

**RESULTS:** Total costs (Table 1) were similar for each method in the <10 and 10–20 phlebectomy stab incision groups. The profit margin (Table 1) was higher for the EA group independent of the number of phlebectomy stab incisions. We calculated the opportunity cost multiplier (\$21/min) by dividing the profit margin/case of an EA with 10–20 stab incisions by its operating time. The SVS method tended to be less efficient and, hence, incurred an opportunity cost (Table 1) that made it more expensive to perform than EA.

Table 1

Year 2008	< 10 Phlebectomy Stab Incisions		10–20 Phlebectomy Stab Incisions		20 Phlebectomy Stab Incisions	
	Endovenous Ablation	Saphenous Vein Stripping	Endovenous Ablation	Saphenous Vein Stripping	Endovenous Ablation	Saphenous Vein Stripping
Cases (#)	8	6	18	22	9	4
Net revenue (\$)	75,530	40,191	178,446	18,444	110,854	38,440
Direct costs (\$)	38,244	26,924	96,226	110,145	54,544	19,437
Indirect costs (\$)	11,790	10,451	30,817	43,554	16,883	7,520
Total costs (\$)	50,034	37,375	127,043	153,699	71,427	26,957
Total costs/cases (\$)	6,254	6,229	7,058	6,986	7,936	6,739
Profit margin (\$)	25,496	2,816	51,403	34,745	39,427	11,483
Profit margin/cases (\$)	3,187	469	2,856	1,579	4,381	2,871
OR time (min)	116	149	136	164	143	155
OR time difference		33		28		12
Opportunity cost/cases (\$)		693		588		252

**CONCLUSIONS:** Endovenous ablation may be more profitable and efficient when compared with traditional saphenous vein stripping for the treatment of varicose veins. Future cost-effective analysis is needed to determine societal benefits.

### Conditional survival after wide-local excision of cutaneous melanoma: Population-based analysis

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**INTRODUCTION:** Because melanoma survival curves are nonlinear, current estimates may not accurately predict long-term outcomes after a certain survival period. Our objective is to examine whether conditional survival data are a more useful tool in predicting long-term melanoma survival in patients following wide local excision (WLE).

**METHODS:** We used the Surveillance, Epidemiology, and End Results database (1992–2005) to identify patients who underwent WLE for nonmetastatic melanoma. We included patients with T2, T3, or T4 disease and with known nodal status. Patients were stratified into low-risk (T2–3N0M0) and high-risk (T4N0M0 or T2–4N1M0) categories. We defined conditional survival as time-specific estimates conditioned on living to a certain point in follow-up and performed unadjusted conditional survival analysis using the Kaplan-Meier method. We adjusted for potential confounding covariates using a Cox proportional hazards regression model ( $\alpha=0.05$ ).

**RESULTS:** 8,759 patients met inclusion criteria. At diagnosis, low-risk patients had a significantly improved 10-year survival rate (low-

risk, 82%; high-risk, 49%;  $p<0.001$ ). On conditional survival analysis, however, this difference holds only until 8 years after WLE; at that point, conditional survival rates are no longer significantly different ( $p=0.51$ ) between low- and high-risk groups (adjusted low-risk 97.6%, adjusted high-risk 97.0%;  $p=0.73$ ). Further cancer-specific survival beyond 8 years is not predicted by age, gender, location, or ulceration.

**CONCLUSIONS:** As survival time increases, melanoma conditional survival data are discordant with traditionally used, AJCC-based rates. These findings can have important implications for surveillance and counseling, as high-risk melanoma survivors 8 years after WLE may require no more intensive surveillance than low-risk patients.

### Readmission after colectomy for cancer predicts 1-year mortality

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**INTRODUCTION:** Early hospital readmission is a common and costly problem in the Medicare population. Beginning in 2009, the Centers for Medicaid and Medicare Services will mandate hospital reporting of disease-specific readmission rates. We sought to determine the rate and predictors of readmission after colectomy for cancer, as well as the association between readmission and mortality.

**METHODS:** Medicare beneficiaries who underwent colectomy for stage I–III colon adenocarcinoma from 1992–2002 were identified from the SEER-Medicare database. Multivariate logistic regression identified predictors of early readmission and 1-year mortality. Odds ratios were adjusted for multiple factors, including measures of comorbidity, socioeconomic status, and disease severity.

**RESULTS:** Of 42,375 patients who were discharged, 4,662 (11%) were readmitted within 30 days. The most common causes of rehospitalization were ileus/obstruction and infection. Significant predictors of readmission included male gender, comorbidity, emergency admission, prolonged hospital stay, blood transfusion, ostomy, and discharge to nursing home. Readmission was inversely associated with hospital procedure volume, but not surgeon volume. After adjusting for potential confounding variables, the predicted probability of 1-year mortality was 16% for readmitted patients, compared with 7% for those not readmitted ( $p$ -value  $<0.001$ ). The difference in mortality was significant for all stages of cancer.

**CONCLUSIONS:** Early readmission after colectomy for cancer is common and due in part to modifiable factors. There is a remarkable association between readmission and 1-year mortality. Early readmission is therefore an important quality-of-care indicator for colon cancer surgery. These findings may facilitate the development of targeted interventions that will decrease readmissions and improve patient outcomes.