



News from the President

Welcome to our first Newsletter of 2013 and the start of our activities within the framework of the IAAS Eastern European Year. The IAAS will concentrate its activities this year to support the development of high quality Ambulatory Surgery in Eastern European Countries.

Coming up is the 10th IAAS International Congress in Budapest (further details below). Not only will this Congress promote professional exchange but it will also provide a showcase for IAAS international initiatives. In fact, two sessions of the congress will be dedicated to dissemination of results from the European Projects DAY SAFE and the Day Surgery Data Project.

During the course of this year, the IAAS will be organizing 4 training workshops in 4 different Eastern European countries. The main objective of these workshops is to provide participants with effective, practical tools for both the improvement in performance of existing Day Surgery and for the design and organization of new centres in countries that are just beginning their activity. More information on these courses will be forthcoming.

This year's activities 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.

It will be an exciting year for the IAAS and I invite you all to participate and help us in the development of our projects. I look forward to seeing you in Hungary for the 10th IAAS International Congress in Budapest.



Carlo Castoro, President

International News and Comments

Dexamethasone for PONV and Pain

Pain, emesis, and fatigue are not uncommon symptoms after ambulatory surgery having impact on patients' satisfaction with quality of care. Multimodal management of postoperative pain and nausea and vomiting has become standard of care. The benefits versus risk associated to single preoperative i.v. dose of dexamethasone seem positive based on current evidence facilitating the recovery reducing pain and postoperative nausea and vomiting [1]. There are further recent studies supporting the positive benefit risk profile. De Oliveira et al conducted and just recently published a systemic literature review of published studies around dexamethasone as a prophylactic drug to reduce postoperative nausea and/or vomiting [2]. They found that a 4-mg to 5-mg dose of dexamethasone seems to have similar clinical effects in the reduction of PONV as the 8-mg to 10-mg dose when dexamethasone was used as a single drug or as a combination therapy. These findings support the current recommendation of the SAMBA guidelines for PONV, which favors the 4-mg to 5-mg dose regimen of systemic dexamethasone. There is an ahead of print paper in Anesthesia and Analgesia by Bolac et al presenting the results from a retrospective study conducted in order to determine whether intraoperative dexamethasone for PONV prevention increases the risk or severity of postoperative wound complications [3]. Women who underwent laparotomy for endometrial cancer between 2002 and 2007 were identified from a tumor registry. Medical records were reviewed to identify wound complications including cellulitis, superficial surgical site infection, wound separation, and fascial dehiscence. Four hundred thirty-one patients met inclusion criteria; 192 (44.6%) received dexamethasone (4-12 mg) and 31.1% developed a wound complication. In unadjusted analysis, there was no difference in the risk of developing a wound complication based on dexamethasone exposure; 53 of 192 patients (27.6%) who received dexamethasone developed a wound complication, compared with 81 of 239 (33.9%) who did not receive dexamethasone: odds ratio (OR) (95% confidence interval [CI]) = 0.74 (0.49, 1.13), $P = 0.16$. There was no difference in the distribution of wound complication types based on receipt of dexamethasone ($P = 0.71$), or in the incidence of wound complications based on the dose of dexamethasone ($P = 0.48$). They concluded that intraoperative dexamethasone for PONV prophylaxis does not seem to increase the rate or severity of postoperative wound complications in women undergoing laparotomy for endometrial cancer. BMI and smoking were significant predictors of wound complications in this patient population. The single-intravenous preoperative dexamethasone dose may also have an impact not only on PONV but also on pain. Waldron et al performed a systematic review to evaluate the impact of a single i.v. dose of dexamethasone on postoperative pain and explore adverse events associated

with this treatment published in BJA February 2013 [4]. Forty-five studies involving 5796 patients receiving dexamethasone 1.25-20 mg were included. Patients receiving dexamethasone had lower pain scores at 2 h {mean difference (MD) -0.49 [95% confidence interval (CI): -0.83, -0.15]} and 24 h [MD -0.48 (95% CI: -0.62, -0.35)] after surgery. Dexamethasone-treated patients used less opioids at 2 h [MD -0.87 mg morphine equivalents (95% CI: -1.40 to -0.33)] and 24 h [MD -2.33 mg morphine equivalents (95% CI: -4.39, -0.26)], required less rescue analgesia for intolerable pain [relative risk 0.80 (95% CI: 0.69, 0.93)], had longer time to first dose of analgesic [MD 12.06 min (95% CI: 0.80, 23.32)], and shorter stays in the post-anaesthesia care unit [MD -5.32 min (95% CI: -10.49 to -0.15)]. There was no increase in infection or delayed wound healing with dexamethasone, but blood glucose levels were higher at 24 h [MD 0.39 mmol litre(-1) (95% CI: 0.04, 0.74)]. Thus the body of evidence to support the positive benefit vs. risk profile for preoperative single-dose iv. dexamethasone is further increasing.

[1] Jakobsson J. Preoperative single-dose intravenous dexamethasone during ambulatory surgery: update around the benefit versus risk. *Curr Opin Anaesthesiol.* 2010 Dec;23(6):682-6. Review.

