 2003. Last but not least, the Committee on Development was asked to survey SAMBA's patrons in order to determine how this mutually beneficial relationship might be strengthened.

In summary, it has been a wonderful, busy and productive year for SAMBA, and it has been my great pleasure and honor to serve as your President. I would also like to extend my most heartfelt thanks to the SAMBA Board of Directors, our committee chairs and members and our general membership for all of their hard work during the year to help make these many accomplishments possible. With that, I turn over the reins to a most capable President-Elect, Frances Chung, M.D., Toronto, Ontario, Canada. Please note that you



Lydia A. Conlay, M.D., Ph.D.

will see her incoming "President's Message" in this edition of *Ambulatory Anesthesia*.

Thank you for this marvelous opportunity. 

**SOCIETY FOR
SAMBA ULATORY
NESTHESIA**

FUTURE MEETINGS

19TH ANNUAL MEETING

APRIL 30 - MAY 2, 2004
SEATTLE WESTIN HOTEL
SEATTLE, WASHINGTON

2004 MID YEAR MEETING

OCTOBER 22, 2004
(ONE DAY PRIOR TO THE ASA
ANNUAL MEETING)
LAS VEGAS, NEVADA

20TH ANNUAL MEETING

MAY 13-15, 2005
MARRIOTT'S CAMELBACK INN
RESORT AND SPA
SCOTTSDALE, ARIZONA

2005 MID YEAR MEETING

OCTOBER 21, 2005
(ONE DAY PRIOR TO THE ASA
ANNUAL MEETING)
NEW ORLEANS, LOUISIANA



Guidelines or Gut? Preoperative Screening in 2003

By Babatunde O. Ogunnaike, M.D.
University of Texas Southwestern
Medical Center at Dallas
Dallas, Texas

Preoperative screening was a major topic for discussion at the SAMBA 18th Annual Meeting held in Boston, Massachusetts, on May 8-11, 2003. This session was moderated by **Barbara S. Gold, M.D.**, Minneapolis, Minnesota, and covered various aspects of preoperative screening.

The presentation by **Donald M. Matthews, M.D.**, Valhalla, New York, discussed how to utilize available information to determine the appropriate preoperative testing in the current climate, including application of the American Society of Anesthesiologists (ASA) Practice Advisory on Preanesthesia Evaluation.

In her talk "Adolescent Pregnancy and Outpatient Surgery," Dr. Gold remarked that no other preoperative test raises so many medical, legal and ethical issues as preoperative pregnancy testing. She highlighted the fact that the odds of encountering a pregnant teen for ambulatory surgery is high since significant numbers of adolescents are sexually active, and more than 60 percent of all surgical procedures are performed on an outpatient basis. She began with a case of a 13-year-old girl who had a positive pregnancy test during preoperative screening for cystoscopy for urinary tract infections.

The first controversy discussed was the need for performing a pregnancy test. Dr. Gold emphasized that the incidence of unrecognized pregnancy in teenagers presenting for outpatient surgery range from 0 percent to 2.4 percent, depending upon patient demographics and preoperative inquiry. According to the ASA Task Force on Preanesthesia Evaluation,¹ history and physical examination may be insufficient for identification of early pregnancy, and pregnancy testing may be considered for all female patients of childbearing age. Malviya et al.² suggested, however, that routine pregnancy testing might

not be necessary because a detailed history regarding the last menstrual period, contraception, sexual activity and the possibility of pregnancy correlates with the results of a pregnancy test. Therefore pregnancy tests should only be done if indicated by patient history. Other authors³⁻⁵ are not in agreement with this recommendation, though, and they suggest that detailed history alone cannot be relied upon to rule out the possibility of pregnancy in teenagers and adolescents since they do not readily volunteer that they are sexually active or possibly pregnant. It is therefore recommended that pregnancy testing in adolescent surgical patients be mandatory. In a survey of anesthesiologists, Kempen⁶ found that only 20 percent of anesthesiologists perform pregnancy testing based on patient history while the majority routinely



Babatunde O. Ogunnaike, M.D.

live birth, but this was also associated with increased incidence of death within 168 hours of birth and an increased incidence of low birth weights. They could not, however, associate

... the odds of encountering a pregnant teen for ambulatory surgery is high since significant numbers of adolescents are sexually active, and more than 60 percent of all surgical procedures are performed on an outpatient basis.

performs preoperative pregnancy testing in adolescents.

