



# AMERICAN COLLEGE OF SURGEONS

## SURGERY NEWS



LAWRENCE LEA/LSUHSC-S

"When technical misadventures occur in the presence of behavioral violations, we create a perfect storm," said Dr. F. Dean Griffen.

## Liability Claims Linked To Surgeons' Behavior

BY BRUCE JANCIN  
Elsevier Global Medical News

NEW YORK — Behavioral deficiencies emerged as a key preventable element in a national review of 460 closed liability claims against general surgeons involving payouts in excess of \$25,000.

The closed-claims review panel, composed of 40 board-certified surgeons, identified at least one discrete surgeon behavioral deficiency in 78% of cases. Some closed claims featured as many as five distinct behavioral deficiencies, Dr. F. Dean Griffen said at the annual meeting of the American Surgical Association.

"These data are interesting in that they show that a technical

misadventure in itself is a disaster, surely, but on the other hand, when technical misadventures occur in the presence of behavioral violations, we create a perfect storm," said Dr. Griffen, an ACS Fellow who chaired the American College of Surgeons' Patient Safety and Professional Liability Committee and is professor of surgery at Louisiana State University Health Sciences Center in Shreveport. He defined the behavioral dimension of surgical practice as elements of care requiring more time, patience, commitment, and diligence than knowledge and skill. The most common behavioral failures, in descending order, were not com-

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## Physician Pay Is In Limbo After Senate Inaction

ACS pushes for retroactive solution.

BY MARY ELLEN SCHNEIDER

Elsevier Global Medical News

The Bush administration gave Congress some extra time to work out a compromise that will keep a 10.6% Medicare physician pay cut from going into effect this year and at the same time issued a proposed rule that would cut fees by at least 5.4% and reform Medicare in a number of ways next year.

Health and Human Services Secretary Mike Leavitt announced at the end of June that the federal government will exercise its legal authority to "minimize the impact" of the cuts on providers and beneficiaries. With that as the goal, officials at the Centers for Medicare and Medicaid Services have instructed the agency's contractors not to process any physician and nonphysician practitioner claims for the first 10 business days of July.

Agency officials estimate that by holding claims for services provided on or after July 1, they will not make payments based on the 10.6% cut until July 15 at the earliest.

With just days to go before the original July 1 deadline, the Senate considered a bill that would have kept the current Medicare payment rates for the rest of 2008 and provided a 1.1% fee increase in 2009. However, the bill was never subjected to an up-or-down vote because a motion to end debate (cloture), which requires 60 votes to pass, failed by 2 votes. The bill, called the Medicare Improvements for Patients and Providers Act (H.R. 6331), passed the House by an overwhelming margin (355-59) earlier in the week.

Senate leaders will have another chance to pass the legislation when they return from their week-long recess on July 7.

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## Aetna Tops Cigna in Insurance Payments

BY ALICIA AULT

Elsevier Global Medical News

Aetna has taken over from Cigna as the fastest and most accurate national insurer for paying physicians, according to the third annual ranking of payer performance by one of the nation's largest physician management companies.

Cigna achieved the top rank in 2006, and Aetna was No. 2, having moved up from the fourth spot in the 2005 survey by AthenaHealth.

The 2007 data are based on 30 million charge lines collected by AthenaHealth, and cover 137 national, regional, and government payers and 12,000 medical providers. The company, which is based in Watertown, Mass., collected almost \$3 billion for its 980 physician clients in 2007.

According to the company, several trends were apparent in the data. Payers have moved to make Web portals more available to physicians, and they've become more proactive about contacting physicians with guideline changes. This has resulted in an almost 3% drop in the number of days that claims are in accounts receivable, at least for regional payers.

