

BRIEF COMMUNICATION

Different Faces of Ambulatory Anaesthesia - A Reality Check of Practices

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ABSTRACT Ambulatory anaesthesia (AA) remains an alternative to the concerns of various stakeholders about the setbacks with in-patient anaesthesia and surgery. It will continue to be so especially with continued technological advancements of the present era, improved anaesthesia drugs and techniques that enhance faster recovery, faster pace of life that makes patients seek early re-union with family and return to work, as well as overall reduction in costs. Cost reduction especially is a major concern to patients, hospitals and National Health Services. In the light of these reasons and more, there are already different settings where ambulatory anaesthesia is practised wholly, or as part of its processes in patient care. This brief communication seeks to highlight those real clinical scenarios which are already with us in our different settings (faces), where AA is being practised or will be on the rise as advances in surgical and anaesthesia care with the principles of enhanced recovery increase.

Keywords: Ambulatory anaesthesia, Practice, Different faces.

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INTRODUCTION

Ambulatory Anaesthesia (AA) has been in existence and practised for ages but has evolved as a subspecialty and will continue to evolve in the face of changing patterns in surgical care globally. From records in the early twentieth century when Day case surgery was started in 1909 by James Nicoll - a professor of paediatric surgery; it was met with criticisms, but the disadvantages associated with the period of non-ambulation following surgery began to be of interest from the middle of that century. By the 1970s, day surgical units (DSUs) proliferated in hospitals in the United Kingdom (UK), with the Government and General practitioners emphasizing benefits from AA and the need to develop standards and guidelines of operation.¹

The British Association of Day Surgery (BADs) has championed the cause of AA in the UK and the Society for Ambulatory Anaesthesia (SAMBA) in the USA, both being pioneer regulating bodies for standardization/regulation of practice and for the establishment of postgraduate subspecialty training.^{2,3}

This brief account identifies the various “faces” (settings) of anaesthesia services where AA is wholly practised or

incorporated as part of its general scope, with same day patient review, operation/performance of procedure and discharge, irrespective of location; provided it fulfills these criteria.

DEFINITION

Ambulatory anaesthesia (AA) can be defined therefore as anaesthesia services for carefully selected, elective surgeries or procedures, in patients admitted, assessed, operated and discharged on the same day. The present-day speedy lifestyle, deemphasis in extended family structure, work pressure, and resumption of daily routine to maintain social and professional balance are some reasons for increasing trends and demand for AA. It has further been enhanced by advances in anaesthesia and analgesia techniques and the use of S.A.F.E (short acting, fast emergence) drugs characterized by minimal side effects, and minimal access surgeries (MAS).^{2,4,5}

INCIDENCE

In the US, AA services have been put at over 70%, and in the UK, NHS is insistent with a directive that 75% of all elective surgeries are to be ambulatory.^{3,5} Besides, other reasons such as safety and convenience, AA is

cheaper for all stakeholders. No national figure for Nigeria was found, but a study on urological day surgeries in a centre recorded 67.8%.⁶

TYPES OF AA UNITS

Different closely related terminologies have been employed for AA over the years such as “day case, same day, day care, day stay and outpatient anaesthesia”. Considering location of practice, it is Hospital integrated when AA is within the main operating complex, a Dedicated unit when situated as a separate building within the main hospital and a Stand-alone unit when completely satellite, distant from the main hospital, but has a designated referral hospital (for admissions and emergencies).^{4,5,7}

DIFFERENT FACES OR SETTINGS

There have also been different facets of practice incorporating the concept of AA that have also developed. These include Office based anaesthesia (OBA), anaesthesia in remote/unusual locations and more recently, “non-operating room anaesthesia” (NORA) which can be practiced in diverse locations. Some surgical outreaches as seen in developing economies have also incorporated practices of AA in patient care with beneficiaries at such surgical outings admitted, operated and discharged on the same day; and with favourable outcomes.⁸