Dr. Gold also discussed the harmful effects of anesthetic drugs on the developing fetus. She noted that although a survey of the literature suggests the possibility of higher rates of spontaneous abortion and teratogenic damage, a cause-and-effect association has not been conclusively proven. Mazze and Källén⁷ examined 5,405 cases from the Swedish birth registry in an attempt to define the risk of adverse reproductive outcomes after nonobstetric operations during pregnancy. The parameters examined included incidences of congenital anomalies, stillbirth, death within 168 hours of birth and low birth weights. They found an increase in the incidence of

these increased incidences with any specific type of anesthesia or surgery. Other authors found an increased risk of spontaneous abortion⁸ or an unclear association^{9,10} between birth defects and anesthesia and surgery.

It is not far-fetched to expect litigation and possible legal liability imposed on the anesthesiologist for inadvertent administration of anesthesia to a patient with undiagnosed pregnancy. There are only two cases within the past 20 years, though, in which anesthesiologists have been sued for unknowingly administering anesthesia to pregnant women. One case was settled out of court; the other was dismissed.

A pertinent issue relating to this topic is the sharing of information about a positive adolescent/underage

pregnancy test. In this regard, Dr. Gold emphasized that the laws vary between states. As of 1999, no state explicitly required the parent to consent for prenatal care.⁴ She pointed out that it is the responsibility of health care providers to report suspected child abuse. Kempen⁶ found out from 169 anesthesiologists through an anonymous questionnaire that less than 4 percent would report pregnancy in a minor to appropriate authorities even though 82 percent thought pregnancy in a minor constituted child abuse and 98 percent recognized the legal requirement to report child abuse. This suggests that the legal and more difficult issues such as child abuse are generally ignored, meaning that the results of the pregnancy test were only used to address immediate anesthetic issues (e.g., postponing or canceling the case or employment of another anesthetic technique). In Kempen's study, 33 percent of anesthesiologists had hospital policies that mandated preoperative pregnancy testing. More recently, however, Hennrickus et al.⁵ suggested that the legal and social responsibilities regarding issues of a positive pregnancy test in a minor are being channeled to the appropriate authorities.

Dr. Gold concluded that there is no standard for preoperative pregnancy testing. Mandated pregnancy testing in adolescents and women of child-bearing age is ordered by 30 percent to 50 percent of practitioners³⁻⁵ due to concerns of unreliability of pregnancy history and the possible abortive and teratogenic effects of anesthetics. In contrast opponents of mandatory testing² suggest that asking the patient in private (specifically not in the presence of parents) should generate a reliable history regarding possibility of pregnancy. State laws govern with whom a positive pregnancy test should be shared as well as the options available to adolescents.

Alec Rooke, M.D., Ph.D., Seattle, Washington, focused his presentation on the controversial area of laboratory testing in geriatric patients. He stated

that the reasons for ordering laboratory tests include screening for occult disease, assessment of perioperative risk and preoperative optimization and to determine baseline values to enhance these tests obtained intraoperatively and postoperatively. The practice of performing a battery of tests (i.e., "shotgun" approach) for screening is futile. Furthermore laboratory testing on the basis of age alone is not indicated unless history and physical examination findings suggest the likelihood of disease.¹¹

It is not far-fetched to expect litigation and possible legal liability imposed on the anesthesiologist for inadvertent administration of anesthesia to a patient with undiagnosed pregnancy.

Routine electrocardiography (ECG) to screen for cardiac disease also is inappropriate. Although abnormal ECG findings in the elderly are common, presence of abnormalities is low in absence of cardiac history.¹² Even high-risk patients have less than a 0.5-percent incidence of asymptomatic new myocardial infarction (diagnosed by ECG) over a six-month period. Although some studies recommend preoperative chest X-ray in all the elderly because of a high incidence of abnormal findings even in healthy individuals, others suggest that chest X-rays are indicated only in patients with pulmonary symptoms and signs.¹³ It also was emphasized that except for surgical procedures involving removal of lung tissue, pulmonary testing does not predict postoperative pulmonary complications.

Preoperative laboratory tests do not predict perioperative complications. Schein et al.¹⁴ randomly assigned 18,000 patients scheduled for cataract procedures to either no tests or a battery of laboratory tests (ECG, complete blood count, electrolytes, blood urea nitrogen, creatinine and glucose). There was no difference between the groups with respect to the incidence of perioperative complications or the incidence of cancellations.