Claims denial and resubmis-

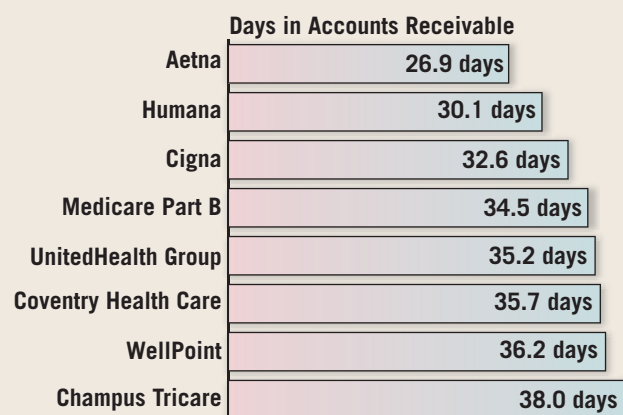
sion rates increased, however, partly due to problems implementing the new National Provider Identifier number required by Medicare. The full impact of that transition may not be felt until this year, according to AthenaHealth.

After Aetna and Cigna, the top performers were Humana, Medicare Part B, UnitedHealth

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### VITAL SIGNS

#### Of National Insurers, Aetna Pays Quickest



Note: Based on 2007 data for 30 million charge lines.  
Source: AthenaHealth

## Up From No. 2 Spot

Payments • from page 1

Group, WellPoint, Coventry Health Care, and Champus Tri-care. Humana and Medicare were the top two payers in 2005; United, Wellpoint, Coventry, and Champus have more or less held steady.

"We commend Aetna for their progress in improving what should be any insurer's core competency: paying insurance claims accurately and promptly," said Dr. William F. Jessee, president and CEO of the Medical Group Management Association, in a statement.

Aetna CEO Ronald A. Williams said in a statement, "While we are pleased that the progress we have made has been recognized, we are committed to continuous improvement in this area."

Rankings are calculated by scores given to performance in seven areas. If a payer paid quickly and fully, it tended to receive a higher ranking overall. Fifty-eight percent of the score came from days in accounts receivable (DAR), first pass resolve rate, and percentage of billed charges that were deemed the patient's responsibility.

Physicians have a greater collections burden when payers ask patients to foot more of the bill. There was a 19% increase in patient liability in 2006, but it only rose 0.4% in 2007. Increased availability of real-time claims adjudication has helped cut the physician collection burden, according to AthenaHealth.

Aetna's DAR was 26.9 days, compared with 32.6 for Cigna, and 35.7 for Coventry, which holds the No. 8 overall position. Blue Cross Blue Shield of Rhode Island had the lowest DAR for the second year in a row, at 15.8 days. Aetna had the lowest denial rate among national payers, at about 6%. The highest denial rate—38%—was at Health Choice Arizona. The lowest denial rate overall was 3.17%, at Blue Cross Blue Shield of Rhode Island.

The New York state Medicaid program came in for special criticism, because it lagged in most of the key measures. The program had the highest DAR of any payer—for the second year running—coming in at 137.3 days in 2007, compared with the national median of 35.4. New York Medicaid also had the lowest first pass resolve rate, at 57%, compared with 97% for Blue Cross Blue Shield of Ohio, the top performer in that category.

According to AthenaHealth, the New York program "ranked at the bottom on the clarity of why the program rejects a medical claim."

The best overall Medicaid program, in South Carolina, had a DAR of 40 days, and a first pass resolve rate of 92%. The number two Medicaid performer, the North Carolina program, had similar rates. ■

The rankings are posted at [www.athenapayerview.com](http://www.athenapayerview.com).

## Hope Hinges on Grassroots Advocacy

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Physician leaders called the lack of action by Congress disappointing and predicted that it could force physicians to limit the number of Medicare patients they can see in their practices.

Officials at the American College of Surgeons have vowed to put the "full arsenal" of advocacy resources into getting Congress to pass legislation that will retroactively stop the 10.6% pay cut. Thousands of ACS fellows contacted members of Congress over the past few weeks to urge action to avert the pay cut in one of the largest-ever grassroots advocacy efforts, according to the ACS.

The failed legislation would also have phased out higher copayments for psychiatric services under Medicare, increased bonuses under the Physician Quality Reporting Initiative (PQRI), and delayed implementation of the Medicare competitive acquisition program for the purchase of durable medical equipment, prosthetics, orthotics, and supplies.

Under the bill, the increased physician fees would have been financed in part through cuts to Medicare Advantage plans. Officials at America's Health Insurance Plans, which represents the health insurance industry, estimated that the proposed Medicare Advantage cuts would have resulted in \$13.8 billion in budget savings over the next 5 years.