Office-based (OBA) is a practice where Physicians' offices are the locations for very minor surgeries, pain clinics and diagnostic/therapeutic procedures, with distinct and regulated practice guidelines and seen more in developed climates than in our environment.^{4,9}

NORA comprises of sedation, analgesia or anaesthesia outside the operating room (OR) in patients with pre-operative anxiety or undergoing painful and/or uncomfortable procedures. Among others, the increase in NORA is related to the rise in conduct of less invasive procedures, proficiency of interventionists, the aging population with more co-morbidities, need for patient's cooperation and difficulty with installing some equipment for procedures in theatre suites. Locations of NORA include the dental, endoscopy, radiotherapy, electro-convulsive therapy (ECT), burn, radiology (CT scan, MRI, Interventional radiology) suites, etc.^{4,9}

Monitored Anaesthesia Care is also practiced in some patients scheduled for AA. It is the provision of anaesthesia service for minor surgeries, diagnostic and therapeutic procedures under local anaesthesia administered by the Surgeon, but with the Anaesthetist present to provide one or more support services. These services include additional analgesia, conscious sedation, oxygen administration/airway maintenance, fluid management and monitoring.

A concept of “Fast-tracking in the ambulatory setting” also known, is the transfer of selected patients from the operating room to the Phase II (step-down) recovery area, bypassing the post-anaesthesia care (PACU) unit and

from where they are discharged after a short stay, though some can undergo same day discharge.

A recent addition is outpatient-based robotic surgeries driven by advancements in technology, growing surgeon experience, and increasing patient demand for less invasive and more convenient options.⁴

Generally, in all types, some basic enhanced recovery from anaesthesia and surgery (ERAS) principles remain key in ensuring safe and timely recovery. These principles have revolutionised anaesthesia and surgical practice thereby increasing surgical and patient options! Therefore, ambulatory surgery has expanded beyond performing simple procedures on healthy patients as more extensive procedures have been done, these being criteria that were not previously considered feasible for ambulatory surgery.⁴

BENEFITS OF AA

One overarching gain from AA irrespective of other benefits is the reduced costs to all stakeholders (patient, facility and NHS), with more efficient resource utilization and greater comfort. There are reduced waiting lists, large patient turnover, increased bed space, less post operative morbidity (nosocomial infections and VTE), minimal separation (especially in children) and speedy normalization of work, family and social balance, among others.⁷

SAFETY AND QUALITY CARE IS KEY

Irrespective of the “face” or perspective from which anaesthesia service appears ambulatory, optimal quality of care and patient safety protocols as practiced in standard operating rooms is sacrosanct for a good outcome and must be same for all patients.^{4,5,9}

Safety in AA is therefore optimised by skilled staff (Anaesthetists, Surgeons, and Nurses, etc), ideal facility and equipment, proper patient selection, appropriate procedure selection, adequate preparation, specialised anaesthesia equipment and drugs, right anaesthetic choice, standard monitoring (with full complement of recommended basic monitors) and an appropriate discharge plan.

GOALS should also remain same in the face of the different settings – These according to the American Society of Anesthesiologists (ASA): (Committee on Ambulatory Surgical Care) guidelines emphasizes among others:¹⁰

- A safe practice with qualified staff.
- Use of “SAFE” drugs.
- Rapid, smooth induction of anaesthesia.
- Stable haemodynamics with good operating conditions.
- Intraoperative amnesia.
- Prompt recovery.

- Minimal postoperative morbidity.
- Short period of readiness for discharge
- A responsible accompanying adult.
- Low rate of unanticipated hospital admissions.
- High level of patient satisfaction at all ages.

CONCLUSION

Ambulatory anaesthesia has evolved due to advancements in the fields of surgery and anaesthesia, to a subspecialty that also features in different facets of practice.

With great benefits for patients and all healthcare team members, standards of practice in basic operating rooms must be upheld for safe outcomes; and the establishment of a regulating body for training and standardization of the practice of ambulatory anaesthesia as found in high income countries, should no longer be a distant thought in our environment.

Conflicts of interest: There are no conflicts of interest.

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