The laboratory tests that may have some predictive utility are creatinine and albumin. The American College of Cardiology and American Heart Association guidelines for cardiovascular evaluation for noncardiac surgery suggest that patients with high creatinine (>2 mg/dl) undergoing high-risk surgery should undergo preoperative cardiac testing.¹⁵ A Veterans Administration study in more than 54,000 patients found that albumin was the most significant predictor of perioperative complications, even greater than the ASA physical status.¹⁶

Dr. Rooke stated that even the utility of preoperative testing based on known medical disease or anticipated changes during surgery can be questioned and thus needs further research. He concluded that there is no benefit from routine laboratory testing, and preoperative laboratory tests should be based on the patient's medical status and the anticipated effects of proposed surgery.

References:

1. Practice Advisory for Preanesthesia Evaluation: A report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology*. 2002; 96:485-496.
2. Malviya S, D'Errico C, Reynolds P, et al. Should pregnancy testing be routine in adolescent patients prior to surgery? *Anesth Analg*. 1996; 83:854-858.
3. Azzam FJ, Padda GS, DeBoard JW, et al. Preoperative pregnancy test-

Continued on page 11

Avoidance of Hyperoxia and Repeated Episodes of Hypoxia-Hyperoxia in Infants: < 1500g Is Successful in Decreasing the Incidence of Severe Retinopathy of Prematurity

By Kumar G. Belani, M.D.
 J.J. Buckley Professor
 Interim Head
 Department of Anesthesiology
 Professor of Pediatrics
 University of Minnesota
 Minneapolis, Minnesota

Premature infants and infants of low birth weight can be born with incomplete vascularization (maturation) of the retina. Maturation of the retina is closely linked to the vascular endothelial growth factor (VEGF). In utero, the retinal artery partial pressure of oxygen in the arterial blood (PaO₂) averages 22-24 mm Hg. After

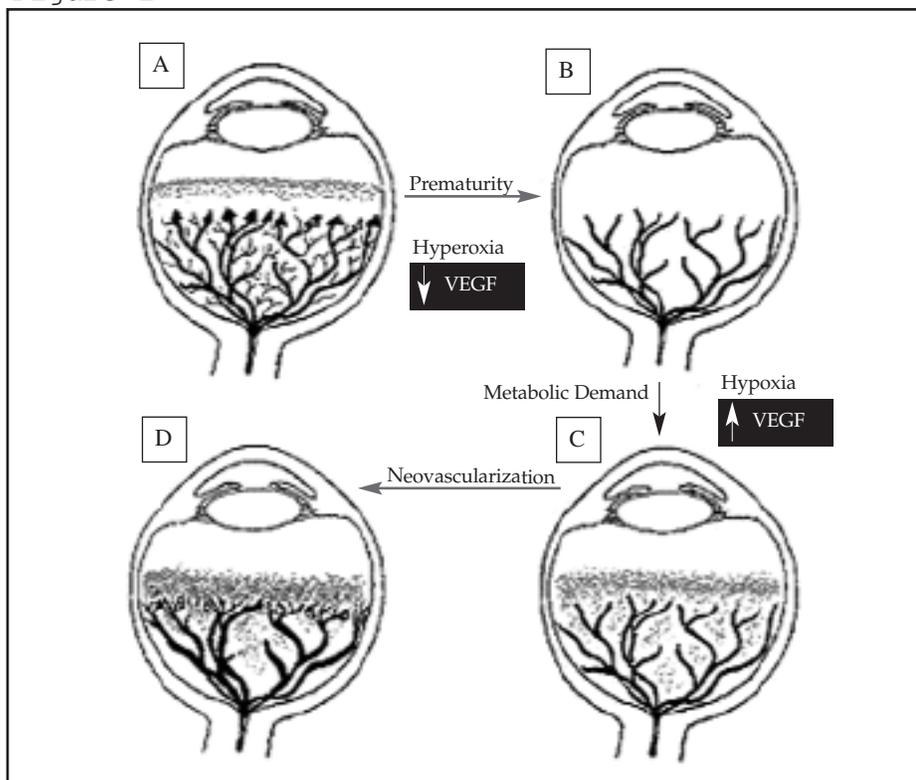
birth, premature babies may become relatively hyperoxic even while breathing room air or if they are prescribed supplemental oxygen therapy. Sustained hyperoxia can down-regulate VEGF production, which can arrest the retinal maturation process. Despite this, the metabolic demands of the growing eye result in VEGF stimulation, thus resulting in retinal neovascularization. When neovascularization is severe, retinal fibrosis and detachment occur [Figure 1].

