

Abstracts

Premedication with EMLA cream for ambulatory surgery in children

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Objectives: The objective of this study was to confirm the ability of EMLA[®] cream (Eutectic Mixture of Local Anaesthetics, Astra, Sweden) to provide effective dermal analgesia after topical application on the skin of the dorsum of the hand 1 h before venous cannulation for anaesthetic induction. *Material and Methods:* Prospective, randomized, double blind study. We included 100 children, ASA I-III, distributed into three groups: Group EMLA (E, $n = 34$), Placebo (P, $n = 33$) and Control (C, $n = 33$). *Results:* The EMLA group of patients (E) referred an evaluation of pain (visual analogical scale (mean = 2.34 ± 2.41), significantly smaller than the other groups (Placebo = 5.54 ± 3.40 , Control = 6.03 ± 2.77). *Conclusion:* EMLA cream, when topically applied 1 h before venous cannulation, provides effective dermal analgesia for venous cannulation. No general or local adverse reactions were observed.

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Quality indicators in ambulatory surgery. A prospective study

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Introduction: Ambulatory Surgery has emerged and developed in Spain in a similar way as in other occidental countries. Once established as a model for surgical care, results must be improved using objective quality indicators to assure minimal morbidity, efficient use of resources and satisfaction of patients and family. *Objective:* To provide a list of quality assessment indicators in Ambulatory Surgery and to discuss the necessity of obtaining a general consensus regarding the complexity of both the operations and the patients undergoing surgery. *Design:* Prospective and descriptive study. *Patients and Methods:* The study was performed on 833 ambulatory patients operated on in the Ambulatory Surgical Unit of the Can Misses Hospital of Ibiza. Surgical specialities involved were General Surgery, Ophthalmology, Orthopaedics, Urology, Gynaecology, and E.N.T. All diagnoses and proceedings were classified according to the CIE-9 and DGR systems, showing as an example the codes related to the General Surgery department. Quality Indicators evaluated were: (a) unplanned admission index; (b) re-admission index; (c) emergency department consultations; (d) cancellation index; (e) substitution index; and (f) postoperative pain evaluation. *Results:* Specialities involved were: Ophthalmology 277 patients (33.2%), General Surgery 189 (22.8%), Orthopaedics 142 (17%), Urology 90 (10.8%), E.N.T. 79 (9.5%) and Gynaecology 56 (6.7%). Unplanned Admission Index was 7.2%; Re-Admission Index 0.4%; Emergency department consultation 1.6%; Cancellation Index 3.3% and Substitution Index 70%. The

reasons for unplanned admission were due to specific complications in 36 cases (60.1%), followed by those secondary to an inadequate selection of the patient in 22 cases (36.6%). *Conclusions:* It is necessary to apply a series of Quality Indicators in Ambulatory Surgery. Their systematic evaluation may help us define national standards in order to continuously improve our results.

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Outpatient surgical unit: critical review after the first year of operation

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Introduction: Outpatient surgery has been quickly accepted by many hospitals, showing a lot of advantages, both in the quality of health care and also in hospital management. Following this trend, our Hospital started operating an Outpatient Surgical Unit in May 1997. *Objectives:* Once we had reached our 'cruising speed', we thought it wise to make a critical review of our experience. *Material and methods:* We have reviewed 331 patients who underwent surgery during the first year of operation, with special attention to the acceptance of this type of surgery by the population in general, and to the changes in pre-operative and post-operative protocols that this process has caused. *Results:* The rate of admission was 3.02%, and all of them occurred after 24 h. We found 57 minor complications (spotty dressing, mild inflammatory signs) on the first day assessment, but only 16 patients had referred complications. 91.5% of the questionnaires sent back by the patients qualify the experience as good or excellent. *Conclusions:* Outpatient Surgery is a good solution for many surgical pathologies, as it is well accepted by the general population. Inclusion and exclusion parameters regarding age, architectural obstacles and post-operative care can become selectively more lax.

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Contribution of the outpatient surgery unit ITO the general surgery department of a district hospital

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Introduction: The creation of Outpatient Surgery (OPS) units to combine the quality of medical attention and rationalize costs allows for greater efficiency in the use of resources. *Aim:* To report our series of patients undergoing surgery at the OPS units integrated into our Hospital (Type II). *Patients and method:* Between May 1994 and March 1998, 832 outpatients, of a total of 5230, underwent surgery at our General Surgery Unit. The criteria for exclusion from the pro-

gramme depended on the patient and the environment or resulted from the operation itself. *Results:* Mean patient age was 47.5 years; there were 420 males and 412 females. Surgery was performed for 229 inguinofemoral hernias, 47 umbilical-epigastric hernias, nine incisional hernias, 193 pilonidal sinuses, 156 mammary nodules, 65 varicose veins, 64 arteriovenous fistulae and 69 proctology operations. The most common anesthesia techniques performed were rachianesthesia and local anesthesia. Eight point seven percent of the patients required admission (OPS failure), the most frequent causes being excessive pain, orthostatic-syncope hypotension, nausea and vomiting and urine retention. There was no morbidity or mortality. *Conclusion:* OPS is a highly efficient procedure for resolving the most common pathologies in General Surgery. The anesthesia technique was an important factor in the rate of failure.

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Treatment of the abdominal wall defects in an ambulatory surgical setting: our experience

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Introduction: The creation of Outpatient Surgery (OPS) units has allowed to reduce the costs and the waiting lists in an efficient fashion. We describe our series of patients operated on for abdominal wall defects, a pathology suitable for ambulatory surgery. *Patients and methods:* Between May 1994 and March 1998, 206 inguinal hernias, 23 femoral hernias, 47 umbilical-epigastric hernias and nine incisional hernias were operated on in an ambulatory surgical setting. The patients were selected following the selection criteria previously established (related to the patient, the environment and the surgical procedure). The average age was 45 years, and the distribution by sex, 210 men and 75 women. Spinal anesthesia was preferentially performed. The surgical techniques employed were Lichtenstein's hernioplasty and Shouldice and Bassini procedures for inguinal hernias; Lichtenstein's plug technique for femoral hernias and simple closure or preperitoneal mesh for the middle line defects. *Results:* 44 patients needed readmittance to hospital (failure of OPS), the most important causes being excessive pain, urinary retention and nausea/vomiting. There was no severe morbidity nor mortality. *Conclusion:* Surgery for abdominal wall defects constitutes a group of procedures suitable for efficient and low risk OPS programs.

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