EDITORIAL

OUTPATIENT SURGICAL PROCTOLOGY – past, present and future

HEADINGS - Intestinal diseases, surgery. Ambulatory surgical procedures. Anesthesia, local.

Outpatient surgery either at home or outside the hospital environment is not a new concept and is probably the oldest known modality, easily confirmed by Egyptian papyruses.

In the Iliad and Odyssey Homer, mentions accurately, the removal of arrows from the bodies of soldiers, classifies the sound and describes the care with dressings to provide proper healing.

For centuries operations were performed externally outside hospitals, and only recently were moved to surgical centers. The important progress in surgical technique, medications (antibiotics, anesthetics, etc.), and chiefly the result of great technological advances, surgeons began to carry out increasingly more complex and prolonged procedures, requiring more sophisticated hospital infrastructures.

Currently, large hospitals are complex structures that combine extremely expensive apparatus and equipment, allowing the surgeon to realize procedures with great safety and comfort.

As a result, the surgeon has transferred almost all his activity (minor, medium and major surgeries) to these "luxurious" hospitals, vastly increasing the cost of medical treatment and resulting long waiting lists hampering hospital admissions. Consequently, a significant number of procedures that do not require special equipment, preoperative preparation and hospital stay, are realized in these hospitals.

This has resulted in long waiting lists for hospitalization, shortage of beds for major surgeries, high cost of bed/day, and a great increase in medical assistance due to expensive hospitalization.

This system of hospitalization with its elevated costs, has determined the need for revision of these concepts, terminating with many surgical procedures moving from the hospital environment to the outpatient sector. This migration began in the last century with the study by Emil Reis (1899) in Chicago, USA. Later, the Royal Glasgow Hospital for Children (1909) realized numerous outpatient surgeries in children with excellent results. In Scotland, HERZFELD[8] published his good results obtained on 1,000 outpatient pediatric herniorrhaphies performed under general anesthesia. FARQUHARSON[4], realized 487 outpatient herniorrhaphies under local anesthesia with satisfactory results, similar to those observed by hospitalization and like those observed by Knapp (1940). Until the seventies, operative procedures irrespective of their complexity, were realized in hospitals, very few surgeons risked performing them on an outpatient basis.

The rediscovery, improvement and broadening of outpatient sectors only occurred during these last four decades, more precisely starting in 1961 when the first modern program of outpatient surgery was created in Michigan (USA). Two other great centers, one at the University of California (Los Angeles) and the other in Phoenix (Arizona), USA, followed this trend. The good results achieved by these centers, stimulated the interest of other hospitals throughout the world.

The organization and standardization in these centers with the objective of providing qualified, very safe medical assistance at a low cost to patients was adopted by other medical centers.

The development of outpatient surgical sectors with surgical and anesthetic conditions capable of providing safety and comfort to both patients and surgeons, the improvement in hospital quality and postoperative care, besides reducing the resulting costs of hospitalization stimulated a growing improvement of the system in many other countries.

In the United States, in 1980, 16% of surgeries were realized on an outpatient basis, in 1985 – 35%, in 1990 – 50%, in 1995 – 60% and in 2000 - 67%, according to data published by the American Hospital Association in 2003.

In the United Kingdom, about 50% of all surgeries are realized without need for hospitalization[5].

In South America, namely in Bogotá (Colombia), the first outpatient surgical center was installed in the "Centro Hospitalar San Juan de Dios", with the publication of a brochure on "Outpatient Surgery".

The advancement of outpatient surgery in Brazil occurred early in the eighties, with the publication by some authors of satisfactory results in several centers[7, 9, 12, 13, 14, 16, 17, 19, 20, 22, 25, 26, 27, 28, 29, 32, 33, 34, 35].

