

This edition of *Ambulatory Surgery* was scheduled to contain abstracts from the European Congress of the Association in Madrid, taking place in April. Unfortunately, the implications of coronavirus infection meant that the meeting was cancelled at short notice. Indeed, like many other countries across the globe, the United Kingdom has been in 'lockdown' for over 6 weeks now, and as I write, there are green shoots developing which means that amelioration of the draconian measures implemented may start soon. COVID-19 is no respecter of status, as the UK heir to the throne and the Prime Minister have both been affected with infections, as have healthcare workers, many of whom have sacrificed their lives in the ongoing battle. We salute you all, in addition to all those struggling across the world to overcome the virus, and hope that in due course, there will be a return to normal working and the ongoing development of ambulatory surgery.

The *Journal* has the usual four papers for publication; a comparison of the types of meshes used in ambulatory hernia repair; the reasons for same day cancellation of day surgery in a dedicated English hospital; factors that contribute to 30 day readmission after surgery and the hypothesis that pre-operative rehabilitation prior to anterior cruciate ligament reconstruction may improve outcomes.

Babo and colleagues evaluated three different meshes used for ambulatory hernia repair to see whether there were changes in acute discomfort, haematoma, seroma or infection, or more chronic complications such as recurrence or chronic pain. The only significant difference obtained was with the duration of surgery, where the use of a self-adherent mesh decreased operative time to 43 minutes, from 51 minutes for the sutured and bi-layered mesh.

Askari et al have contributed two papers from the United Kingdom for this edition. The first one evaluates the reasons for cancellation on the day in a dedicated day surgery unit where they reviewed a two year cohort of patients. Within this time period, they found 8%, or a total of 1692 cancelled on the

day. Nearly one half were due to patient factors, one third for medical reasons, and one sixth for hospital/administrative causes. The authors provide details of potential initiatives to improve these figures with better patient information provision and optimised communication between medical teams, and one hopes such data might improve with subsequent audits.

The second paper reviews the factors associated with readmission within 30 days, following day surgery. The authors found, perhaps predictably, that advanced age (over 75 years), ASA status, surgical speciality, but not obesity influenced the readmission rate. Their overall readmission rate was around 8%. Unfortunately, Askari's paper did not detail the reasons for readmission, so it is difficult to know why obesity should not predispose to return to hospital. Perhaps this provides a fertile opportunity for further work on the subject.

The final paper examines whether pre-operative exercise in the form of a standard protocol improved rehabilitation scores after surgery for anterior cruciate ligament repair. The authors found there were early improvements in the post-operative range of motion at three and six weeks, but these differences had disappeared after three months when compared with a cohort not undergoing such rehabilitation. The authors point out that this is a small study with only 41 patients in both groups, so perhaps larger numbers might produce a more marked difference in outcomes.

Finally, as the impact of COVID-19 begins to regress, there remains a long period of convalescence before we return to normal work and life patterns. Normality will return, and with it, the ongoing development and improvement of Ambulatory Surgery. Until then, stay safe and well.

Mark Skues
Editor-in-Chief

