Efficacy of preadmission testing in ambulatory surgical patients

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A retrospective study was done with 325 patients who had preadmission testing prior to ambulatory surgery. At least one laboratory abnormality was noted in 84% of the patients. The serial multiple analysis (SMA)-7 was abnormal 61% of the time. Abnormalities were seen in 54% of the SMA-12 panels and 38% of the urinalyses performed. Twenty-four per cent of the patients treated had an abnormal electrocardiogram (ECG). An abnormal chest roentgenogram was found in 19% of the patients. Only three (1%) patients potentially benefited from preadmission testing. Ninety-six per cent of the abnormal laboratory results were ignored by the attending physicians. Therefore, we conclude that preadmission testing should be done on a selective basis. Patients older than 50 years of age should have an ECG. A haematocrit should be obtained only if major blood loss is anticipated. Other tests should be ordered based on the history and physical examination.

Comments
Patients eligible for ambulatory surgery usually have ASA 1 or 2 classification. For ASA 1 and 2 patients very little preadmission testing is necessary. This has been found before for inpatient patients. The paper is important in demonstrating that no other policy is necessary in ambulatory surgery. It will help surgeons and anaesthetists to limit 'defensive' tests. One of the major reasons to support ambulatory surgery is cost reduction in health care. This paper promotes even more cuts in expenditure.

Intra-articular morphine, bupivacaine, and morphine/bupivacaine for pain control after knee videoarthroscopy

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Opioid analgesia has been associated with activation of opioid receptors within the central nervous system. Evidence has also accumulated that exogenous as well as endogenous opioids can produce pronounced anti-nociceptive effects by interacting with opioid receptors in peripheral tissues. Thus low doses of intra-articular morphine, injected at the completion of arthroscopic knee surgery, can produce relatively long-lasting postoperative analgesia apparently via activation of local opioid receptors in the knee joint. The authors studied 33 patients who received either morphine (1 mg 20 ml−1 NaCl n = 11), bupivacaine (20 ml 0.25%; n = 11), or a combination of the two (n = 11) intra-articularly at the completion of the surgery. After 1, 2, 3, and 4 h and at the end of the first and second postoperative days, pain was assessed by a visual analogue scale, and supplemental analgesic requirements were recorded.

Pain scores were significantly greater in the morphine group than in the other two groups at 1 h. There were no significant
differences at 2 and 3 h. From 4 h until the end of the study period, pain scores were significantly greater in the bupivacaine group than in the other two groups. Analgesic requirements were significantly greater in the morphine group than in the other groups at 1 h but more significantly greater in the bupivacaine group than in the other groups throughout the remainder of the study period. The authors showed that in patients having undergone arthroscopic surgery, intra-articular bupivacaine yields postoperative analgesia of immediate onset but only of short duration (2–3 h), whereas intra-articular morphine produces an analgesic effect of delayed onset, about 2 h post injection, but of remarkably long duration. The combination of these two drugs results in satisfactory analgesia throughout the entire observation period.

Comments
Postoperative pain is one of the most common complaints in ambulatory surgery. Persistent pain is also one of the causes of unanticipated admission. This exciting clinical study demonstrated the effectiveness of intra-articular morphine in inhibiting postoperative pain by activation of peripheral opioid receptors within the joint. Thus the practical application of the combination of intra-articular morphine and bupivacaine will enable more complicated joint surgery to be done on an outpatient basis.

Outpatient open cholecystectomy

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A prospective study to evaluate discharge of patients from the hospital the day of open cholecystectomy was performed. Patients were selected for outpatient operation if they were less than 55 years of age, did not undergo exploration of the common bile duct and had no significant co-morbidity. During a six month period, 94 consecutive patients underwent cholecystectomy. Forty-four of 64 eligible patients were discharged on the day of operation. Patients were walking and receiving oral liquids soon after operation. Marcaine (bupivacaine hydrochloride) was injected subfascially in all patients and vertical incisions were used in 34 of 44. One patient required readmission for 12 hours, three days after operation. The satisfaction rate was high and the patients returned to their usual activity in seven to 21 days. Outpatient open cholecystectomy is safe, and appropriate therapy and the data established a standard with which to compare that of laparoscopic cholecystectomy.

Comments
Many papers on laparoscopic cholecystectomy claim that the laparoscopic procedure reduces the operative morbidity so much that this procedure can be done as an outpatient procedure. A laparoscopy is less traumatizing than a laparotomy. Saltzstein et al. shows that in selected patients the open cholecystectomy can be performed safely as an outpatient procedure. Surgeons had never thought of doing this in the era before laparoscopic cholecystectomy. This paper should not advocate an outpatient procedure for open cholecystectomy, but emphasize that more factors exist than laparoscopy alone leading to early patient discharge from the hospital. This