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Outpatient proctological surgery

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Abstract

Outpatient proctological surgery is feasible if patients are carefully selected, if surgery is meticulous, if postoperative wound care is optimal, if postoperative analgesia is adequate and if patients confidence is established. An 18 year experience has proven to us that 70% of anal canal surgery can be done on an outpatient basis using local or posterior perineal block anesthesia with a low complication rate of 0.5%. Proctological surgery can be done on an outpatient basis with the same success rate as any other day case procedure.

Keywords: Outpatient; Proctological surgery; Postoperative

1. Introduction

Today, many surgical procedures are performed on an outpatient basis or ambulatory basis. There are several reasons for this (Table 1).

Patients are usually anxious about proctological surgery, as they fear postoperative pain.

Can the good results observed after outpatient surgery in many other surgical specialities be expected after surgical proctology?

To give an answer to this question we will present our own experience at the Outpatient Clinic for Surgery at the University Hospital of Geneva.

We have been running an outpatient clinic for proctology since 1976. With increasing experience and confidence more surgical procedures have been performed on an outpatient basis.

The development of posterior perineal block anesthesia has allowed us to operate on more patients of any age, with a reduced risk of complication.

Table 1
Advantages of outpatient surgery

Patients life is only minimally disturbed
Patient anxiety is lessened
Reduced rate of nosocomial infections
Better administrative management of operative programme
Earlier return by the patient to normal activities
Time off work is reduced
Costs of outpatient surgery are less than for inpatient surgery
Overall health expenditure is reduced
Hospital beds can be occupied by more severe cases

2. Selection criteria

As for any ambulatory procedure, patients are selected according to precise and well established social and medical criteria (Table 2)

Any patient fulfilling these criteria may be considered for ambulatory surgery.

Laboratory investigations are not routinely performed before local anesthesia, posterior perineal block or caudal block. In special cases, blood samples are analyzed according to the patients medical conditions.

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Table 2
Selection criteria

Age <60 years (relative contraindication)
ASA I and ASA II
Any severe concommitant medical condition should be well controlled (diabetes, hypertension, angina, etc.).
Patient should not take any anticoagulant medication
Patients should have a positive attitude towards outpatient surgery
Patient should not be at home alone during the first 24 h postoperatively
Family should be willing to participate in the postoperative treatment
Social circumstances should be adequate
Patient should have easy access to a bathroom and toilet
Telephone should be accessible
Patient should not drive postoperatively
Distance from home to hospital should not be >60–100 km
Transportation facilities should be available in case of emergency or complications
Hospital or medical facilities should be accessible 24 h a day

3. What procedures?

Many proctological surgical procedures can be considered. They concern the anal margin, anal canal and lower rectum. They should not require complicated and time consuming postoperative care, special dietetic measures or result in any risk of major secondary bleeding. Table 3 give a list of possible procedures:

The patient should be completely informed about the procedure and possible complications.

Strict recommendations should be given to the patient about postoperative care, local hygienic measures, dressings, consumption of alcoholic beverages, painkiller medication, physical exercise and driving.

According to national regulations, a consent form should be filled and signed by the patient.

4. Anesthesia and preoperative measures

Most of our cases are performed under local anesthesia or a posterior perineal block. Caudal block is used in cases of extensive septic lesions but in the absence of any pilonidal sinus.

We do not routinely use any premedication. Only in very anxious patients we give 5–10 mg diazepam orally, 30 min before surgery. The patient should not be fasting. The patient is asked to pass stool and urine before the operation. Neither enema nor preoperative laxative is used.

In the case of a caudal block, intravenous access is obtained.

A resuscitation emergency kit and monitoring facilities are always available.

5. Practical organisation

The patient comes to the proctologic clinic minutes before the planned time for surgery. He takes his clothes off and is put on the operating table in the lithotomy position. The operative field is not shaved. After disinfection, the anesthetic is given. The surgical procedure is carried out. After surgery, we show to the patient, by means of a video camera and a monitor, how the wounds are and how he should treat them and apply an adequate dressing. The patient immediately leaves the theater, dresses and is allowed to go to the hospital cafeteria. A total of 40–60 min later he is called back and the wound is checked by the nurse. The dressing is renewed, if necessary, by the nurse to insure that there is no bleeding. The patient receives a leaflet about postoperative care after proctological surgery and a detailed prescription for sitting baths or showers, dressings, local ointments, pain killers and a bulk forming laxative. An appointment is planned for the fifth postoperative day. Altogether, the patient leaves the hospital within 60–90 min. In case of a complication, a phone number is communicated to the patient, which he may call 24 h a day.

6. Postoperative care

The patient is instructed to take, 3–4 times a day, a shower or a sitting bath to keep the wounds clean. Contact with faeces increases postoperative pain. The application of some wound healing ointment may be useful. Systemic antibiotics are administered preoperatively in case of extensive cellulitis, in patients suffering from heart valve insufficiency or those who have undergone prosthetic valvular replacement.

