Middle Articles

HOSPITAL TOPICS

Use of Day Beds in Gynaecology

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Summary: Over a ten-year period more than 3,000 patients have been admitted to 12 day beds for minor gynaecological operations. Of the first 500 women, five were detained in hospital, but subsequent experience indicated that in only about 0·4% was admission necessary. Most patients approved of the scheme and underwent their operations more readily. Provided sufficient day beds, theatre accommodation and equipment, and staff are available, greater use of day beds for minor procedures would reduce both gynaecological waiting lists and costs.

Introduction

This paper reports my experience in the use of day beds for patients requiring minor gynaecological procedures. The method is not new. Kelly (1925) advocated that curettage for diagnostic purposes could safely be done on the office table "provided that it was done by a gynaecologist." Strittmatter (1925) claimed to have performed an average of three a day for 15 years and stated that the patients were never detained in the office for longer than 15 minutes. In 1938 Israel and Mazer reported on the safety and advantages of office curettage. Vermeeren *et al.* (1957) reported a series of 10,000 minor gynaecological operations that had been performed on an outpatient basis and in which there were few complications and no deaths. Mills (1959) working in two hospitals, one admitting these patients and the other treating them as day patients, and considered that both did equally well. In 1965 Gelli and Redving reported that the use of a five-day 10-bedded treatment ward had resulted in an increase of 511 patients treated in a year. The average treatment period in their series was 1·8 days. Littlepage *et al.* (1969) reported on the safety of the procedure when carried out under local anaesthesia.

Present Study

Selection of Patients

For the past 10 years almost all patients under my care requiring any of the following procedures have been dealt with as "day cases" and have rarely spent more than four hours in hospital: examination under anaesthesia, dilatation and curettage, tubal insufflation, cauterization of the cervix, vaginal dilatation, and the removal of small cysts and papillomata from the cervix, vagina, and vulva. Patients are not considered as potential day cases if their general medical state is unsatisfactory, nor are those requiring termination of pregnancy, curettage as part of the investigation of uterine fibroids, or excision of Bartholin cysts. Those who live some distance from the hospital and women who cannot find someone to remain with them at home for a number of hours after their return are not considered suitable.

Once the decision is made to treat the patient as a day case she is informed of the date of admission and that it is hoped to return her home by 1 p.m. An admission card and a sheet of simple instructions (see Appendices I and II) are issued and the clinic nurse ensures that the patient understands the importance of strict adherence to them. The family doctor receives a letter intimating the nature and date of the proposed operation and that the patient will be treated as a day case.

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Hospital Arrangements

Patients are asked to report to the hospital at 8 a.m. and are admitted to the day ward, which contains 12 beds. This ward is staffed by a State-registered nurse, a State-enrolled nurse, and a nursing auxiliary. The vulva is shaved and atropine 0·6 mg. is given intramuscularly. About eight patients are dealt with at each session, beginning at 9 a.m. and ending about one hour later. Patients return to the day ward on completion of the operation and remain there under the observation of the nursing staff. They are seen by me, my assistant, or the anaesthetist if there is any anxiety and a decision is made about their fitness for discharge. It is usual for patients to be fully conscious and able to get up and dress themselves by 11 a.m.

The theatre sister is informed the preceding day of the number and types of operations. She is responsible for providing the necessary sterile instruments (five sets of curettage instruments are available). She also ensures that there is adequate staff to maintain the flow of patients and to assist with documentation. The surgeon records the operative details in the case records and completes a stencilled letter, which is collected by the medical secretary and posted to the family doctor on the day of operation.

Anaesthetic Arrangements

The anaesthetist is responsible for the final decision to proceed with the operation, and occasionally he decides that it would be unwise. This is explained to the patient and alternative arrangements are made. The anaesthetic agents are intravenous thiopentone followed by halothane, nitrous oxide, and oxygen.

Results

More than 3,000 patients under my care have been admitted to day beds for minor gynaecological operations, and there have been no deaths. The incidence of admission for observation in the total series was 0·4%. Of the first 500 patients five required admission to the ward either direct from the day bed or within 48 hours after discharge from hospital. Two of the five were admitted because of persistent bleeding, though treatment was not required. Another two patients were admitted because of complaints of severe lower abdominal pain for which there was no obvious cause and which subsided spontaneously. One patient was detained in hospital because of some apprehension about a perivenous injection of thiopentone.

The admission rate of 1% in the first 500 cases fell with increasing experience and confidence. Subsequently a review

Comparison of Work-load of Two Gynaecological Units

	No. of Patients Receiving Inpatient Treatment	No. of Patients Treated as Day Cases	% Bed Occupancy	Average Daily No. of Beds Vacant	Average Length of Stay in Hospital	
					All Cases	Minor Cases
Unit A: 20 beds, day beds not used	891	Nil	80·6	3·88	6·67 days	2 days (approx.)
Unit B: 20 beds, day beds used	729	330	90·9	1·82	8·8 days	4 hours (approx.)

of another 500 case records failed to show any additional complications, with the exception of one patient who developed a pulmonary embolism 14 days after operation. She was treated at home and made a complete recovery. Of the total series of 3,000 patients two required admission to hospital for further observation because of uterine perforation, but they did not need operative treatment. In addition five patients were admitted because ectopic pregnancy was suspected.

Acceptance by Patients.—Patients in general approved of the procedure and many expressed their appreciation of the short stay in hospital. Of 500 patients interviewed eight stated that they would have preferred admission for a few days. Complaints have not been made by those requiring unexpected admission. It appeared that many women accepted the need for curettage more readily when informed that it would entail a stay in hospital of only a few hours.