[2] 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.

[3] Bolac CS, Wallace AH, Broadwater G, Havrilesky LJ, Habib AS. The Impact of Postoperative Nausea and Vomiting Prophylaxis with Dexamethasone on Postoperative Wound Complications in Patients Undergoing Laparotomy for Endometrial Cancer. *Anesth Analg.* 2013 Jan 21. [Epub ahead of print]

[4] Waldron NH, Jones CA, Gan TJ, Allen TK, Habib AS. Impact of perioperative dexamethasone on postoperative analgesia and side-effects: systematic review and meta-analysis. *Br J Anaesth.* 2013 Feb;110(2):191-200.

Shoulder surgery in Beach Chair Position

Shoulder surgery in the beach chair position is associated with significant reductions in cerebral oxygenation compared with values obtained in the lateral decubitus position [1]. Patients undergoing shoulder surgery in the beach chair position may be at actual risk for adverse neurologic events due to cerebral ischemia. In 2010 Dippman et al [2] present 2 patients in whom a reduction in mean arterial pressure after anesthesia provoked a decrease in frontal lobe oxygenation to below the level that causes presyncopal symptoms in the awake subject. They also found that intravenous administration of ephedrine rapidly restored cerebral oxygenation. Jeong et al [3] studied forty patients undergoing shoulder surgery in BCP were randomly assigned to receive sevoflurane-nitrous oxide (S/N) or propofol-remifentanyl (P/R) anesthesia. Four patients taking angiotensin II receptor antagonists were excluded post hoc. They found that mean arterial pressure decreased by beach chair positioning in both groups. It was, however, significantly higher in S/N (n = 19) than in P/R group (n = 17) at 7 to 8 min after the positioning. Jugular venous bulb oxygen saturation (SjvO₂) also significantly decreased after beach chair position in both groups, the magnitude of which was lower in S/N than in P/R group (11 ± 10% vs. 23 ± 9%, P = 0.0006). The incidences of SjvO₂ <50% and mean arterial pressure less than 50 mmHg were lower in S/N group, but SctO₂ and the incidence of cerebral desaturation (more than 20% decrease from baseline) did not significantly differ between the groups. Thus it is of importance to maintain mean arterial pressure at adequate levels when surgery must be undertaken in the beach chair position. Decrease in blood pressure should be rapidly adjusted. This may be a patient group where angiotensin inhibitors should be withdrawn morning of surgery and maintenance with sevoflurane and nitrous oxide may be associated with less risk of drop in blood pressure as compared to a propofol/remifentanyl combination.

[1] Murphy GS, Szokol JW, Marymont JH, Greenberg SB, Avram MJ, Vender JS, Vaughn J, Nisman M. Cerebral oxygen desaturation events assessed by near-infrared spectroscopy during shoulder arthroscopy in the beach chair and lateral decubitus positions. *Anesth Analg.* 2010 Aug;111(2):496-505.

[2] Dippmann C, Winge S, Nielsen HB. Severe cerebral desaturation during shoulder arthroscopy in the beach-chair position. *Arthroscopy.* 2010 Sep;26(9 Suppl):S148-50.

[3] Jeong H, Jeong S, Lim HJ, Lee J, Yoo KY. Cerebral oxygen saturation measured by near-infrared spectroscopy and jugular venous bulb oxygen saturation during arthroscopic shoulder surgery in beach chair position under sevoflurane-nitrous oxide or propofol-remifentanyl anesthesia. *Anesthesiology.* 2012 May;116(5):1047-56.

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

10th IAAS Congress

The next IAAS International congress on Ambulatory Surgery will be held in Budapest, Hungary on 5-8th May 2013. Organized by the IAAS youngest Full Member, the Hungarian Association For Ambulatory Surgery, this event will mark the tenth anniversary in the History of IAAS Congresses. The IAAS initial objective is to encourage the development and expansion of high quality surgery and to promote education and research in the subject. This initiative is also the aim of our Congress, and we have invited an impressive array of international experts on day surgery to present the up to date knowledge of this subject. Our Congress will be held in our beautiful city of Budapest, the capital of Hungary, which is famous for its hospitality, city tours and gastronomy. Whenever you need more information, please do feel free contact us anytime.

We are looking forward to seeing you in Hungary.

Gamal Mohamed, MD, Congress President



The banner for the IAAS 10th International Congress on Ambulatory Surgery features a dark blue background with a large, ornate golden seal on the left. The seal contains the text 'INTERNATIONAL ASSOCIATION FOR AMBULATORY SURGERY' and 'one day'. To the right of the seal is a circular logo with the number '1' and the text 'Napos Sebészeti Társaság' and 'Hungarian Association for Ambulatory Surgery'. The main text on the banner reads 'IAAS 10th International Congress on Ambulatory Surgery' in white and gold, followed by 'Budapest, Hungary' and '5-8 May, 2013'. Below this, it says 'for the Development & Expansion of Ambulatory Surgery'. On the left side, there is a vertical list of topics: Welcome note, Accommodation, General information, Preliminary programme, Social programmes, Registration, Sponsorship, Exhibition, Cancellation terms, Important dates, Contact, and CME. The bottom of the banner shows a night view of the Hungarian Parliament Building and the Hungarian flag.