It is believed that repeated cycles or episodes of hypoxia and hyperoxia provide a significant stimulus for retinopathy of prematurity (ROP).



Kumar G. Belani, M.D.

Figure 1



VEGF is believed to play a major role during the maturation of the retinal vasculature. Hyperoxia will decrease VEGF whereas metabolic demands will increase VEGF. The resulting effect on the retinal vasculature is diagrammatically depicted above (from: Chow et al.¹).

... O₂ therapy in these VLBW newborns must be administered precisely to avoid abrupt changes in F_IO₂ to minimize periods of hyperoxia combined with episodes of hypoxia.

The incidence of ROP varies from center to center, and is most likely related to differences in clinical practices. In a recent study by Chow and associates, including the Cedar Sinai Medical Center Oxygen Administration Study Group,¹ the investigators initiated a total quality management program to decrease ROP in very low birth weight (VLBW) babies, including an educational program and a strict policy for oxygen prescription and monitoring (Masimo signal

extraction technology pulse oximetry). In addition, the Caring Responsible Approach to Development in the Lives of Extremely Low Birth Weight Infants (CRADLE Club) philosophy was utilized. A specially designated care group of nurses and respiratory therapists along with physician specialists served as care team leaders for the VLBW infants. The team prescribed oxygen (O_2) as listed in Table 1.

Using the above goals, the investigators were successful in decreasing quite markedly the incidence of ROP over a five-year period [Figure 2].

Thus, O_2 therapy in these VLBW newborns must be administered precisely to avoid abrupt changes in $F_I O_2$ to minimize periods of hyperoxia combined with episodes of hypoxia. This process will allow for the proper maturation of the retina, thereby decreasing the occurrence of severe ROP with its associated morbidity.

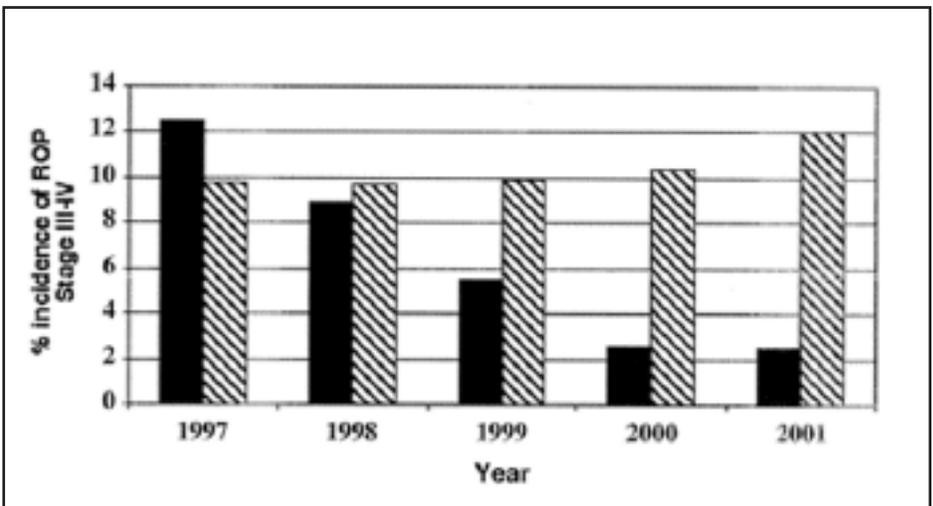
Reference:

1. Chow LC, Wright KW, Sola, et al. Can changes in clinical practice decrease the incidence of severe retinopathy of prematurity in very low birth weight infants? *Pediatrics*. 2003; 111:339-345. [SMB](#)

Table 1

Goals of O_2 Therapy for VLBW Newborns*†
<ul style="list-style-type: none"> • Reduce unnecessary O_2 use (remember that O_2 is a drug) • Minimize abrupt changes in $F_I O_2$ • Accept the following SpO_2 ranges: <ul style="list-style-type: none"> ≤ 32 weeks gestation: 85% - 93% > 32 weeks gestation: 85% - 95% • Avoid periods with $SpO_2 >93-95%$ (i.e., prevent large swings in SpO_2)
<p>*Applied for 4-8 weeks postnatally or longer based upon gestational age, duration of oxygen therapy and vascular maturity of the retina.</p> <p>†The same goals were applicable while procedures were being performed on VLBW infants.</p>

Figure 2



There was a progressive decline in the incidence of severe ROP using the goals listed in Table 1 by the investigators (dark bars); the striped bars represent data from the Vermont Oxford Network registry for ROP (from: Chow et al.¹).

