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Review article

Twenty-Five Years of Ambulatory Laparoscopic Cholecystectomy[☆]



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ABSTRACT

It is accepted by the surgical community that laparoscopic cholecystectomy (LC) is the technique of choice in the treatment of symptomatic cholelithiasis. However, more controversial is the standardization of system implementation in ambulatory surgery because of its different connotations. This article aims to update the factors that influence the performance of LC in day surgery, analyzing the 25 years since its implementation, focusing on the quality and acceptance by the patient. Individualization is essential: patient selection criteria and the implementation by experienced teams in LC, are factors that ensure high guarantee of success.

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Veinticinco años de colecistectomía laparoscópica en régimen ambulatorio

RESUMEN

Es bien aceptado por la comunidad quirúrgica que la colecistectomía laparoscópica (CL) es la técnica de elección en el tratamiento de la colelitiasis sintomática. Sin embargo, más controvertida es la estandarización de su realización en régimen de cirugía mayor ambulatoria (CMA) por las diversas connotaciones que presenta. Este artículo tiene por objeto actualizar los factores influyentes en la realización de la CL en régimen de cirugía sin ingreso, analizando estos 25 años desde su implantación, incidiendo en la calidad y aceptación del proceso por parte del paciente. Es fundamental la individualización del proceso: un estricto criterio de selección de pacientes y la realización por equipos con experiencia en CL, son factores que aseguran una alta garantía de éxito.

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Palabras clave:

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Introduction

The postoperative period after laparoscopic cholecystectomy (LC) follows a very short course, allowing patients to rapidly reinstate oral intake and begin walking.¹ Likewise, the intraoperative time of this technique has been progressively reduced. Due to these characteristics, most LC for uncomplicated cholelithiasis is currently conducted with short hospitalizations of 12–24 h.

This situation led some authors in the early 90s to consider the possibility of performing LC as ambulatory surgery (ALC) with the highest possible level of safety. This would improve healthcare quality due to the reduced rate of nosocomial infection, cause minimal changes to patients' habits and lifestyle, and optimize hospital resources by reducing the number of beds needed, increasing the volume of procedures and thereby reducing surgical waiting lists.² It has been suggested that implementing ALC in our country would entail a savings of some 70 million euros (reduction in hospital stay costs), even before considering the costs eliminated from healthcare provided during hospitalization.³

But the main reticence about this ambulatory procedure is that many surgeons prefer time periods of at least 24 h with an overnight hospital stay in order to quickly detect the appearance of any vital complications during the immediate postoperative period. A series of basic principles are therefore necessary to determine the use of ALC and ensure the highest probability of success with the utmost safety for patients:

- (a) selection criteria for patients who, after providing adequate preoperative information, accept this type of surgery without hospitalization;
- (b) meticulous surgical technique by surgeons trained in this type of laparoscopic approach;
- (c) analysis and prevention of early postoperative complications;
- (d) rigorous discharge criteria;
- (e) strict immediate postoperative monitoring with a series of clinical checks;
- (f) evaluation of patients' degree of satisfaction and quality perceived.

The aim of this article is to review all the factors that currently play a fundamental role in the implementation of ALC and influence the quality and acceptance of the process, while analyzing the last 25 years since its implementation in the surgical community.

Methods

We have carried out an electronic search on Pubmed and the Cochrane Library (January 1989–December 2014) of scientific articles (originals and reviews) in English as well as Spanish with the keywords: "laparoscopic cholecystectomy", "outpatient laparoscopic cholecystectomy", "ambulatory surgery", "day-case laparoscopic cholecystectomy" and "ambulatory laparoscopic cholecystectomy". The different keyword combinations identified 206 references. We ruled out 58 articles that

either did not adequately meet levels of evidence or were written in a language other than English or Spanish. In the end, we reviewed a total of 148 articles by assessing the abstracts of all the studies and thoroughly analyzing the entire article in 54 cases (Fig. 1). We have relied on the principles of evidence-based medicine to establish the levels and categories of the main recommendations in certain sections of the review (Table 1).

Historical Background

Although Muhe in Germany is considered the precursor of ALC,⁴ Reddick and Olsen influenced this concept in 1990 by publishing a series of 83 LC, providing the possibility for outpatient treatment in 45%, with a negligible percentage of complications.⁵ In successive years, numerous groups have obtained acceptable results in terms of the substitution rate (65%–99%), with a high level of reliability and safety for patients^{5–44} (Table 2). These results, however, show an enormous overdispersion, which is clearly indicative that the selection and process execution protocols are quite variable among different authors.

In our country, the multicenter study published in 2006 by the Spanish Association of Surgeons (AEC) to develop the clinical implementation of LC⁴⁵ obtained data from 37 hospitals and 426 patients, of which only 16 (3.8%) had been operated on in a major outpatient surgery (MOS) program, which, without the added value of a national survey, was sufficiently indicative of the limited utilization of ALC. In spite of these data, certain groups (Table 3) have obtained good results in the initial series.^{1,3,46–57}

By analyzing Tables 1 and 2, we have observed that the mean weighted percentage of failures is situated at 15.10% internationally and 20.27% in our setting. Any significant deviation from these percentages would point to poor indication or inadequate selection criteria, or, contrarily, they would mean that the results were outstanding.

In these last 3 years, there have been studies evaluating the possibility of MOS programs for single-port (SILS) laparoscopic cholecystectomy, although they have been interpreted based on overnight stays.^{58,59}

Table 1 – Levels and Categories of the Recommendations Following the Principles of Evidence-Based Medicine.

<i>Level of evidence</i>	
Level I	Evidence from at least one randomized clinical trial or meta-analysis
Level II	Evidence from at least one non-randomized clinical trial, cohort or case-control study (preferably from a single center), or uncontrolled studies
Level III	Evidence of opinions from scientific authorities or observational studies
<i>Categories</i>	
Cat. A	Recommendations approved by consensus (at least 75% of the expert panel)
Cat. B	Controversial recommendations (approved by 75%–50% of experts)
Cat. C	Recommendations that cause disagreement among panel members

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