Republican senators who voted against consideration of the bill said sending the legislation to the president would have been useless since he had threatened to veto it if it contained cuts to Medicare Advantage plans. Instead, the senators called for more time to reach a bipartisan compromise.

Sen. John Kyl (R-Ariz.) objected to the legislation, saying that it made "radical changes" in Medicare. The cuts to Medicare Advantage plans would minimize patient choice, he said, estimating that about 2 million seniors would have lost their fee-for-service plans by 2013 under the bill.

"We can do better than this," Sen. Kyl said on the floor of the Senate. "We should return to the

bipartisan negotiations and pass a truly bipartisan bill which will ensure that physicians will be paid and Medicare patients will be served."

Physicians have been facing scheduled fee cuts over the last several years, but Congress has usually stepped in at the 11th hour with a temporary fix. Mostly recently, Congress voted at the end of last December to provide a 6-month reprieve on payment cuts and give physicians a 0.5% reimbursement bump.

Physician leaders have been lobbying Congress for the past 6 months to pass an 18-month temporary fix that would allow them time to craft a new payment system.

In the meantime, CMS officials issued the agency's proposed 2009 Medicare Physician Fee Schedule, which contains a 5.4% cut in physician payments next year.

The proposed rule also calls for changes to the PQRI. For example, the CMS is proposing that in 2009 physicians would be able to report on groups of measures related to a specific condition (see story on p. 9). The CMS is also proposing to begin accepting limited PQRI data from electronic health records next year, pending a successful test this year.

The proposed rule would also require that physicians who perform diagnostic testing services meet most of the quality and performance standards established for Independent Diagnostic Testing Facilities. These include requiring a supervising physician to prove proficiency in the performance and interpretation of each diagnostic procedure and maintaining an inventory of diagnostic testing equipment. However, CMS officials are considering whether to limit the requirement to certain testing services. For example, the CMS could choose to limit the requirements to only those procedures that generally involve high-cost testing and equipment.

Comments on the proposed rule will be accepted until Aug. 29; the final physician fee schedule is expected to be issued by November. ■



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## 460 Closed Claims Reviewed

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municating sufficiently with patients; not pursuing an abnormal sign, symptom, test, or simple postoperative problem; not adequately assessing primary surgical problems before surgery; not enlisting consultant support in a timely way; and not obtaining cross-coverage. Other common behavioral deficiencies were operating outside one's proper scope of practice, not assessing comorbidities before surgery, and not checking test results.

Behavioral deficiencies were significantly less frequent in closed claims involving older and emergency patients. Patients over age 59 were involved in 35% of cases with no behavioral violations but only 25% of cases with behavioral deficiencies. Similarly, patients receiving emergency care comprised 37% of cases involving no behavioral violations and only 18% with behavioral shortcomings.

Behavioral deficiencies were common in cases involving delayed treatment, failure to treat, or wrong treatment.

Diagnosis-related adverse events, involved in 250 cases, were a feature of 61% of claims involving surgeon behavioral deficiencies but only 31% of claims without such deficiencies.

Technical misadventures marked 229 of the 460 claims. Panelists judged 78% of complications in technical misadventure cases with behavioral deficiency as preventable, compared with only 45% of

complications in technical misadventure cases lacking behavioral violations.

In cases with no technical misadventure and no behavioral violations, no complications were judged preventable, he said.

His report prompted some frank soul searching among his fellow surgeons.

"He has shown who the enemy is—and it is us," declared Dr. James A. O'Neill Jr., an ACS Fellow who is professor and chair emeritus of surgical sciences at Vanderbilt University, Nashville, Tenn.

Dr. Alden H. Harken observed that patients understand that to err is human, and they accept it. "What they don't accept is the misbehavior or the behavioral stumble. We surgeons are pretty good with the basic knowledge and the clinical skills. Where we stumble is in the interpersonal skills and the professionalism.

"Surgeons have to be self-confident. The problem is when that self-confidence becomes errors," said Dr. Harken, an ACS Fellow who is professor and chairman of surgery at the University of California, San Francisco, East Bay Campus, Oakland.

