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Contraintes, avantages et perspectives de la chirurgie sénologique en ambulatoire : expérience de l'Institut de Cancérologie de l'Ouest

F. Dravet

Pour en savoir plus

Dravet F, Belloin J, Dupré PF *et al.* (2000) Classe Place de la chirurgie ambulatoire en chirurgie sénologique. Étude prospective de faisabilité. Ann Chir 125: 668-76

But de l'étude : Le but de cette étude prospective était d'apprécier les possibilités de prise en charge ambulatoire de la chirurgie sénologique, d'évaluer les raisons d'hospitalisation traditionnelle, les causes et le taux de « conversion », et la morbidité postopératoire après chirurgie ambulatoire.

Patientes et méthodes : Au cours de l'année 1999, sur 625 patientes susceptibles d'être prises en charge en chirurgie ambulatoire (chirurgie à visée diagnostique et chirurgie conservatrice du sein), 418 ont été programmées en chirurgie ambulatoire (67 %) et 207 en chirurgie traditionnelle (33 %). Les causes de non prise en charge en chirurgie ambulatoire étaient plus environnementales (64 %) que médicales (16 %).

Résultats : Le taux de conversion a été de 12,4 %. Le taux réel de chirurgie ambulatoire a été de 58,6 %. Les causes de conversion ont été plus souvent médicales (50 %) et environnementales (21 %) que chirurgicales (23 %). La morbidité, hors lymphocèle axillaire, a été équivalente dans les deux modes d'hospitalisation. Après curage axillaire, le taux de lymphocèles a été plus élevé en cas de chirurgie ambulatoire (27,4 % contre 16,1 %).

Conclusion : La chirurgie ambulatoire est une bonne alternative à l'hospitalisation traditionnelle, en sénologie notamment pour la chirurgie à but diagnostique. Pour la chirurgie mammaire avec curage axillaire, ce mode de prise en charge est également possible ; une information claire doit faire accepter la surmorbidité mineure. Une étude sur l'indice de satisfaction des patientes est indispensable.

Dravet F, Dupré P, Peuvrel P *et al.* (2001) La chirurgie du sein peut-elle se faire en ambulatoire, en France ? J Le Sein 11: 161-6

Classe JM, Dupré PF, François T *et al.* (2002) Axillary Padding as an alternative to closed suction drain for ambulatory axillary lymphadenectomy. A prospective cohort of 207 patients with early breast cancer. Arch Surg 137: 169-73

Marchal F, Dravet F, Classe JM *et al.* (2005) Post operative care and patient satisfaction after ambulatory surgery for breast cancer patients. EJSO 31: 495-9

Dravet F, Robard S, Labbe D, Pioud R, Peuvrel P, Classe JM (2007) Chirurgie sénologique oncologique en ambulatoire : avantages et éléments limitants. La lettre du Sénologue 36: 10-4

Dravet F, Peuvrel P, Robard S, Labbe D (2011) Limiting factors for development of ambulatory breast surgery in the French hospital network. J Visc Surg 148: e135-9

Ambulatory breast surgery is not well developed in France. This is especially true for oncologic *procedures*, between January 2005 and June 2006, we performed a retrospective evaluation of the factors thought to limit the development of this type of hospitalization.

The principal limiting factors were distance restrictions (respect of the 100 km perimeter), the complexity of patient management for small *breast* tumors (several practitioners involved) and last, the non-motivating reimbursement policy.

By changing to the Anglo-American ("one day *surgery*", i.e. hospital stay less than 24 hours) or hybrid system (less than 12 hours+1 day *surgery*), *ambulatory surgery* could easily be offered to patients excluded by the current system (*ambulatory* department open less than 12 hours).

Marla S, McMillan DC, Stallard S (2012) Factor's influencing postoperative length of hospital stay after breast cancer surgery. Breast [Epub ahead of print]

As part of a feasibility study to restructure the *breast* cancer services in Glasgow, factors influencing 'postoperative length of stay' (LOS) and bed utilisation in

patients undergoing *surgery* for *breast* cancer were examined. Data for patients admitted at five hospitals between March 2007 and February 2008 was collected prospectively. Age, socio-demographic and clinico-pathologic factors were recorded. Independent affects of variables predicting prolonged LOS were assessed using binary logistic regression analysis. Of the 519 women, 252(49%) had screen-detected cancers with a median LOS of 1 day while 267(51%) had symptomatic cancers with a median LOS of 4 days ($p < 0.001$). On multivariate analysis, axillary procedure performed independently influenced prolonged LOS in both screen-detected and symptomatic cancers. In symptomatic cancers, comorbidities and deprivation also had some influence. While mastectomy with or without axillary *surgery* utilised 51% of the bed days, a further 20% were utilised by patients having re-operations. This study has helped in the planning of *ambulatory surgery* services and inpatient bed requirements for patients undergoing *breast* cancer *surgery* in Glasgow.

Sabel MS, Jorns JM, Wu A (2012) Development of an intraoperative pathology consultation service at a free-standing ambulatory surgical center: clinical and economic impact for patients undergoing breast cancer surgery. Am J Surg 204: 66-77

Second surgeries represent a significant detriment to *breast* cancer patients. We examined the impact an intraoperative pathology consultation service had on multiple factors of *breast* cancer *surgery*.

We compared the 8 months before the establishment of a pathology laboratory, when intraoperative pathology consultation was not available, with the 8 months subsequent, when it was performed routinely.

The average number of surgeries per patient decreased from 1.5 to 1.23, and the number of patients requiring one *surgery* increased from 59% to 80%. Re-excisions decreased from 26% to 9%. Frozen section allowed 93% of node-positive patients to avoid a second *surgery* for axillary lymph node dissection. A cost analysis showed savings between $400 and $600 per *breast* cancer patient, even when accounting for fewer axillary lymph node dissections based on the American College of Surgeons Oncology Group Z0011 data.

Incorporation of routine intraoperative margin/sentinel lymph node assessment at an outpatient *breast surgery* center is feasible, and results in significant clinical benefit to the patient. Use of frozen section decreased both the time and cost required to treat patients.