

# Editorial

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## *Emergency Day Surgery*

**This issue of the journal** contains three articles with the theme of urgent non-elective day surgery. This form of care is usually conveniently described as “emergency day surgery”, although this is somewhat of a misnomer. Most genuine emergencies require fairly immediate surgery and many also require specialist postoperative care, but there are also many less acute non-elective patients managed through the emergency surgery process. These patients, who often require fairly minor procedures, commonly get a raw deal with their treatment. During the daytime, they are often passed over for more complex and more urgent emergencies, yet by late evening they are deemed to be of insufficient urgency to have their operation performed “out of hours”. This obviously results in unnecessarily prolonged hospitalisation, but is also horribly cruel. Imagine the frustration (and anxiety) of constantly awaiting an imminent operation, only to have those hopes dashed late at night. These patients are kept fasted all day in readiness for the procedure which never comes, but by the time the decision to cancel is finally made (and communicated to the ward), there is usually precious little left to eat and probably even less desire to actually eat it! In the worst cases, this whole cycle may be repeated two or three times over. In addition, to this already bad patient experience, we must also add poorly controlled pain, the acute discomfort of an abscess or recent fracture, or the emotional turmoil following an incomplete miscarriage.

What these cases have in common is that the surgery is relatively quick and simple and need not be performed immediately. By sending the patient home with appropriate analgesia and bringing them back the following day for a planned procedure at a definite time, the operation is usually performed at least as quickly, but the uncertainty and waiting around in hospital is removed. This is the concept of emergency day surgery; it is not particularly new, but does not yet seem to have become as common as it undoubtedly should. The papers published in this issue provide good, clear models by which such services can be established, but also outline some of the reasons why the process can be difficult to sustain.

Some of the first models for emergency day surgery were presented at the BADS ASM in Bournemouth in 1999<sup>1,2</sup> and one of these was described in more detail two years later<sup>3</sup>. This model identified suitable patients and accommodated them on “unplanned gaps” on elective day surgery and inpatient operating lists. While this model successfully treated 70% of eligible patients as day cases and also treated 80% of patients within 24 hours of presentation<sup>3</sup>, it was rather dependent on suitable operating capacity being available within existing elective lists. As time has passed, the drive for efficiency means that such spare capacity should be less common. In addition, there is no guarantee that the appropriate surgical expertise will be available on the day unit every day. However, most acute trusts have now also established

dedicated surgical emergency (or NCEPOD) lists<sup>4</sup>, where suitable expertise should always be available. Therefore, the model eloquently described by the Torbay group (pages 10–13) may be the most appropriate. We adopted something similar in our trust several years ago (but never thought to publish it!) and it generally works very well. Because of their acute nature, there is often a delay at the beginning of the NCEPOD list while the surgeons decide which patients require operations and in which order; indeed the Torbay group audited this and found 87.3% of emergency lists had their start delayed by at least an hour, with half delayed by two hours. The anaesthetist allocated to this list has little to do until suitable patients are presented and it is usually possible to make one surgeon available so that this time can be profitably used for planned emergencies, admitted that morning to the day unit. We have found that two slots can usually be provided, one for surgical conditions and another for evacuation of retained products of conception, without causing a significant delay. Truly life or death emergencies obviously take priority, but these are comparatively uncommon and most “emergencies” will not suffer from any small delay imposed by completing a quick procedure.

For emergency day surgery to be successful, the condition must obviously be safe to leave untreated for a while (a given, if these patients are already experiencing delays) and be manageable with oral analgesia. The Torbay group provided oral morphine for patients to take home

while awaiting day case treatment. While this may appear somewhat excessive, some conditions (e.g., abscesses) may be much more painful before, rather than after, surgery. As well as benefiting from true patient-controlled analgesia in the comfort and convenience of their own home, the day surgery process also ensures patients are properly preassessed, any co-existing conditions are noted and appropriate information is provided. These factors all help to explain the high levels of patient satisfaction reported here.

Despite being one of the first to establish protocols for emergency day surgery<sup>1,3</sup>, the group from the Whittington (pages 5–8) found that, more than five years later, barely half of all suitable patients were being given access to their pathway. Indeed, even more patients may have been missing out, as the day surgery selection criteria were relatively conservative. Recognising that education of the constantly changing junior staff is a regular problem, the group suggest dedicated proformas which incorporate the protocol and education and empowerment of the permanent members of staff, such as the senior nurses, as a more effective solution.

The principles of emergency day surgery apply equally well to minor trauma; indeed a day unit for the emergency treatment of hand trauma was described back in 1997<sup>5</sup>. This was a purpose built, tertiary referral unit providing emergency hand surgery by

specialist surgeons using regional anaesthesia<sup>5</sup>. A more generalisable model for day case trauma is described by the Bristol group (pages 23–26). They identified patients according to appropriate criteria in a similar way to the surgical examples, and then managed the patients on their existing trauma lists. Theatre capacity was somewhat limited by the need to accommodate major trauma, but 56% of patients still managed to get their procedure done on the day of presentation, although less than half of these were actually managed as day cases. While the authors make a good case for a dedicated day case trauma list, identifying early morning slots within existing capacity might achieve the same result with only minimal delay to the bigger cases. An additional benefit they found to day case management was that the procedure was more likely to be performed by a specialist surgeon. This is not an unexpected finding from planned daytime operating when, at the very least, specialist expertise is more readily available. This has obvious benefits, even for minor procedures. For example, how often is an underlying fistula missed when an acute abscess is drained by an inexperienced surgeon?

Although they all take slightly different approaches, these three papers all show the benefits which emergency day surgery has to offer. As well as dramatically improving the patient's experience, significant pre- and postoperative resources are made available to treat other

patients. This is a familiar enough story in the elective setting, where there are still further gains to be made, but the potential for service improve within the non-elective arena is even greater. The latest BADS Directory already includes suggested targets for a few emergency day surgery procedures<sup>6</sup>, but this is an area which we hope to expand somewhat in the future. You can help by publishing your experiences with non-elective procedures.

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## References

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