

**References:** A randomized trial of local anesthesia with intravenous sedation vs general anesthesia for vaginal correction of pelvic organ prolapse. *Int Urogynecol J Pelvic Floor Dysfunct.* 2007 Jul;18(7):807-12. Segal JL, et al. New concepts and trends in vaginal prolapse surgery. *Acta Obstet Gynecol Scand.* 2009;88(3):251-4. Flam F, et al

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## 8AP7-7

### Rate and causes of surgery cancellation in a central hospital

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**Background and Goal of Study:** Surgery cancellation reduces operating room efficiency and increases costs. It is stressful and costly to patients. Cancellation rate assesses quality of patient care and quality of management. There is no consensus on the acceptable rate to define efficient operating room but less than 5% is recommended. The aim of this work is to access the cancellation rate and causes in our hospital.

**Materials and Methods:** Operating room records of elective surgery from January 2014 to June 2014 were retrospectively reviewed.

Inclusion criteria: patients >18 years old, scheduled for inpatient surgery whose operation was cancelled (n=209). We excluded cancellations made 2 or more days before surgery (n=143). So we defined "cancellation" as those procedures cancelled on the day or the day before surgery. Patient records were analysed to identify the cancellation cause.

**Results and Discussion:** 66 patients included, mean age was 55.2 years old and 40.7% were male.

Procedures from various specialities were cancelled and the global cancellation rate was 1.2% (table 1).

|   | General Surgery | Plastic Surgery | Vascular Surgery | Gynaecology | Neuro-surgery | ENT  | Orthopaedics | Urology | Total |
|---|-----------------|-----------------|------------------|-------------|---------------|------|--------------|---------|-------|
| Cancelled surgeries (N)                 | 21              | 1               | 6                | 16          | 10            | 2    | 4            | 6       | 66    |
| Cancelled surgeries (%)                 | 1,6%            | 2,7%            | 1,8%             | 2,1%        | 1,9%          | 0,4% | 0,4%         | 0,9%    | 1,2%  |
| Contribution to total cancellations (%) | 31,8%           | 1,5%            | 9,1%             | 24,2%       | 15,2%         | 3,0% | 6,1%         | 9,1%    | 100%  |

[Number and rate of cancellation]

Causes for cancellation were divided in 8 categories: lack of theatre time (64%), change in surgery indication (9%), acute change in baseline disease (7,5%), acute disease (7,5%), non compliance with protocol to stop chronic medication (6%), patient did not attend (3%), patient refusal (1,5%), lack of intensive care bed (1,5%).

Anaesthesia-related cancellations were due to acute changes in baseline medical disease (acute pulmonary oedema and acute asthmatic episode), acute disease (respiratory infection and angina) and non-compliance with the protocol to stop anti-coagulant drugs before surgery.

**Conclusion:** Our results show a lower cancellation rate when compared to previously published studies, which might translate operating room efficiency, or may be due to different inclusion criteria or to inadequate records in our centre. Causes for cancellation are similar to the previously reported.

The decision to cancel surgery must consider economic and emotional factors but also the increased risk of prolonged hospital stay. To abolish potentially avoidable cancellations it is necessary to optimize patient's clinical condition and schedule theatre time in a realistic manner.

## 8AP7-8

### Effects of ERAS Program implementation in major colorectal surgery

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**Background and Goal of Study:** Enhanced recovery after surgery (ERAS) employs a multimodal perioperative care pathway with the aim of attenuating the stress response to surgery and accelerating recovery<sup>1</sup>. The ERAS protocol has been demonstrated to reduce the hospital length of stay (LOS) and postoperative complications<sup>2</sup> suggesting that ERAS should be regarded as a new standard of care for patients undergoing elective colorectal resection<sup>3</sup>. The aims of this study were to evaluate the effects of an ERAS protocol for colorectal surgery at a tertiary medical centre.

**Materials and Methods:** 53 patients undergoing elective colorectal resection according to a standardized ERAS protocol (ERAS group) were compared to patients (N=52) operated in the same institution (control group) with traditional methodology. Anaesthesiologic management included blended analgesia with thoracic epidural catheter, intravenous anaesthetics and short acting opioids, restrictive intravenous fluid replacement. Postoperative analgesia was obtained by local anaesthetic administered by the epidural catheter. Functional recovery time, morbidity, LOS, and readmission rate were compared.

**Results and Discussion:** Patients were homogeneous in terms demographics characteristics (age, sex and ASA classification). The outcome variables are presented in the following table: **Variables**

**ERAS group (N = 53)**

**Control group (N=52)**

**P value**

**Time to intestinal activity (days)**

2 (1 - 2)

3 (2.3 - 4)

**0.001**

**Pain control on oral analgesic (days)**

3 (2.5 - 4)

4 (3 - 5)

**0.023**

**Postoperative day fit for discharge (days)**

4 (3 - 5)

7 (6 - 8)

**0.001**

**Minor complications (grade I - II)**

7 (13.2%)

9 (17.3%)

0.5

**Major complications (grade III - IV)**

0

3 (5.8%)

0.2

**Hospital length of stay (days)**

5 (4 - 7)

8 (7 - 10)

**0.001**

**30-day re-admission**

0

1 (1.9%)

0.6

**30-day mortality**

0

0

**Conclusion(s):** Our data show a significant reduction in functional recovery, morbidity and postoperative LOS with no increase in the readmission rate within 30 days.

**References:**

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- Varandhan KK et al. *Clin Nutr* 2010;29(4):434-40.
- Miller TE et al. *Anesth Analg* 2014 May;118(5):1052-61.