Dr. O'Neill said a Vanderbilt closed-claims study showed that behavioral deficiencies are a major problem in lawsuits involving all specialties, not just general surgeons. Because physicians and surgeons with behavioral problems have an increased number of liability claims, Vanderbilt has established a process whereby

providers with behavioral problems must either enter a formal intervention program or lose their privileges.

Dr. Graeme L. Hammond proposed that all surgeons be required to have a yearly physical examination with history taken in an effort to identify medically related behavioral problems. Surgeons experiencing depression, alcoholism, and diabetes, for example, may suddenly "start making mistakes and can't quite put their finger on the problem," said Dr. Ham-

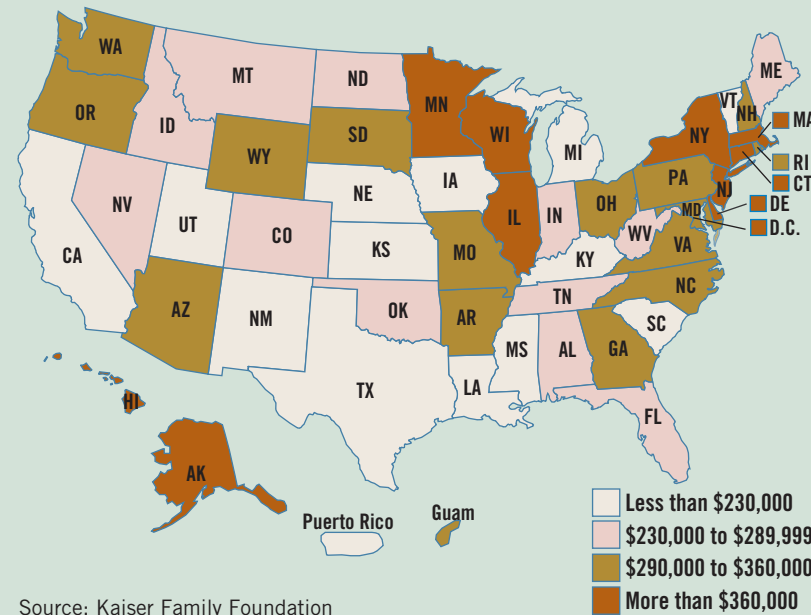
mond, an ACS Fellow and professor of surgery at Yale University, New Haven, Conn.

Dr. Griffen said he and his coinvestigators in this study, which was part of a larger ACS-sponsored medical liability study, believe that educating surgeons in the behavioral sciences may result in safer care.

"Hopefully, with research and development we can establish evidence-based behavioral practices that will enable [us] to provide safer outcomes," he said. ■

### DATA WATCH

#### Average Claims Payments on Medical Malpractice, 2005



## Untreated Depression Tied to High Physician Suicide Rates

BY JANE ANDERSON  
Elsevier Global Medical News

Each day in the United States, roughly one doctor dies by suicide. Studies over the past 4 decades have confirmed that physicians—especially women physicians—die by suicide more frequently than people in other professions or those in the general population.

"Physicians have the means and the knowledge and access to ways to kill themselves," said Dr. Paula Clayton, a psychiatrist and medical director for the American Foundation for Suicide Prevention, in an interview.

But the data on physicians dying by suicide are difficult to come by, and "we certainly don't have any data that [say] any particular specialty has any higher rates of suicide," Dr. Clayton said.

Although no information is available on the risk of suicide in surgeons, researchers know that physician suicides are equally divided between men and women, whereas in the general population, four times as many men kill themselves as do women, according to Dr. Clayton.

Awareness of the problem remains low, and professional and cultural barriers deter or prevent physicians who are depressed from seeking treatment for their illness, Dr. Clayton said. For example, most physicians do not have a regular source of health care; only 35% of doctors have a personal physician, and even fewer interns and residents have a doctor themselves.

Dr. W. Gerald Austen, an ACS Fellow and surgeon-in-chief emeritus at Massachusetts General Hospital, has first-hand experience with physician suicide. Twenty-eight years ago, when he was surgeon-in-chief, one of his younger staff committed suicide. And about 11 years ago, a surgical resident committed suicide.

