



**Vol. 15-2**  
**July 2009**

## *Ambulatory Surgery Journal*



A product of IAAS (International Association for Ambulatory Surgery).

[www.iaas-med.com](http://www.iaas-med.com)

## **Editorial**

Ambulatory Surgery Journal has now been published for about two years as an internet based journal. It has partly been a success since it has been proved that with small economic investments it has been possible to produce a readable Journal.

On the other hand the number of new contributions has been and is still a problem. This is rather difficult to understand since the International Association for Ambulatory Surgery (IAAS) has 17 member countries and a further number of personal and associated members, and each member country has at least two members in the General Assembly, showing a great interest in the structure and results for Ambulatory or Day surgery.

If each country or each member of the GA contributed with at least one paper every year, we would have a very favourable situation. Why is that not the case?

One explanation could be that our Journal is not yet listed in the big databases for scientific Journals (e.g. PubMed). It is highly ranked on a Google search indicating that it is often read at the internet but for scientific reasons it will be an advantage with more scientific impact via the databases. On other reason can be that other Journals are more attractive or that the topic day surgery is not interesting enough for scientific papers. I will not think of other reasons like lacking interest from the member countries and their members or even lacking activity in the member countries.

Therefore it was discussed at the GA meeting during the congress recently in Brisbane that it is necessary to improve the web based Journal so that it entirely fulfil the demands for listing in the databases. Up till now the expenditure to the web based Journal has been small and is free for everyone at the internet. A new concept may be costly and it can be necessary to ask for a subscription fee in the future. However a possible contribution from vendors or help from members may make it possible even in the future to publish for free.

The editors are now in a process where the required changes will be described and input from members is very welcome.

Because of the shortage of new papers this edition is smaller than usually. The next edition in September will include abstracts from the recent very successful International Congress in Brisbane, Australia.

Claus Toftgaard,  
Associate editor,  
Immediate Past President, IAAS

## **Day Case Urology in a Dedicated Day Case Surgery Unit in a Nigerian Teaching Hospital.**

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## **Abstract**

*Aim:* To find out the extent of day care urologic surgery at the Obafemi Awolowo University teaching hospital complex, Ile-Ife, Nigeria.

*Patients and Methods:* For this retrospective study we reviewed the data of all urologic patients treated at the day case surgery unit between January 2004 and December 2007. The parameters studied were: age, type of surgery/procedure, anaesthesia administered and the rank of the surgeon.

*Results:* In total, 532 patients were managed, 218 (41.0%) children aged between one day and 15 years and 314 (59.0%) adults aged between 16 and 85 years. General anaesthesia (GA) was primarily used in children (110 children vs. 8 adults), while local anaesthesia with sedation and topical anaesthesia alone was only used in adults. Topical anaesthesia with sedation was used in 8 (3.7%) children and 65 (20.7%) adults. 100 (45.9%) children (all the circumcision cases) and 50 (15.9%) adults had no anaesthesia. The majority of the procedures were carried out by the senior registrars (367 patients, 69%). The most common procedures performed in adults were prostate biopsy (97 cases, 30.9%), orchidectomy (70 cases, 22.3%), urethral bouginage (65 cases, 20.7%) and urethrocystoscopy (40 cases, 12.7%), while male circumcision (100 cases, 45.9%), hydrocelectomy (57 cases, 26.1%) and orchidopexy (40 cases, 18.3) were the most common procedures performed in children.

*Conclusion:* The day care surgery unit is now established. Presently, more adults than children are treated. Most procedures are performed by resident doctors under supervision which allows them to obtain very good hands on experience. The most common procedures are prostate biopsy, orchidectomy, urethral bouginage and urethrocystoscopy in the adults, while male circumcision, hydrocelectomy and orchidopexy are the most common procedures in children.

**Keywords :** *Day care urology; Day surgery unit (DSU); Paediatric and adult anaesthesia.*

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## **Introduction**

Day case surgery is defined as the performance of a planned surgical procedure with the patient being discharged on the same day. In the USA, it is also called “ambulatory surgery”, because the patient is discharged within 23 hours of the procedure.

Day case surgery was first reported in 1909 by James Nicoll, a Scottish surgeon, and in 1912 by Ralph Walter in the USA<sup>1,2</sup>. Initially there was a slow progress and acceptance of this innovation in both the UK and USA, until in the 1960s and 1970s it became more expensive to keep in-patients on admission and the availability of beds decreased causing prolonged waiting lists. During this time, the day surgery unit (DSU) was introduced by Walter Reed<sup>2,3</sup>, and since then there has been increased improvement in the management of patients on a day case basis and an improvement of methods of anaesthesia ensuring patients’ fitness after discharge. In our environment of limited resources and increased hospital attendance very few hospitals so far have established a DSU.