PACU Discharge: When Is It 'Just in Time?'

By Stephen A. Cohen, M.D., M.B.A.
Harvard Medical School
Director, Ambulatory Anesthesia and
Preprocedure Testing
Beth Israel Deaconess Medical Center
Boston, Massachusetts

Speakers at the "Discharge Issues and the PACU Nurse's Perspective" panel at the SAMBA 18th Annual Meeting on May 8-11, 2003, in Boston, Massachusetts, presented some of the latest advances in fast-tracking patients through recovery from ambulatory day surgery and reviewed certain discharge criteria and problems. Panel members addressed medical and systemic difficulties and recommended strategies for improvement.

Paul F. White, M.D., Ph.D., Dallas, Texas, described his institution's "Fast-Tracking in Day Surgery" program. He explained that the rationale for fast-tracking arose from the rapid changes in health care delivery, which are driven by cost containment, new technologies and increased competitiveness in the marketplace. He emphasized practicing value-based anesthesia while optimizing anesthetic technique and keeping patient safety and comfort paramount. Dr. White stated that although anesthetic drugs are relatively inexpensive, the processes and personnel can be costly. He also noted a recent study suggesting that whereas ambulatory centers may save 5 percent to 7 percent in costs by eliminating postoperative nausea and vomiting (PONV) or may be using short-acting anesthetics to decrease time to awakening, streamlining the recovery process can yield a 35-percent savings.

Dr. White stated that recovery can be optimized both by choice of anesthetics and a combined use of local, regional or general anesthesia techniques. He advocated the use of local anesthesia in virtually every anesthetic technique. In patients undergoing inguinal hernia, monitored anesthesia care (MAC) with a field block allowed patients to bypass the postanesthesia

care unit (PACU) and be home-ready significantly sooner than patients who had spinal or general anesthesia. This technique also resulted in lower marginal costs while significantly increasing patient satisfaction and reducing nursing overtime pay. Moreover it may permit centers to "squeeze in" an additional case during the regularly scheduled operating room day.

When general anesthesia is preferred or required, Dr. White recommended the use of nitrous oxide (N₂O) because of its rapid pharmacokinetics and its ability to reduce the amount of inhalational anesthetics and analgesics. The combination of N₂O and



Stephen A. Cohen, M.D., M.B.A.

Dr. Chung debunked two "sacred cows" regarding the taking of oral fluid and voiding before discharge. She noted that patients who electively wish to drink water have significantly less PONV and are fit for home sooner than patients who are mandated to drink.

inhalational anesthesia with prophylactic antiemetics renders as low an incidence of PONV as seen with propofol total intravenous anesthesia. He stressed using no opioids. Local anesthetics and nonsteroidal anti-inflammatory drugs provide analgesia, and the cyclo-oxygenase-2 inhibitors hold much promise. Dr. White expressed a preference for small doses of fentanyl or remifentanyl for intra-abdominal surgery when opioids may be required. He suggested that β -blockade helps to blunt the transient autonomic responses seen during various stages of surgery and minimizes the use of anesthetic agents.

Frances Chung, M.D., Toronto, Ontario, Canada, addressed "Discharge Criteria: What Are the Issues?" She noted that having admission, operation and discharge home occurring on the same day presents certain unique challenges. Moreover the problems ambulatory centers face become more

difficult as increasingly more complicated cases are performed in them. While the driving force behind ambulatory surgery may have arisen out of economic concerns, Dr. Chung noted that allowing earlier return to the pre-morbid physiological state confers definite benefits, including fewer complications, reduced disability and earlier resumption of normal daily activities.