Effect on Bed Occupancy and Waiting-lists.—The amount of work done during 1968 in two units each of 20 beds, one using day beds for nearly all minor cases and the other admitting patients in the traditional way, is compared in the Table. It shows that the use of day beds allows a considerably greater number of patients to be treated and ensures a high bed occupancy. Both units make full use of convalescent beds for major cases. Analysis of my waiting-list shows that minor cases constitute less than 10% of the total.

Discussion and Conclusion

Figures supplied to me by the Leeds Regional Hospital Board (Lewis, personal communication) show that the average stay of patients requiring minor gynaecological surgery in 1966 was 4·2 days for all regions and 3·8 days for the Leeds Regional Hospital Board region. The gynaecological waiting-list for the Leeds Regional Hospital Boards hospitals and the United Leeds hospitals was 3,317 at 31 December 1968, and probably at least half of these patients required minor surgery of the type referred to in this paper. They could be treated as day cases if the necessary facilities were available and the surgeons concerned were satisfied that the procedure is safe.

The types of operations performed are easily and quickly done in nearly all cases and, if proper case selection is exercised, should not be associated with any significant mortality or morbidity. (It is noteworthy that Braungardt *et al.* (1963) reported a series of 502 patients with incomplete abortion treated in a somewhat similar manner, and of these 74·2% were uncomplicated.) Decenzo and Cavanagh (1967) reported a series of 300 patients with incomplete abortion who were treated in the emergency room of their hospital with satisfactory results and with a resultant reduction of stay in hospital from 56 hours to 8 hours for this type of patient. (Fleming (1963) also reported satisfactory results in similar cases.) More recently there have been reports of legal abortions being performed in a similar manner—but it may well be some time before reliable figures regarding these results are available. The operation can be done under general or local anaesthesia as practised by Mengert and Slade (1960) and by Littlepage *et al.* (1969). General anaesthesia probably allows the operation to be done more quickly and avoids the embarrassment complained of by some patients in the series of Littlepage *et al.*

The common practice of admission to hospital for three or four days could be abandoned with advantages to the patient and a saving in cost. It can, however, be done only where there is ample day bed accommodation and the necessary theatre accommodation, equipment, and staff to enable the operation to be performed properly and with safety.

I wish to thank the nursing staff of the Bradford Royal Infirmary for their willing co-operation, which has enabled these patients to be treated expeditiously; and also to acknowledge the help and co-operation I have received from my gynaecological colleague Miss J. M. B. Muirhead and my anaesthetist colleagues Dr. W. E. Arnold and Dr. Barbara Brown. I thank also Dr. F. N. Bamford for his helpful criticism and advice in the preparation of this paper.

References

Braungardt, C. D., Kaufman, R. H., and Franklin, R. R. (1963). *American Journal of Obstetrics and Gynecology*, **86**, 151.
Decenzo, J. A., and Cavanagh, D. (1967). *American Journal of Obstetrics and Gynecology*, **97**, 17.
Fleming, A. R. (1963). *American Journal of Obstetrics and Gynecology*, **86**, 159.
Gelli, M. G., and Redving, I. (1965). *Läkartidningen*, **62**, 2410.
Israel, S. L., and Mazer, C. (1938). *American Journal of Obstetrics and Gynecology*, **36**, 445.
Kelly, H. A. (1925). *American Journal of Obstetrics and Gynecology*, **9**, 78.
Littlepage, B. N. C., Daniel, D. G., Ahmad, S., and Turnbull, A. C. (1969). *Journal of Obstetrics and Gynaecology of the British Commonwealth*, **76**, 163.
Mengert, W. F., and Slade, W. G. (1960). *American Journal of Obstetrics and Gynecology*, **79**, 727.
Mills, W. (1959). *British Medical Journal*, **2**, 1254.
Strittmatter, I. P. (1925). *American Journal of Obstetrics and Gynecology*, **9**, 125.
Vermeeren, J., Chamberlain, R. R., and Te Linde, R. W. (1957). *Obstetrics and Gynecology*, **9**, 139.

Appendix I

BRADFORD ROYAL INFIRMARY
Telephone number Bradford 42200, Ext. 228
Gynaecological Clinic—Ward 9A
Please attend at 8 a.m. on Tuesday .....
Do not take any food or drink before coming to hospital. If for any reason you cannot attend please inform Mr. Craig's secretary at the above telephone number.

Appendix II

BRADFORD "A" HOSPITAL MANAGEMENT COMMITTEE
Telephone 42200
Bradford Royal Infirmary,
Duckworth Lane,
Bradford 9.

Instructions for Outpatients having Minor Operations or Examination under Anaesthesia

1. PLEASE have nothing at all to eat or drink after the time stated on the card. *This is very important*, and it can be dangerous for you if you ignore these instructions.
2. You will normally be allowed home on the same day.
   YOU WILL NOT BE ALLOWED TO DRIVE YOURSELF HOME OR BE ALLOWED TO RETURN HOME BY PUBLIC TRANSPORT.
   The following arrangements will therefore be made:
   (a) You may be sent home by ambulance, in which case no relative or friend must call to collect you, as the ambulance will only take patients.
   OR
   (b) Arrange for a friend or relative *with transport* to take you home. You must be collected at the *ward* and not arrange to be met elsewhere.
   (c) If you wish to take a taxi home you will still require a friend or relative to be with you. The taxi fare will be your own responsibility.
3. YOU MUST NOT WORK OR DRIVE FOR AT LEAST EIGHT HOURS FOLLOWING YOUR ANAESTHETIC.