The day case surgery unit of the Obafemi Awolowo University Teaching Hospital, a semi urban tertiary centre in Ile-Ife, Nigeria, was opened in January, 2004, and this study aims to identify the scope of day case urologic surgery in our DSU.

## **Patients and Methods**

This retrospective review of the records of the day case unit covers a period of four years (January 2004 to December 2007). We analysed the following data both for paediatric and adult patients admitted for urologic procedures: age, sex, indications for treatment, type of anaesthesia administered and the rank of the performing surgeon. The data were collected in a proforma and analysed using SPSS version 13 using simple statistics.

## **Results**

In total, 532 urological cases were treated in the DSU; of these 502 major urological procedures were performed in the main operating theatre. 218 (41.0%) patients were children aged between one day and 15 years and 314 (59.0%) were adults aged between 16 and 85 years.

Approximately 99% (n=530) of the urology day cases were males.

The indication for management was therapeutic in 378 (71%) patients and diagnostic in 154 (29%) patients. Tables 1 and 2 show the number and type of day case procedures performed in adults (Table 1) and children (Table 2). The most common procedures carried out in adults were prostate biopsy (n=97, 30.9%), orchidectomy (n=70, 22.3%) and urethral bouginage (n= 65, 20.7%), while male circumcision (n=100, 45.9%), orchidopexy (n=40, 18.3%) and hydrocelectomy (n=57, (26.1%) were the most common procedures performed in children.

General anaesthesia (GA) was primarily used in children (110 children vs. 8 adults), while local anaesthesia with sedation and topical anaesthesia alone was only used in adults. Topical anaesthesia with sedation was used in 8 (3.7%) children and 65 (20.7%) adults. 100 (45.9%) children (all the circumcision cases) and 50 (15.9%) adults had no anaesthesia. (Table 3)

The majority of the procedures were carried out by senior registrars (367 patients, 69%), while 88 (16.5%) cases were managed by consultants and 77 (14.5%) by junior registrars.

There was only one hospital admission, namely a child following a glandulo-cavernosal shunt; all other cases were managed in the DSU and discharged on the same day.

## **Discussion**

In the UK, USA and Australia DSUs became established fifty, sixty and eighty years, respectively, after their initial introduction<sup>1,2,4</sup>. In view of the limited resources in developing countries and the need to maximize the use of available resources, the DSU was introduced in the Obafemi Awolowo University Teaching Hospital in January 2004, approximately in the 30<sup>th</sup> year of our hospital's existence.

In this review, day case urologic procedures constituted 51% of all urologic surgery carried out in our hospital during the study period, which compares favourably with a reported 50% in the UK and Australia<sup>2,4</sup>. In the USA and Canada, day surgery constitutes about 90% of all elective surgical procedures<sup>5</sup>.

Part of the requirement for a successful day case surgery practice anywhere is the availability of good anaesthesia. A patient undergoing day case surgery must recover quickly from anaesthesia and ambulate early. The role of cost effective anaesthesia, particularly short acting anaesthetic drugs, in this regard is well established<sup>6</sup>. In our study 50% of the children benefited from general anaesthesia. This low percentage is mainly due to the fact that a significant proportion of paediatric day-case surgery in our environment involves neonatal circumcision, which rarely requires the use of general anaesthesia. As mentioned in an earlier study by Agbakwuru et al.<sup>7</sup>, local anaesthesia with sedation is well tolerated by adult Nigerian patients; it was the commonest type of anaesthesia used in our study (n=104, 33.1%), followed by topical anaesthesia alone (n=87, 27.7%).

Given the fact that a significant proportion of the patients undergoing day case surgery in our hospital are handled by senior registrars and registrars, we believe that the DSU may be an

avenue to improve the efficiency of this group of trainee surgeons in urological procedures.

However, this does not mean that the DSU should be left without adequate supervision by the consultants.

Studies have shown that day case surgery is well accepted by patients even in our environment<sup>8-10</sup>. Provided that the necessary technical equipment and an adequately experienced surgeon are available, procedures such as hydrocelectomy, orchidectomy, orchidopexy, male circumcision, transurethral resection of the prostate (TURP) are feasible on a day case basis<sup>7, 10-12</sup>.