Dr. Chung emphasized that recovery occurs continuously but can be considered to pass through three phases: 1) patients emerge from anesthesia, 2) they meet discharge criteria and 3) they return to their preoperative physiological state. In order to minimize hospital readmission and litigation, patients must be discharged according to rigorous written criteria, which is often delegated to PACU nurses. Dr. Chung developed a Postanesthesia Discharge Scoring System (PADSS) that rates vital signs, am-

bulation, nausea and vomiting, pain and surgical bleeding. A score of >9 (out of 10) permits patients to be discharged. She claimed that most patients can be discharged to home within one to two hours after surgery.

Dr. Chung debunked two "sacred cows" regarding the taking of oral fluid and voiding before discharge. She noted that patients who electively wish to drink water have significantly less PONV and are fit for home sooner than patients who are mandated to drink. Recent data show that patients with risk factors for urinary retention such as prior retention, spinal or epidural anesthesia, pelvic or urologic surgery and bladder catheterization may not need to void prior to discharge. They can be sent home after receiving instructions to seek medical help if unable to void six to eight hours later. The 2002 American Society of Anesthesiologists Standards for Postanesthesia Care incorporate both of these recommendations. She also noted that patients who have had peripheral nerve blocks could be sent home prior to the return of normal sensation if given a sling and clear verbal

and written instructions to prevent injury.

Nancy Brooks, R.N., Boston, Massachusetts, addressed "The PACU Nurse's Role in Managing Postoperative Complications and Discharge." She focused on complications that lead to an increased length of patient stay in the PACU, unplanned hospital admissions and hospital readmission within 24 hours of surgery. She stressed that the most common complications after day surgery include PONV, pain, urinary retention and ineffective instructions.

PONV risk factors include perioperative opioids, a previous history of PONV or motion sickness and female gender. These patients usually receive multiple prophylactic antiemetics. Because eating and drinking increase the incidence of PONV, patients are no longer required to do either prior to discharge. Pain management begins preoperatively with patient education to set expectations about how their pain will be assessed and ultimately handled. Ms. Brooks opined that patients benefit when they learn that they will go home with good pain control. Patients receive fentanyl as the

main analgesic in phase one and the oral analgesics prescribed for their home use in phase two recovery. A multidisciplinary team addresses failures of initial therapy.

The Brigham and Women's Hospital requires patients who have had gynecologic, genitourinary and hernia procedures or spinal anesthesia to void. Ms. Brooks extolled the utility of a bladder ultrasound scanner in helping to decrease the incidence of postoperative catheterization. She also emphasized the importance of postoperative telephoning to inquire about the patient's condition and ability to follow instructions. Such surveys supply vital information for performance improvement and increased patient satisfaction.

The three panelists reviewed some of the issues confronting ambulatory surgical centers and presented workable solutions and improvements. Despite significant improvements, ambulatory centers must work harder to provide the highest quality care and be competitive in the marketplace. 

SAMBA 19th Annual Meeting April 30 - May 2, 2004

Plan now to attend the SAMBA 19th Annual Meeting to be held at the Seattle Westin Hotel in Seattle, Washington! This unique educational experience brings together internationally known experts from across the field of ambulatory anesthesiology and presented in the magnificent Pacific Northwest.

The SAMBA Annual Meeting is recognized for its stellar educational programs, providing both a tremendous learning opportunity for those involved in ambulatory anesthesiology as well as an outstanding networking forum that promotes the sharing of ideals and

Electronic abstract submission deadline is February 15, 2004. Only abstracts submitted electronically through the SAMBA Web site at <www.sambahq.org> will be considered for grading.

'Day Surgery in the U.K. — The Brits Are Coming'

By Brian M. Parker, M.D.
Staff Anesthesiologist
Department of General Anesthesiology
Cleveland Clinic Foundation
Cleveland, Ohio

The informative panel, "Day Surgery in the U.K. — The Brits Are Coming," opened with consultant surgeon **David Ralphs, M.D.**, President of the British Association for Day Surgery. His presentation, "Where Are We? How Did We Get Here?," briefly discussed the advent of day surgery in the United Kingdom (U.K.), which is credited to James Nicoll, M.D., a pediatric surgeon who worked in Glasgow, Scotland, in the late 19th and early 20th centuries. In addition some years later during the 1930s, many surgical procedures such as tonsillectomies were still being performed in the home with patient recovery occurring there as well.