The number of outpatient surgeries in the USA, have increased yearly, so that currently about 30 million of these procedures are realized yearly; in France after its organization that occurred in the early nineties, a significant increase occurred, with predominance of outpatient surgeries compared to those realized by hospital admissions[10, 18, 30]. The same occurred in Italy, especially when we analyze anorectal operations[1, 21].

In coloproctology, the high incidence of anorectal diseases and the economic impact of various types of

surgical treatment involved have motivated interest for outpatient management of these ailments. While circa 30%-50% of all surgeries can be safely realized in outpatient sectors, this rate corresponds to 90% in anorectal operations[31, 35]. Only 11% of hemorrhoidectomies in Australia in 1996-1997 were performed as outpatient procedures, compared with 74% of such operations in the United States during 1994[3, 23].

In this way, during the last 30 years, outpatient proctologic surgery has received special attention due to the need for reducing hospital costs and to release beds for major surgeries.

In Brazil, specifically in the public hospitals, the long wait for anorectal operations via hospital admission demonstrates the size of the problem. In mid 1988, the "Hospital das Clínicas" of the University of São Paulo Medical School, realized a community project of orificial diseases whereby 20 outpatient operations per day were successfully realized always on Saturdays over 8 consecutive weeks[15].This project was discontinued because of economic conditions; however, it was useful because it reduced the waiting list in the outpatient clinic, which at the time exceeded almost four hundred ready and prepared patients, awaiting surgery. It was concluded that the concept of day-hospital in public tertiary services is feasible, with the possibility of treating an expressive number of patients with benign orifice pathologies, over a short period of time, with quality and low rates of complications.

Recently, some major procedures, that were traditionally performed by laparotomy by hospitalization, mainly cholecystectomies, are now done by videolaparoscopy in outpatient sectors with safety, low morbidity and reduced costs; in this way broadening the outpatient system[2, 24, 36]. Despite being a controversial subject, the realization of videolaparoscopic surgery in mid-sized procedures, is possible, so long as the criteria of safety in patients previously informed and motivated is strictly adhered to.

We must remember that in the so-called developed countries mentioned, there was a concerted government effort with the support of health insurance companies, medical groups and hospital associations, which terminated in this healthy trend toward outpatient treatment for selected cases.

The known advantages of realizing selected procedures in an outpatient environment, with reduced costs, benefits for patients and without detriment to surgeons, have justified investments in this sector[6, 11, 35].

Despite the social, economic and medical advantages reported by various authors, the majority of surgeons in Brazil are loath to utilize it, either because of possible inadequate pain control, or fear of postoperative complications, or resistance of many patients, or for lack of dissemination, or mainly because of the lower payment paid by the health insurance plans.

In Brazil, almost the entire experience acquired in outpatient operations is the result of university and/or public hospitals; since the private health insurance companies insist on lower payments, or better yet, they pay 50% of the amount of the procedure realized without hospital admission.

This forces the professional to operate all cases, even minor ones, via hospitalization, otherwise he is punished by receiving a lower fee.

It demonstrates clearly that in developed countries, and in a competitive capitalist world, the attainment of better economic rates and administration of all their costs has been sought for continuously, significantly increasing the number of outpatient surgeries, whereas Brazil is proceeding in the opposite direction, encouraging waste, without concern for costs and even discouraging the realization of outpatient surgeries by lower fees for analogous procedures.

Up to now, insofar as I know, few Brazilian health insurance plans pay the same fee for the same procedure realized either in an outpatient sector or by hospitalization.

During these last three decades, the practice of medicine especially surgery, has been undergoing important changes guided by economic and social aspects, so that surely one of the most important and exciting changes is the transfer of many patients from the hospital environment to the outpatient one, always motivated by financial reward and without impairing quality.

I would like to conclude by stating that the future of outpatient surgery is promising, and the time is ripe to sit down with government institutions, private health care managers, medical and health care groups and hospital associations, for the purpose of elaborating a study so that the health care system becomes more effective and efficient, providing broader and better quality assistance both available at a lower cost and to the entire population.

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