



# Editorial



It is estimated that at the end of 2002 approximately 70% of all surgical procedures in the United States were being performed on an ambulatory basis. This is nowhere near as high in South Africa, where home facilities and means of getting home are often the rate limiting steps for performing ambulatory anaesthesia. More and more cases, however, particularly in the private sector, are being performed on an outpatient basis. This requires us to look at many factors, the most important being: the decision on exclusion criteria for accepting patients; the types of anaesthetics and procedures that can be performed; and the decision on when the patient is suitable to be discharged home.

Inappropriate patients fall into many groups, the most important being unstable ASA 3 and 4 patients, those who are morbidly obese or suffer from obstructive sleep apnoea, those who have recently abused illicit drugs, patients who are MH (malignant hyperpyrexia) susceptible, porphyrics and those whose home circumstances are not suitable for recovery after ambulatory surgery. The elderly, and patients taking monoamine oxidase inhibitors are both controversial.

The types of anaesthetics and surgical procedures depend on many factors, and should probably be decided on by the surgeon and anaesthesiologist as a team.

Discharge criteria have been debated at length in the literature. Aldrete proposed a postanaesthesia recovery score in 1970. Chung subsequently modified this to a modified postanaesthetic discharge scoring system, which places less emphasis on taking orally and being able to void prior to discharge. He suggests that Aldrete's score (which was subsequently modified, using the same criteria) be used to determine ward readiness from the recovery room, and that Chung's modified score be used to evaluate home-readiness. He emphasises that scoring systems are very useful, but must be used together with common sense and clinical judgement.

This makes the article in this issue of SAJAA by Lennox et al very relevant, in that they question who should in fact be scoring the patients after ambulatory anaesthesia, the nurses or perhaps the patients themselves?

Many of our hospitals in Southern Africa do not have proper blood warming devices, hence the need to warm units of blood in buckets of warm water in theatre. Dr Nienaber looks at the safe recommended temperature for these water baths, in her research article in this issue.

Professor "Bosie" Bosenberg provides us with another Paediatric syndrome in our regular slot – Syndromic Vignettes in Anaesthesia. In this issue he discusses Freeman Sheldon Syndrome. Our regular obstetric author, Professor Kuczkowski, alerts us to the anaesthetic problems associated with anaesthetising pregnant patients who abuse dagga, a problem that is on the increase world-wide.

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