

The results of 1 day surgery in proctological practice

P. Labaš*, B. Ohrádka, M. Čambal, J. Fillo

University Hospital Bratislava, Comenius University, Mickiewiczova 13, 813 69 Bratislava 1, Slovak Republic

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Abstract

In the last 9 years the authors have operated on 745 patients with proctological problems in the out-patient department under local regional or caudal peridural anaesthesia. These included 432 haemorrhoidectomies, 29 lateral internal sphincterotomies, 166 anal stretches, 56 trans-sphincteric fistulas, 41 ischiorectal abscesses and 21 rectal prolapses. Patients were discharged home after a mean stay of 5.3 h. About 6.4% (48) of operated patients had some problems in the first 24 h (bleeding, pain, discharge, retention of urine). All patients were checked after 3, 7 and 14 days. About 87% of patients were satisfied with their surgical treatment. Most proctological diseases could be operated on as 1 day surgery cases safely. Day surgery is an attractive alternative to inpatient surgery as it lowers cost without increasing morbidity.

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1. Introduction

The benefits of day surgery have been amply emphasised over the past few years. Early mobilisation, reduced nosocomial infection, prevention of thromboembolic disease, psychological benefits and reduced costs are the factors encouraging the surgeon to discharge the operated patient from hospital as soon as possible. Adopting such a programme can lead to significant savings without compromising the quality of care. The physical and psychological benefits of such an approach outweighs any minor inconveniences for patients and their families (Kambouris, 1996 [7]).

2. Material and methods

In the last 9 years we have safely operated on 745 patients with proctological problems in the out-patient department under local regional (100 cc 0.5% Xylocain with adrenalin 1:200 000) or caudal peridural anaesthesia using 20 ml 0.5% Marcain or 30 ml 1% Xylocain).

For postoperative analgesia we used a combination of long lasting analgesics and non-steroidal antiinflammatory drugs. The procedures included 432 haemorrhoidectomies (Morgan–Milligan procedure), 29 lateral internal sphincterotomies, 166 anal stretches with alcohol blockade, 56 trans-sphincteric fistulas (silk thread, elastic ligatures), 41 ischiorectal abscesses (drainage, silk thread), 21 rectal prolapses (Delorme-Rehm + Thiersch plastic with wire). Patients were observed for a mean of 5.3 h (0.5–8 h) postoperatively and then discharged home. The operating surgeon was on call for any postoperative problem that might occur (Table 1).

Table 1

Type of operation	Mean age	Number of operations
Haemorrhoidectomy	36.7	432
Anal fissure	32.3	195
Perianal transsphincteric fistula	38.5	56
Anal and rectal prolapse	67.4	21
Ischiorectal abscess	43.7	41
Together		745

* Corresponding author. Tel.: +421-2-529-21765; mobil: +421-905-618-925; fax: +421-2-529-23842

E-mail address: peterlabas@hotmail.com (P. Labaš).

3. Results

About 6.4% (48) of operated patients had some problem in the first 24 h postoperatively (bleeding, pain, discharge, retention of urine). Of these five patients were admitted due to retention of urine or pain. The rest were discharged home after being seen.

All patients were checked after 3, 7 and 14 days. Up to the third postoperative day 11.4% of patients had a problem—all were analgesic related. About 87% of patients were satisfied with this type of treatment: 13% would have preferred hospitalisation (social and hygienic problems).

About 79.5% (592) of patients were operated on under caudal peridural anaesthesia (20 cm³ 0.5% Marcain) with optimum and satisfactory analgesia and the rest were operated on under local anaesthetic infiltration (Xylocain 0.5% and adrenaline 1:200 000. Postoperative pain was satisfactorily controlled with a combination of a long acting analgesic (Tramadol) and a non steroidal antiinflammatory drug (Diclofenac).