In conclusion, we believe that day care urology in our DSU has now been well established as shows the increasing number of patients treated. Urology surgical residents have the opportunity to obtain more hands on experience under supervision. It is hoped that more urological procedures will be performed as time goes on. A further prospective study of complications and their outcome is now needed in order to improve the service delivery through our DSU. This review should encourage other teaching hospitals in resource limited areas to introduce a DSU<sup>13</sup>.

### **Acknowledgements**

We would like to thank Professor O. Adejuigbe, Chief Medical Director, Obafemi Awolowo University Teaching Hospital (OAUTHC), Ile- Ife, Nigeria who pioneered the day surgery unit.

We also thank Mr. Badru, the Director of the DSU, Obafemi Awolowo University Teaching Hospital Complex, Ile- Ife, Nigeria and Drs. T.N. Oyebamiji and O.J. Atijosan, who helped us to retrieve the data

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**Table 1: Number of day case procedures/surgery in adults during the study period**

Diagnosis	Type of Procedure	Number	%
Prostate cancer	prostate biopsy	97	31.0%
Prostate cancer	bilateral total orchidectomy	70	22.3%
Urethral stricture	bouginae	65	20.7%
Bladder outlet obstruction	urethrocystoscopy	40	12.7%
Vaginal hydrocele	hydrocelectomy	22	7.0%
Bladder cancer	bladder biopsy	6	1.9%
Bladder stone	open cystolithotomy	3	1.0%
Varicocele	varicocelectomy	3	1.0%
End-stage renal disease	arteriovenous fistula	2	0.6%
Post pyeloplasty	DJ stent removal	2	0.6%
Male infertility	testicular biopsy	2	0.6%
Stage-1 urethroplasty	2 <sup>nd</sup> stage urethroplasty	2	0.6%
Total		314	100%

**Table 2: Number of day case procedures/surgery in children during the study period**

Diagnosis	Type of Procedure	Number	%
Intact prepuce	circumcision	100	45.9%
Congenital hydrocele	hydrocelectomy	57	26.1%
Undescended testis	orchidopexy	40	18.3%
Urinary incontinence	urethrocystoscopy	9	4.1%
Meatal stenosis	meatotomy	8	3.7%
Urinary extravasation	suprapubic cystostomy	3	1.4%
Priapism	glandulo-cavernosal shunt	1	0.5%
Total		218	100%

**Table 3: Type of anaesthesia used**

Type of anaesthesia	Children	%	Adults	%
General	110	50.5%	8	2.6%
Local + sedation	0	0	104	33.1%
Topical + sedation	8	3.6%	65	20.7%
Topical alone	0	0	87	27.7%
No anaesthesia	100	45.9%	50	15.9%
Total	218	100%	314	100%

# **Informed Consent for Local Anaesthesia in Cosmetic Surgery.**

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## **Abstract**

Laws regarding informed consent vary from country to country. In the Islamic Republic of Iran for any approach to cosmetic surgery, written informed consent is obtained when anaesthesia involving sedation or general anesthesia is used. Although local anaesthesia is extremely safe, some common or rarely more serious complications may occur secondary to its administration. Thus, consent for the use of local anaesthesia should be obtained as for other types of anaesthesia.

**Keywords :** *Local anaesthesia; Cosmetic surgery; Informed consent.*

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## **Introduction**

Consent means voluntary agreement compliance or permission. Consent may be expressed and implied. Laws regarding informed consent vary from country to country. It is important to remember that having a patient sign a written consent form does not excuse the cosmetic surgeon from the responsibility of having an adequate discussion with the patient about the proposed treatment and explaining the risks benefits and possible alternatives to the proposed treatment. (1) Informed consent generally is required for a health care professional to validly defend against liability from responsibility for complications that may occur during treatment or observation. The purpose of this article is to stress the importance of informed consent before local anaesthesia.

Obtaining consent (2): To examine, treat, manage or operate upon a patient without consent is assault in law, even if it is beneficial and done in good faith. The patient may recover damages. If a doctor fails to give the required information to a patient before asking for his consent to a particular operation or treatment, he may be charged with negligence.