"It wasn't as if the institution and the department weren't aware that they had some problems," he said in an interview. "Both of these individuals were under psychiatric care. They were believed by both their doctors and their contemporaries and colleagues to be doing rather well."

In each case, the surgery department reviewed the situation with the psychiatry department, Dr. Austen said, and "we certainly did everything we could in terms of their family in both cases." But he said the department didn't find any procedures to change internally as a result of the deaths.

It's possible that increasing awareness of physician depression could help get physicians the help they need before it's too late, Dr. Austen said. "Friends who work with people in medicine need to be aware that, if they see something that concerns them, they need to transmit the message to the powers that be."

But it's difficult to know the difference between someone who is simply unhappy, and someone who is clinically depressed and potentially at risk for suicide, he added.

"[Physicians believe] their job is to help other people with problems. If they have

a problem themselves, they would prefer to not have people know about it," said Dr. Austen.

"There's this proudness about their ability to cope," Dr. Clayton said. "They are reluctant to seek help because they fear the stigma will harm them—people won't refer them patients, the hospital might revoke their privileges, and licensing could become a problem."

State medical licensing boards ask for information on whether the person applying for licensure has been treated for a mental illness, and that information can affect licensing, she said. "I worked with a physician who took lithium," she said. "The state board made him get blood drawn periodically to prove he continued to take it. That's punitive—they don't do that for other illnesses."

However, some progress has been made in reducing the stigma: A total of 19 states now focus specifically on whether an applicant is impaired because of psychiatric illness, she said.

Dr. Clayton's group recently funded the production of three films on physician suicide as part of an ongoing outreach campaign that seeks to educate physicians about depression. The goal is to help them better recognize the symptoms in themselves and their patients while also cultivating a more thorough understanding of mood disorders in the community at large.

One of the films was designed as an educational video for use at medical schools. Because many of the mood disorders that can lead to suicide might become evident

first during medical school, where professional and institutional barriers already exist, the goal of that program is to encourage medical students to seek help for depression. Good treatments exist, Dr. Clayton said. ■

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# THE 20/20 VISION

## Evolutionary Changes in Surgical Practice

# Private Groups Roll Out Health Care Reform Plans

BY MARY ELLEN SCHNEIDER  
*Elsevier Global Medical News*

**M**ore and more players in the health care arena are unveiling plans to provide health care coverage for all or most Americans.

For instance, the Commonwealth Fund's "Building Blocks" proposal seeks to cover 44 million of the 48 million Americans estimated to be uninsured in 2008 through a national health insurance connector that would allow small businesses and individuals without large employer insurance to shop for a health plan.

The connector would feature both private plans and a "Medicare Extra" option. The Medicare Extra plan would offer premiums of \$259 a month for individuals and \$702 a month for families, 30% lower than the average premium charged to employers today, according to the Commonwealth Fund, a private foundation that supports research on health policy reform.

The plan also calls for expanding Medicaid and the

State Children's Health Insurance Plan (SCHIP) to cover all adults and children below 150% of the federal poverty level. And the plan would include both individual and employer mandates for health coverage.

Using modeling from the Lewin Group, officials at the Commonwealth Fund estimate that the proposal would add \$15 billion to current total health spending in the United States during the first year and about \$218 billion over 10 years. But the plan could actually save \$1.6 trillion over 10 years if it is combined with other reforms, according to the Commonwealth Fund.

"This approach builds on group insurance coverage and the national reach of Medicare and at the same time addresses the high administrative and premium costs for individuals and small groups," Karen Davis, Commonwealth Fund president, said in a statement.

In the meantime, the Healthcare Leadership Council, a coalition of hospitals, health plans, and pharmaceutical and device manufacturers that aims to improve the quality and affordability of health care, has brought

forward its own market-based proposal aimed at covering all Americans. Called "Closing the Gap," the proposal calls for subsidies and tax breaks to help individuals afford coverage, improving health care quality through health information technology and care coordination, and realigning the financial incentives in the health care system to pay for value.

For example, the plan calls on the government to provide premium subsidies to help employees afford their employer-sponsored insurance premiums. The plan also calls for applying the same tax breaks to individually purchased health insurance as apply to employer-sponsored coverage. However, the group did not endorse individual mandates for health insurance.

