Implementing an Outpatient Laparoscopic Hysterectomy Program: 8 Steps Toward Success

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Laparoscopic hysterectomy can be performed in a completely outpatient environment with discharge home within 4 hours of surgical completion. There is no need for an expensive robot, overnight stay, or a hospital environment. This approach can yield profound cost savings and enormous patient satisfaction.

The merits of laparoscopic hysterectomy over abdominal hysterectomy have been described widely in literature, including improved quality of life postoperatively. Despite evidence validating the safety and shortened recovery of minimally invasive surgery, fewer than 40% of women are aware of minimally invasive options as alternatives to traditional hysterectomy.

Ambulatory surgery centers (ASCs) are continually required to validate safety in order for specific surgeries to be deemed appropriate for outpatient management by the Centers for Medicare and Medicaid Services (CMS). Hospitals do not respond amicably to the potential loss of revenue, and proposed legislation can create blockades in the name of patient safety, when the real issues at hand are economic consideration. As surgeons, we need to be the stewards of patient safety, and our data will pave the way to cost-effective transition.

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More than 500 laparoscopic hysterectomies have been performed at our freestanding ASC since October 2005 (patient statistics: age range, 19 to 64; BMI, 18.7 to 48.6; uterine mass, 70 to 2,000 g; operative time, 36 to 269 minutes; no conversions to laparotomy). All but 2 patients were sent home within 4 to 6 hours postoperatively. One was transferred to a local hospital for a nonsurgical anesthesia-related pulmonary issue that occurred postoperatively and spontaneously resolved, and a second patient was sent for observation after a large bowel injury and repair. Our complication rate has remained below 1%, and infection rates are less than 0.5%. Although we have been fortunate to avoid conversions to laparotomy and emergent hospital transfer, we are fully prepared for either eventuality if the need arises.

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The fixed cost of performing a laparoscopic hysterectomy exceeds the fixed cost of the traditional abdominal or vaginal hysterectomy, secondary to the cost of disposable equipment utilized in the surgery (of course, this assumes that the start-up cost of the laparotomy equipment has been paid off over a prolonged amortization). When comparing venue, the ASC has a very different mechanism of billing when compared to the hospital. Health care economics are complex, and a review of the mechanism of hospital billing would be a lengthy article of its own. There is tremendous dissonance between cost of surgery and billed charges to

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patients and payors. The variable costs of surgery include institutional overhead such heating and cooling, maintenance, leases, tenant improvements, etc—billed charges from large institutions are not based on simple calculations of fixed costs of equipment and medication but are calculated from complex actuarial formulas. The result is variable data on true costs of surgery. On the contrary, CMS has calculated facility reimbursement for ASCs based on fixed cost of the surgery alone, with no consideration for these variable costs, making the reimbursements significantly lower than those relinquished to large institutions.

Clearly, overnight hospitalization adds significant health care costs when compared with same-day discharge home. Additional considerations when exploring cost efficiency include extended time off work, lost wages, cost to employers, and the cost of management of complications, including infection rates and delayed wound healing with laparotomy.

The following 8 steps may help facilitate transition to outpatient hysterectomy:

1. Proceed slowly.
Start with a small uterus in an average-sized patient. Review laparoscopic anatomy. Recruit someone to precept you through your first several cases. Find a colleague or partner to work with on a regular basis.

2. Begin at the beginning.
Successful outpatient surgery begins with the office consultation. Your initial discussion about surgical options with the patient sets a positive tone for the entire patient experience.

3. Happy preop patients become happy postop patients.
In the preoperative holding area, keep patients warm and calm. Bair Paws® gowns are a great addition for both preoperative and postoperative comfort. In the operating room, we add simple creature comforts like a prewarmed surgical table, dimmed lighting, and a genre of music that the patient prefers. Our staff members introduce themselves and explain their roles to the patient.

4. Select your tools and techniques carefully.
There are many techniques available for laparoscopic hysterectomy. I recommend observing and trying several approaches to find the one that best suits you. In our series, we have maintained a relatively consistent surgical technique. We typically use 5 trocars for access, with primary laparoscope access through the umbilicus and 2 assist ports on each side.

We have abandoned the suprapubic port, as it is less ergonomic and provides no strategic advantage for surgical completion of a laparoscopic hysterectomy. While many surgeons promote a technique with fewer access ports into the pelvis, we encourage surgeons to consistently operate with 2 hands, as done in open cases. This will prepare the surgeon for more complex cases requiring extensive retroperitoneal dissection, lysis of adhesions, or suturing. Morcellation is performed transumbilically.

We use a Skytron 6500 operating table, with its steep Trendelenberg and ability to drop to a low position, optimal for advanced laparoscopy. Unlike robotics, using "straight-stick" laparoscopy allows the surgeon to use the table as an additional tool for visualization.

5. Surround yourself with competence, and minimize risk.
Operating rooms respond well to a team concept, especially when roles are defined. Consider the opportunity to observe another surgeon and note efficiencies or inefficiencies, position of the equipment, and nuances of technique. Arrange for a proctor if possible. A skilled scrub technologist and first assistant can dramatically improve your surgical environment.

6. Become friends with your anesthesia team.
How many times have you heard the anesthesia provider referred to as "Anesthesia" during a case?

Learning a few names can serve you well as you try to impose the following recommendations on your anesthesia team.

- Use local anesthetic at trocar sites.
- Avoid use of long-acting narcotics. Such medications lead to somnolence and can potentiate urinary retention.
- Aggressively hydrate your patients.
- Preemptively attack pain and nausea. We prefer a combination of metoclopramide, ondansetron, ketorolac, and dexamethasone in all patients. Scopolamine (transdermal patch) is

used in patients with a proven history of postoperative nausea or motion sickness.

7. Practice the art of early discharge.
Discharging your patient home starts with motivation to leave the facility. While tired from anesthesia, most patients have minimal pain. Remove the Foley catheter in the operating room, encouraging early ambulation and voiding. It is imperative to avoid transfer to a postoperative overnight floor in the hospital, as this typically adds several hours to a patient's stay and "floor nurses" are accustomed to overnight hospitalization in hysterectomy patients. Assuring the patient, family, and nursing staff that you are available will help alleviate concerns with early discharge home. Follow up with a nurse phone call within 24 hours of surgery as a measure of quality and safety control.

8. Track your data.
Proof of success will reside in your data. Quality assurance protocols and patient satisfaction surveys can be used to quickly build a resource for you to enhance your ability to assure patients, your colleagues, outpatient surgery facilities, and payors that outpatient hysterectomy is not only feasible but also provides the patient with a safe, painless, and cost-effective option when compared with traditional hysterectomy.

In a time of uncertain health care reform and reimbursements, a transition to outpatient hysterectomy might be just what the doctor ordered!

FOCUSPOINT

Outpatient hysterectomy is not only feasible but also provides a safe, painless, and cost-effective option when compared with traditional hysterectomy.

The author reports he is surgical preceptor for Olympus America Inc and Ethicon, Inc and cofounder and Chief Medical Officer of SURGiVIEW.com.