Day surgery in the U.K., however, gained little acceptance after World War II with the creation of the Na-

ber of day-surgery cases being performed in the U.K. had leveled off. This occurred for a variety of reasons, including a continued lack of regional acceptance, few stand-alone facilities (such as ambulatory surgical centers), lack of financial incentives and overall system inefficiency. In spite of these barriers, approximately 1.2 million day-surgery cases were performed in the U.K. in 2002.

The anesthesiologist's perspective on day surgery in the U.K. is unique and was presented by **Ian Smith, M.D.**, Consultant Anesthetist at Stoke on Trent Hospital, Staffordshire, U.K. Interestingly after the 1985 publication of the Royal College of Surgeons document on day surgery, many surgeons attempted to perform day surgery on both poorly selected and ill-prepared patients. With education of all members of the day-surgery team and the establishment of guidelines for patient assessment, the pendulum has today swung in the opposite direction. Many surgeons have become increasingly reluctant to bring patients to



Brian M. Parker, M.D.

necessary to link a given pathology with the effects of anesthesia and surgery. Also tonsillectomies as well as many laparoscopic procedures, including cholecystectomy, are not considered day surgery cases in the U.K. at this time, and this surgical bias is unlikely to change overnight. Anesthetic approaches to the day-surgery patient were briefly discussed and were clearly in agreement with the goals of anesthesiologists practicing in North America.

Next the issues surrounding inefficiencies of the health care system in the U.K. were discussed in some detail by **Jill Solly, R.N.**, Director of Modernisation, King's College Hospital, London, U.K. Presumably many of these inefficiencies have led to a lack of growth of day surgery in recent years and include both poor transfer and lack of information provided to patients about their medical condition and planned surgical procedure. In addition waiting times of up to one year for elective surgery are still commonplace, which is an improvement over a previous maximum two-year waiting time. As a result, the British government has established specific goals to improve health care in general as well as to improve the day surgery experience. These goals include reducing the waiting time to three months for both outpatient and inpatient procedures by 2005, providing a choice of

Many surgeons have become increasingly reluctant to bring patients to the operating room for day surgery procedures. Thus many anesthesiologists now feel the patient selection and assessment system they helped to establish for day surgery is underutilized.

tional Health Service (NHS), which gave everyone in the U.K. free access to health care at the "point of need." In 1985 the Royal College of Surgeons of England issued a document that provided guidelines for the performance of day surgery, thus helping to both legitimize it and improve acceptance. The result was a significant yearly increase in day-surgery cases occurring over the next decade. By the mid 1990s, however, the num-

ber of day-surgery cases being performed in the U.K. had leveled off. This occurred for a variety of reasons, including a continued lack of regional acceptance, few stand-alone facilities (such as ambulatory surgical centers), lack of financial incentives and overall system inefficiency. In spite of these barriers, approximately 1.2 million day-surgery cases were performed in the U.K. in 2002.

The anesthesiologist's perspective on day surgery in the U.K. is unique and was presented by **Ian Smith, M.D.**, Consultant Anesthetist at Stoke on Trent Hospital, Staffordshire, U.K. Interestingly after the 1985 publication of the Royal College of Surgeons document on day surgery, many surgeons attempted to perform day surgery on both poorly selected and ill-prepared patients. With education of all members of the day-surgery team and the establishment of guidelines for patient assessment, the pendulum has today swung in the opposite direction. Many surgeons have become increasingly reluctant to bring patients to

possible dates for surgical procedures, improving transfer of information to the patient and addressing the issue of improved postoperative pain control.

Finally "Every Elective Surgical Case Should Be a Day-Surgery Case" was discussed by **Paul Baskerville, M.D.**, Consultant Surgeon, King's College Hospital, London, U.K. Obviously this issue was raised in a somewhat tongue-in-cheek manner. The real challenge to the U.K. health care system, however, is to create pathways that will increase day-surgery rates. In 1985 only 10 percent of all surgeries were day-surgery cases, in contrast to 60 percent by the year 2000. These percentages, however, hide significant variation in day-surgery rates by surgeon, specialty, hospital and region. The recently established NHS target goal is that 75 percent of all surgeries

The recently established NHS target goal is that 75 percent of all surgeries in the U.K. should be day-surgery cases by 2005.

in the U.K. should be day-surgery cases by 2005. In order to attain this goal, significant changes will need to occur, including reorientation of both the surgical and anesthetic cultures in the U.K. such that the patient is now viewed as the "customer," not unlike what has happened and continues to happen in health care in the United States. 

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