Table 3
Possible outpatient surgical procedures

Excision of thrombosed perianal hemorrhoids
Semi-closed and closed hemorroidectomy
Sphincterotomy
Fissurectomy
Skin tag excision
Abscess drainage
Seton drainage
Fistulotomy
Fistulectomy
Slinding flaps
Anoplasty
Perianal skin flaps
Correction of anal stenosis
Correction of Whitehead deformity
Anal warts excision
Polypectomies
Excision of low villous adenomas
Transanal excision of small rectal tumours
Pilonidal sinus surgery
Endoscopy with polypectomy

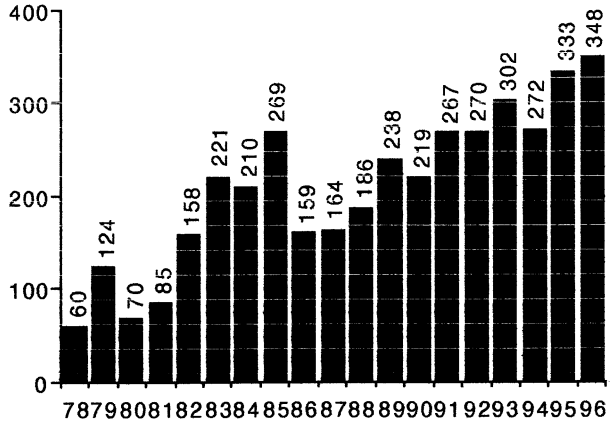

Fig. 1. Number of proctological outpatients procedure per year between 1978 and 1996.

To avoid straining at stools and to achieve daily anal stretching, we order bulk forming laxatives and taking paraffin oil.

The most complex postoperative problem is the control of pain. We routinely advise the patient to take, three times a day, some non steroidal anti-inflammatory drug (NSAID) and paracetamol. Tramadol is prescribed if patients are very sensitive and anxious and if the procedure may result in severe pain (e.g. extensive excision of fistulous tracts).

7. Our experience and results

We have run an outpatient clinic for proctology since 1976. From 1978 to 1996, an increasing number of patients were operated on yearly. Altogether 3955 procedures were performed (Fig. 1). These figures do not include:

1. Minor procedures performed during consultation such as endoscopy, haemorrhoidal sclerosis by injection or infrared coagulation, rubber band ligation and thrombectomies.
2. Procedures performed in the emergency station during the night when the proctological clinic is closed.
3. Major procedures requiring in every case, a hospital stay such as extensive rectal surgery, rectopexy, sphincter repair and colpomyoraphy.

During the last 10 years, 3996 procedures involving anal canal, with exclusion of minor cases mentioned above were performed. A total of 30% (1238) were inpatients and 70% (2758) were outpatients. The conditions are listed in Table 4.

Surgery was performed without mortality and without any infection. Complications (Table 5) were observed in 14 cases (0.5%). Thirteen patients had secondary bleeding on the day of surgery and 11 cases could be treated on an outpatient basis. Two patients required an overnight short stay in hospital (one after hemorroidectomy and one after fistulectomy). No bladder retention was recorded as a result of local anesthesia and there was no use of intravenous infusion.

One patient developed a fecaloma which required manual elimination and enemas.

Table 4
Conditions treated between 1986 and 1996

	Inpatients	Outpatients
Haemorrhoids	777	750
Fissure	46	450
Fistual in ano	292	515
Pilonidal sinus	16	602
Condyloma acuminata	35	222
Tumour, polyp	44	135
Anoplasty	15	16
Others	13	68
Total	1238	2758

8. Remaining problems

Our experience during the last 18 years has shown, that thanks to precise selection, proctological outpatient surgery is possible, safe and has a low complication rate. Furthermore, patient satisfaction is very high as they appreciate avoiding a hospital stay.

The biggest problem we are still facing is the postoperative pain control. We cannot determine preoperatively, if and how a patient will tolerate postoperative pain and if they are a very sensitive person. The intake of a NSAID just before surgery and for 3 days postoperatively seems to be very effective. NSAID should be use with paracetamol three to six times a day.

In case of more extensive and painful surgery, if patients are very sensitive, tramadol (Tramal R) is ordered as drops: 15–20 drops four to six times per day. The patient should take these drugs routinely and not wait until pain occurs or is unbearable. The complications resulting from these medications are very low. They do not result in acute constipation as would opiate analgesics, such as codeine.

Table 5
Complications after 2758 proctological outpatients procedures

Bleeding	13
	4 after fistulectomy
	6 after pilonidal sinus
	2 after hemorrhoidectomy
	1 after sphincterotomy
Infection	0
Fecaloma	1
Bladder retention	0
Hospital admission	2

Topical anesthetic ointments may be useful as an additive measure.

We still need more powerful painkillers with low side effects: no nausea and dizziness, no constipation, no blood pressure drop.

9. Conclusions

Careful patient selection, meticulous surgery, optimal postoperative wound care, adequate postoperative analgesia and patients confidence are mandatory to achieve successful proctological outpatient surgery. In our experience, 70% of anal surgery can be done on an outpatient basis using local or posterior perineal block anesthesia, with a low complication rate of 0.5%. Proctological surgery can be done on an outpatient basis with the same success as other day case procedure.