The plan also calls for a shift from rewarding physicians and hospitals for the volume of services they provide to focusing on evidence-based care and prevention, Dr. Denis Cortese, chair of the Healthcare Leadership Council and president and chief executive officer of the Mayo Clinic, said during a press briefing. ■

# Candidates' Health Plans Leave Cost Questions Unanswered

BY ALICIA AULT  
*Elsevier Global Medical News*

WASHINGTON — While health care has been a key issue in this year's presidential campaign, plans from both Barack Obama and John McCain are light on specifics about how to control costs, and improve efficiency and productivity.

The candidates' wish lists provide few details on how they would accomplish the "fundamental change needed for our delivery system," said Paul B. Ginsburg, Ph.D., president of the Center for Study-

ing Health System Change, at a briefing sponsored by the Alliance for Health Reform.

"They could have a debate over how best to do that," he said.

Economists have estimated that over the next decade, U.S. health spending will double from \$2.2 trillion to \$4.3 trillion. Dr. Ginsburg, along with Princeton University economist Uwe Reinhardt and former Centers for Medicare and Medicaid Services Administrator Dr. Mark McClellan, said that rising costs are largely being driven by variations in practice, growth in

volume, and intensity of services.

Senator Obama has said that he favors health information technology, transparency of price, promotion of quality care, chronic care coordination, payment reforms for value, malpractice reform, and promotion of generics.

Most of these are old, but not worthless, ideas, said Dr. Reinhardt, James Madison Professor of Political Economy at Princeton. "These are not to be laughed off, but they won't get us out of the box," he said.

Dr. Reinhardt called Senator McCain a "true radical" for his proposal to eliminate

the tax exemption for employer-provided health insurance. Individuals who purchase insurance on their own would instead receive a \$2,500 tax credit; families would receive \$5,000.

"This is almost un-American—to take away a tax preference," said Dr. Reinhardt, adding that it is "a shocking idea and not easy to get through Congress."

Dr. Ginsburg called the proposal "a potentially powerful idea," saying that it could make consumers more sensitive to the cost side of insurance, and thus make them a more potent demand force.

There will be no new federal money available to increase access to insurance or initiatives aimed at improving quality or productivity, said Dr. McClellan.

"Next year is going to be a very tight year fiscally," he said. He added that new spending will be next to impossible, especially for a Republican who, politically, must maintain the tax cuts instituted in 2001, and continue to fund the war in Iraq and the war on terrorism.

In fact, tax reform, the Iraq war, and the economy are likely to be higher up on the campaign agenda than health during the general election run-up this fall, said Dr. McClellan and his fellow panelists.

"I'm not persuaded that health care, in fact, will drive the campaign in the fall," said Dr. Reinhardt.

But Dr. McClellan said, "My hope is it doesn't get pushed to the back burner. It will be a major missed opportunity if we don't have health reform next year." ■

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# Survey Defines Residents' Vascular Skills

BY DOUG BRUNK  
*Elsevier Global Medical News*

SAN DIEGO — General surgery residents expect themselves to be more competent with independently performing vascular operations than do vascular surgery program directors, general surgery program directors, or vascular fellows, according to results from a survey.

"There are new procedures coming on board in vascular and general surgery [and] general surgery residents are faced with more procedures to learn and less time to learn them in. This has prompted many of us to ask, To what level of competence can and should general surgery residents be trained to perform open vascular and endovascular procedures?" said Dr. Marc E. Mitchell, an ACS Fellow who is chairman of the surgery department and chief of the division of vascular surgery at the University of Mississippi Medical Center, Jackson.

He and his associates conducted online surveys with 50 vascular surgery program directors, 115 general surgery program directors, 94 vascular fellows, and 48 general surgery residents. As a guide, they used the American Board of Surgery Resident Operative Experience Report, which consists of nine vascular procedure categories that contain 77 vascular procedures, Dr. Mitchell said at the Vascular Annual Meeting.

The survey asked respondents to grade the competency level of finishing general surgery residents for each individual procedure as A (should be competent to perform the procedure independently); B (should be familiar with the procedure, but not necessarily competent to perform independently), or C (need not be familiar with or competent to perform independently).

