

Welcome to the September edition of the Journal.

This quarter's edition includes a plethora of papers of varying interest yet all under the headline banner of ambulatory surgery. There is a review of interscalene analgesia for arthroscopic shoulder surgery, a two year review of oesophageal dilation in a day surgery environment, the benefits (or not) of provision of coffee in the post-operative care unit, and an evaluation of Procedural Sedation Analgesia for minor orthopaedic surgery.

Chao and co-workers evaluated patients undergoing arthroscopic shoulder surgery with an interscalene block and compared them with those who underwent general anaesthesia with multimodal analgesia. Perhaps predictably, they found a reduced time in the postoperative care unit with lower pain scores in the block group for those patients receiving an interscalene block.

An Italian study evaluated differences between oesophageal or pyloric dilation for stricture, and comparing the modes of anaesthesia. The authors found that just over half of achalasia patients had deep sedation via the native airway and caustic stricture was corrected in almost all cases by general anaesthesia. Only 3 of 185 patients developed post-operative complications; 2 had a fever and one developed rapid rate atrial fibrillation, despite nearly 50% having an ASA grade of 3.

A nursing study from the United States evaluated the feasibility of provision of coffee compared with other beverages in the PACU after ambulatory surgery. They found no differences in patient satisfaction, nor discharge times. They did however report a reduction in PONV rates from 11% to 3.8% in those receiving caffeinated beverages. This is an interesting finding as a cursory glance at the literature suggests intravenous caffeine has no effect on emetic rates. Another study beckons, perhaps?

Finally, a paper from the Netherlands assesses the role of procedural sedation analgesia (PSA) for minor orthopaedic surgery. PSA arose during the COVID pandemic when limitation of operating facilities prompted a review of available and feasible solutions. This is basically, propofol sedation with presumed local anaesthetic infiltration to facilitate surgery. The authors found that the use of PSA significantly reduced admission time with no change in complication rates when compared with standard care. Moreover, physician assistants conducted the PSA surgery, rather than orthopaedic surgeons.

In conclusion, Ambulatory Surgery continues to be on the hunt for future articles to publish. Please consider submitting your papers to the Journal for consideration.

Dr Mark Skues
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