Day case surgery and obesity: a changing perspective

Editor—The practice of anaesthetizing morbidly obese patients as day cases has changed radically in recent years. We would like to add a slightly different perspective on this issue to that expressed by Ryan and colleagues. There is no evidence of significant morbidity in the immediate postoperative period when treating morbidly obese patients as day cases. The Association of Anaesthetists of Great Britain and Ireland have recommended that obese patients should not be excluded from day surgery based on their body mass index (BMI) alone.

It is the standard practice in our hospital trust to accept morbidly obese patients for day surgery where management would not be modified if admitted as an inpatient. All patients booked for a procedure in the Day Surgery Unit undergo a nurse-led preoperative assessment, but an experienced anaesthetist reviews the notes of patients with a BMI of more than 36 kg m\(^{-2}\). Between September 2003 and June 2005, the Day Surgery Unit increased its case-load by 13%. Of the 6940 patients with a known BMI, 434 (6.2%) patients had a BMI of \(>35\) (an increase of 68%), 117 (1.7%) had a BMI \(>40\), and 16 (0.2%) were \(>45\). There were fewer unplanned admissions in patients with a BMI \(>35\) (1.2%) when compared with those with a BMI \(<35\) (2.7%), but this did not reach statistical significance.

The obese patient presents specific challenges to both surgeons and anaesthetists. The adverse events are as likely to occur in an inpatient setting as in a day case setting. Although an increased risk of adverse events intraoperatively and in the immediate recovery period in obese patients has been reported, these have not been shown to significantly increase unplanned admissions. Avoidance of hospital admission by choosing ambulatory surgery should therefore result in improved patient satisfaction and significant cost savings without compromising clinical care. Where patients have access to appropriate preparation and expertise, obesity alone should not exclude patients from ambulatory surgery and the latter may offer some benefits over inpatient admission.

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Editor—We applaud Drs Alderson and Montgomery for their rigorous use of the evidence base to inform their practice and congratulate them on the resulting increased productivity. Notwithstanding co-morbidities, this distils into the simple question of ‘Limit or no limit?’ The Association of Anaesthetists have opted for no limit, the NHS Modernisation Agency suggested a BMI limit of 40 kg m\(^{-2}\). The BMI limit of 40 in fact excludes only 3% of the surgical population of Ayrshire and Arran from consideration for Day Case Surgery. We agree that whereas there may be no evidence base to exclude these patients; from an organizational point of view it may be pragmatic to do so, thus it may avoid the problem of the anaesthetist who does the casenote assessment having a more permissive attitude than the anaesthetist who meets the patient in the Day Surgery Unit. Late cancellation or the compromising of an individual anaesthetist’s clinical standards may result. In short, setting a BMI limit may be a reasonable and pragmatic approach in those units where it is appropriate to the local working conditions.

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