## **Legal Standards for Surgical Informed Consent**

Legally, the requirement for physicians to obtain consent from patients for a medical procedure was established in the United States as early as 1914, and the more specific requirement that this consent be informed was added by a court ruling in 1957 (3,4). Since that time, legal requirements concerning the nature and quantity of information given to patients during informed consent have evolved. Currently, the law requires that surgeons disclose information that would be material to the consent decision of patients (5,6). This includes information about the nature of the surgery, its risks and benefits, potential alternatives, and the expected post-operative course. However, determining what counts as “relevant information” and how specific this information should be remains open to interpretation. An early proposed informed consent standard was the “professional practice” standard, requiring physicians to disclose information that is customarily provided by other professionals. More recently, the “reasonable person” standard requiring disclosure of information that a hypothetical reasonable patient would

want to know, and the “subjective standard” requiring disclosure of information shaped by the preferences of an individual have been adopted in most states (5,6).

### **Ethical Principles Underlying Informed Consent**

The legal question of whether or not surgeons are required to disclose personal performance is unsettled. This legal ambiguity reflects the unsettled ethical question of what information surgeons owe their patients. The primary ethical principle underlying informed consent requirements is respect for patient autonomy (6,7). Therefore, one goal of the informed consent process is to enable patients to make medical care decisions that reflect their values and desires. The history of informed consent reflects an evolution of our understanding of how to best serve the interests of patients without harming the physician-patient relationship. The initial movement toward more explicit informed consent during the mid-20th century raised concerns that more information and control over their care would make patients unduly anxious or confused, allow them to make decisions that were not in their best medical interests, or weaken trust in their physician (6). While these tensions still exist, the informed consent process has come to be accepted as an appropriate and necessary expression of respect for autonomy that provides overall benefit to patients.

The question of whether information related to a surgeon's skill should be added to the current list of disclosed items has recently been explored by Clarke and Oakley (8). They argue that because a surgeon's skill, as reflected in a personal performance record, is relevant to patients' decision-making, disclosure is required during informed consent. These authors state that there is widespread agreement that adequate informed consent for a procedure includes disclosure of “reasonably foreseeable risks of an operation,” and argue that because an individual surgeon's skill in performing an operation is a component of foreseeable risk, it should be disclosed. They conclude that, “disclosures that do not include at least some relevant, material information about the performance ability of available surgeons are an inadequate basis for the provision of effective informed consent.”(8). The argument that respect for patient autonomy requires divulging surgeon-specific performance rates presupposes that the information is accurate enough to enhance patient decision making, that patients want this type of information, and that

the benefits of disclosure outweigh the possible harms. We will explore each of these questions in turn.

### **Why informed consent in cosmetic surgery for administration of local anaesthesia?**

Plastic surgeons generally inform patients about both simple, common complications and serious, rare complications that can occur with the proposed procedures; and in doing so they cover both extremes of the spectrum of complications. Local anaesthesia is extremely safe. The most common complications that may occur while administering local anaesthetic in cosmetic surgery are ecchymosis and analgesia. The rare and more serious complications are paraesthesia or permanent anaesthesia and some life threatening conditions (9,10,11). If a complication occurs and informed consent was not obtained in writing, the surgeon may be placed in a difficult position to convince a jury. Cosmetic surgeons are required to obtain informed consent for all of the procedure.

### **Conclusion**

The use of local anaesthetic in cosmetic surgical procedures is well established as an effective and safe mode of anaesthesia delivery. Local infiltration of anaesthesia may be used alone for minor surgical procedures, or it may be used with general anaesthesia or intravenous sedation and analgesia for more complex, lengthy procedures. When considered independently, the use of local anaesthetic agents has undeniable limitations. Local anaesthetics can cause toxicity and side effects. Injection of local anaesthetics for subcutaneous infiltration frequently is painful until sensory anaesthesia occurs. Local anaesthetics have limited efficacy with respect to the intensity and duration of sensory blockade that can be achieved. In some situations, the use of local anaesthesia with the maintenance of an awake patient also may be undesirable for the surgeon and impractical for the patient. Despite these shortcomings, local anaesthetics are fundamentally ideal for use in cosmetic surgery.(12)

In departments of plastic surgery or any cosmetic clinic, written informed consent is obtained for anaesthesia involving sedation or general anaesthesia, as it is for many other procedures, but not for the administration of local anaesthesia. Local anaesthesia is extremely safe, but common to rare serious complications have been reported. So the existence or lack of written informed consent can have significant implications if a

malpractice action is considered after treatment is rendered. Thus, it is strongly recommended that all plastic surgeons must obtain written informed consent before administering local anaesthetics.

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