About 72% of patients with haemorrhoids were of III degree and they were discharged 3 h after the operation. Telephone contact was established with patients until the 6th day after surgery and they were reviewed on the 7th and 14th days after operation. About 42% reported mild post-operative pain but in 12% the pain was severe. Postoperative complications were haemorrhage, perianal abscess, retention of urine and transitory gas incontinence. Late complications included, four recurrences but no stenoses. In 89% of patients results were satisfactory, but 2% of patients were not satisfied with the operation. With the introduction of new analgesic drugs this procedure is now well established in an ambulatory setting with good results and low cost.

The decongestion of the hemorrhoidal cushion is the main principle in treating piles. Haemorrhoidectomy should be performed mainly in cases of haemorrhoidal prolapse. Results of the three most often used techniques (Morgan–Milligan, Parks and Ferguson) are more or less comparable, although the presentation of the details in the literature is contradictory (Buchmann, 1989 [3]; Carditello, 1994 [5]). Each surgeon should use the technique that suits him best. We prefer the operation described by Morgan–Milligan.

4. Discussion and conclusions

One day surgery—defined by the fact that the patient enters the hospital in the morning and returns home late in the day requires the observance of a series of criteria which are absolutely necessary to achieve the highest quality and the greatest possible safety. Most important is good collaboration with the anesthetist. Material conditions, rooms and medical staff have to be appro-

priate. Indications for the performance of day surgery are many but depends on the experience of the surgeon. Limits are ruled by the general status of the patients, their social conditions and surroundings and excellent collaboration with general practitioners. Economic advantages seem to be obvious but still have to be fully calculated. It is above all necessary to persuade the public hospital administration and the social security structures of the advantages of 1 day surgery (Hollender, 1991 [6]).

The principles for operations in the out-patient department are similar for proctology and general surgery. The trained and experienced surgeon is able to perform operations above the pectinate line, for example for polyps or prolapsing tumors without stretching the anal sphincters and without anaesthesia being necessary. Below the dentate line, local anesthesia is sufficient for operative treatment of the following diseases: perianal thrombosis, tumour of the skin and the connective tissue, skin tags, second degree hemorrhoids, segmental anal prolapses, anal fissures, uncomplicated anal fistulas and perineal abscesses. The postoperative treatment follows the rules of healing by second intention (Bock and Jongen, 1991 [2]).

Rubber band ligation could be performed on 44.8% of patients. Postoperative urinary complications (retention of urine) were seen in 20% of patients in hospital care. About 90% of haemorrhoids could be treated conservatively or with rubber band ligation (Bleday et al., 1992 [1]).

The conditions for 1 day surgery operations are the patient's compliance, the cooperation of the family, a fully equipped operating theatre and last, but not least, a qualified surgical team. The pre- and postoperative management must be perfectly organised. Even oncological surgery can be performed provided the general standards for radical tumour surgery can be realised. With careful selection and indication complications are rare in outpatient surgery. None of the patients died (Saeger and Klug 1995, [9]).

With the current expansion of day surgery many patients scheduled for elective surgery will receive their treatment on a day basis. Day case anesthesia exerts a profound effect on the success and feasibility of day case surgery. In patient anaesthetic techniques are not always the most suitable in this area where even minor morbidity is important.

Paediatric surgeons confirm the benefit of this type of organisation in terms of reduced nosocomial infections, reduced local and general postoperative complications, reduced psychological traumas and increased socioeconomic advantages (Burattini et al., 1994, [4]).

Even thyroid and parathyroid surgery is feasible and safe on outpatient basis and results in a 30% savings in hospital cost. After extensive operations patients continue to require admission for postanaesthetic complica-

tions, social reasons or the presence of serious comorbid disease (Mowschenson and Hodin, 1995 [8]).

There is another very important psychological factor from the surgeon's point of view. Even very experienced surgeons, knowing that patient is going to be discharged, are more careful during a 1 day surgery operation. The sense of responsibility for the patient treated at home is greater and this factor could explain the lower complication rate after this type of surgery.

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