1st Iberia Congress on Ambulatory Surgery



Last 14th to 16th of May we've had the honour to welcome in Braga-Portugal the 1st Iberia Congress of Ambulatory Surgery. We are now very pleased to announce that this event turned out to be a huge scientific and organizational success. This event was the result of a very enriching organizing experience of the Portuguese and Spanish Ambulatory Surgery Associations (APCA and ASECMA).

In this beautiful Portuguese town located in the northern region of Portugal called "Minho" we had more than just warm spring weather and magnificent

sights. We've had over 650 participants from the Peninsula (450 doctors of different specialties, 140 nurses, 30 students and 38 Industry representatives) for the two and a half days of the Congress. Three different rooms were almost always full with interested people, listening to more than 30 Presentations, Conferences and Round tables, participating in almost a dozen different Courses and Workshops. Our guest speakers, Dr. Carlo Castoro, Dr. Beverly Phillip, Dr. Danielle Ludwin, Dr. Fernando Docobo, Dr Paulo Lemos and all the other thirty Spanish and Portuguese specialists shared with the audience their vast experience on surgical, anaesthetic, nursing and management areas of interest.

We are also glad to congratulate the authors of the 88 posters and 51 free presentations for the quality of their work and their importance to the growth of both our Associations and for the development of Ambulatory Surgery in Portugal and Spain.

Our experience in Braga was so positive that APCA and ASECMA decided to repeat it in October 2013 in Santiago de Compostela. See you there.

**Vicente Vieira, MD, Chairman of the Local Organising Committee
Member of the Board of the Portuguese Association for Ambulatory Surgery (APCA).**

Calendar

Belgium – February 22nd, 2013

The 10th National Congress of BAAS (Belgian Association for Ambulatory Surgery), will take place in Brussels. For more information please go to <http://www.baas.be/BAAS2013.pdf>

Sweden – April 11-12th, 2013

Swedish Ambulatory Surgery Congress will take place in Västerås – [further information here](#)

Ambulatory Surgery Volume 19.1 January 2013

Editorial

This edition of the Journal of Ambulatory surgery contains 4 disparate but interesting articles. From Copenhagen, we have a thought-provoking variation of Altemeier's Procedure applied to stomal, rather than rectal prolapsed with 8 of the 10 procedures performed in a day case setting. The procedure is elegantly illustrated by a series of photographs demonstrating each step of the operation. The author concludes that the procedure for full thickness prolapsed colostomy stoma offers a safe and easy day surgery option.

The second paper comes from Milton Keynes in the South Midlands of England. The authors are interested in the post-operative outcome of patients undergoing laparoscopic cholecystectomy, where the patients have failed both day case and overnight stay surgery, staying more than 48 hours.. They suggest that in their series, this unfortunate group of patients accounts for 8% of the total and when compared to successful day case laparoscopic cholecystectomies, these patients are more likely to have had acute cholecystitis rather than biliary colic, and have a longer operating time with more drain insertions and conversions to the open procedure. The authors bravely state that some of these factors may be avoidable with greater attention to surgical detail and that their results continue to improve through a continuous audit programme.

Thirdly, comes our first paper from Iran. Here the authors are comparing post-operative pain scores after inguinal hernia repair by local anaesthesia versus general anaesthesia. Not surprisingly, patients in the local anaesthesia group had lower pain scores and a shorter length of stay. The authors are keen to promote local anaesthetic hernia repair in their country where the technique is performed in few centres.

Finally we have a comprehensive overview from Manchester, England, of 25 studies describing the experience of the patient and carer in the immediate post-operative period following day surgery. The author concludes that the main problems are threefold and relate to pain, anxiety and a lack of information. The article suggests that this is the result of the nurse/patient contact becoming more fragmented with the nurse/patient relationship now consisting of brief interactions in the outpatient department, preassessment, in the day surgery unit and in the community with little or no interaction on a professional basis between them. The author proposes that the solution may lie in the enhancement of the hospital/community interface with greater communication between the two.

Douglas McWhinnie

Current contents

The adaptation of Altemeier's Procedure to treat end colostomy prolapse:

A simple option for day surgery

O. Bulut

What factors are associated with prolonged hospital stay following planned day-case

Laparoscopic Cholecystectomy

J. Isherwood, D. P. J. Howard, R. Saunders, Y. Jabri, D. Phillips & D. McWhinnie

Assessment of the effect of local versus general anesthesia on the pain perception after inguinal hernia surgery

M. Hosseinpour, A. Behdad & M. Resaei

Literature review: Home recovery following day surgery

M. Mitchell

Beverly K. Philip, MDEditor-in-Chief

Douglas McWhinnie, FRCS Editor-in-Chief

These articles can be downloaded from www.ambulatorysurgery.org