

Ambulatory Colorectal Surgery: a New Concept or Already Here?

Pawan Mathur*

Royal Free London NHS Foundation Trust, United College of London, London, UK

*Corresponding author: Pawan Mathur, Consultant Colorectal, Minimally Invasive and General Surgeon, Honorary Senior Lecturer, Royal Free London NHS Foundation Trust, United College of London, Pond Street, London, NW3 2QG, UK, Tel: 0208 216 5446; E-mail: pawan.mathur@nhs.net

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Short Communication

Ambulatory Care can involve assessment, investigation and care for a patient without requiring admission to hospital. It is not a new concept and is widely available in many areas of medicine. It is important for the purposes of this paper to distinguish between diagnosis and management. I will focus primarily on diagnosis. Successfully establishing these services however depends on the healthcare environment within which it is to be based.

Ambulatory Colorectal Surgery [ACS] clinics are widely available [1-4] but differ in the extent of services provided depending on whether they are set in a socialised health setting or private. The latter is a straight forward situation whereby the services can be charged and the clinic set up as the clinician or hospital desires; hence the full scale of colorectal investigations are available ranging from endoscopy to anorectal manometry. It is also possible despite conventional thinking to provide colonoscopy as a day case procedure by devising a purgatory formula whereby the patient takes the bowel prep in the early part of the day, waits in the clinic and undergoes colonoscopy once the bowels are cleansed [5].

By taking the official definition of day care (23 h), it is possible to undertake complex colorectal procedures as day cases; Rockall's group elegantly demonstrated that laparoscopic colonic resection can be safely performed with the patient discharged within 23 h of surgery [6]. The patients were closely followed up in the community by the Colorectal Nurse Specialist and were seen in clinic on Day 3 post op. There were no complications and a high level of satisfaction from the patients. This study demonstrates the need for clear concise pre-operative counseling and open lines of communication between patients and health care professionals. However it challenges all conventional thinking of what is possible in a day care/one-stop environment. Delaney et al. had similar results although not in a day care setting; 10 patients of 118 resections were discharged on day 1 post op following laparoscopic resection [7]. Interestingly in both studies patients discharged early had less complications and re admissions.

Challenges arise in the National Health Service (NHS), for instance, as the logistics of setting up such a system as above carry significant organisational dilemmas; the simple task of running a concurrent endoscopy and clinic can be logistically difficult. Most ACS clinics involve seeing a doctor/specialist nurse and ideally undergoing flexible sigmoidoscopy on the day, treating haemorrhoids as a source of bleeding and booking for further tests if deemed suitable [3]. This system is open to 'abuse' however as demands for patients to be seen in hospital increases. Hence not all patients are suitable for ACS clinics;

this extrapolates to wasted clinic slots and ultimately an inefficient use of valuable consultant time and resource.

Central to any initiative is the patient, rather than the ability to provide a service. In a large study reporting the 3 year benefits to patients attending a one stop nurse led colorectal clinic, Smith et al reported that 36% of the total number of malignancies diagnosed in that hospital were initially seen in the clinic. However 49% referrals did not conform to the criteria stipulated by the hospital [8]. This study demonstrates that a nurse led one stop clinic is feasible and important in terms of diagnosis but with half the patients not fitting the criteria, ultimately may prove financially non-viable as all patients referred on the '2 week' rule also need to have their investigations within 2 weeks. Dey et al. in a RCT compared anxiety levels in women attending a dedicated vs non-dedicated breast clinic. 670 women were randomised. Compared with women who attended the dedicated clinic, patients attending the one stop clinic were less anxious 24 h after the visit but not at 3 weeks or 3 months after diagnosis [9]. Wood et al. concluded that screening for gynaecological malignancy in Hereditary Non Polyposis Colorectal Cancer patients did not add psychological morbidity, but the study group was small [10].

It is important that the patient is well informed prior to attendance and knows what to expect; this particularly applies to colorectal clinics [9]. This may differ in different demographics and countries, with areas of higher social class being more knowledgeable and accepting of such a service. Attitudes to colorectal symptoms vary with race, culture and religion [11-13]. However in general when the patient is made aware of what to expect the outcome may be beneficial for the patient and the hospital. Studies in dedicated one stop breast clinics have demonstrated benefit in short term anxiety for the patients when attending a dedicated clinic [8].

Cost is always an issue in the NHS for such initiatives. The cost of a Consultant clinic and the provision of specialised investigations in the outpatient setting need to be weighed up against benefit for the patient and hospital budgets. Dey's group showed an extra cost of 32 pounds per patient attending the dedicated clinic; this was put down to the costs of specialised histological and radiology services [9]. In contrast, in a study of 182 patients referred to a one stop colorectal clinic involving a clinic visit and flexible sigmoidoscopy, if warranted, Walker et al demonstrated that 72% patients were discharged leading to a saving of some 150 euros per patient [14].

In summary, ACS clinics are not a new concept and are definitely already here; many other specialities have similar systems notably one stop breast and gynaecology clinics.

Health care delivery is constantly advancing and with a migratory population, health care initiatives need to be aware of what the patients want. In the NHS the emphasis is to provide as much care as possible as day case and outpatient settings. Whilst this is an admirable

concept, resource does not follow with the desire. Healthcare systems such as in the United Arab Emirates, where funding is available, allow true ambulatory care to flourish and expand.

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