Vascular surgery program directors expected general surgery residents to be neither competent in nor familiar with 38% of vascular procedures, and to be competent in just 12%. For vascular fellows, those expectations were 42% and 10%, respectively. General surgery program directors and general surgery residents expected at least familiarity with all vascular procedures. General surgery program directors expected competence in 22% of procedures, whereas for residents that number rose to 26%.

Amputation, access surgery, and vascular trauma procedures received the highest category scores from all respondents and had the greatest concurrence. Cerebrovascular and

endovascular procedures received the lowest scores from all respondents. Fasciotomy for injury received the single highest score for all procedure categories, followed by below-the-knee amputations. All groups indicated that they expect a moderate level of competence from general

surgery residents with regard to procedures for peripheral obstructive disease and aneurysm surgery.

"Both vascular surgery program directors and general surgery program directors expect general surgery residents to be familiar with, but not competent to inde-

pendently perform, the majority of vascular surgery procedures outside of the amputation and access categories," Dr. Mitchell said. He added that the data "have implications for curriculum development in general surgery and vascular surgery training programs." ■

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A 2-0 silk suture swaged on a cutting needle is inserted from the palatal side between two upper incisors to include 5-6 mm of gingival tissue margin.



COURTESY DR. TED T. HUANG

## Gingival Suturing Secures Endotracheal Tube

BY PATRICE WENDLING  
Elsevier Global Medical News

CHICAGO — Suturing the stem of an airway tube to the gingival tissue is a novel and viable method to anchor an endotracheal tube or laryngeal mask airway, Dr. Ted T. Huang said at the annual meeting of the American Burn Association.

Dislodgement is uncommon, and the su-

tures do not mask or distort the facial features, contrary to what happens when a tube or mask is taped against the cheek, said Dr. Huang of the division of plastic surgery at the University of Texas Medical Branch, Galveston. Furthermore, loosened tape can lead to wound contamination, as well as extubation or dislodgement requiring reinsertion of the airway tube.

The gingival suturing technique was used in 978 of 1,769 children undergoing reconstructive procedures under general anesthesia at the University of Texas between 2001 and 2004. Of these, 931 were head and neck procedures.

Resuturing of the tube was needed in eight of the 978 patients (less than 1%) because the anchoring suture had cut through the gingival tissue, Dr. Huang reported on behalf of lead investigator Mark D. Talon, an anesthetist at the university. No sequelae or complaints of pain resulted from this problem, nor were any dental injuries or airway loss observed.

With this technique, an endotracheal tube or laryngeal mask airway is inserted and then the airway tube is positioned to one side of the midline between both incisors. Using a 2.0 silk suture swaged on a cutting needle, the surgeon places a suture in the gingiva of the upper incisor interdental space. This is achieved by passing a curved needle from the palatal side through the mucosa to the buccal side.

Suturing must include 4-5 mm of mucosal tissue to avoid transecting the mucosa with the tying of the suture, Dr. Huang said. Two loops are placed around the laryngeal mask airway or endotracheal tube and secured with a surgical knot. The tube is tied against the incisor teeth for stability. The technique can be used in young children with no teeth by placing the sutures above the teeth buds.

"This technique is very simple and effective, and it doesn't encroach on the surgical site," Dr. Huang said.

Silk sutures are better than chromic sutures or wire, which can cause dental and gingival trauma, according to Dr. Huang. Gingival sutures used for chronic anchoring should be checked regularly for erosion that might cause unexpected extubation, he cautioned.

Several audience members said they have had success with the technique, including Dr. Debra A. Reilly, who said she uses gingival anchoring for all pediatric and adult patients with facial burn wounds. Dr. Reilly, director of the burn center at the University of Nebraska, Omaha, said she also prefers silk sutures because it is hard for nursing staff to see chromic sutures post operatively and because wire can be difficult to manage in an emergency.

Dr. Steven E. Wolf, who commented on the study, questioned the utility of gingival anchoring, calling it "a bit of overkill." Procedures on the head and neck "are routinely done without such an invasive maneuver, and it is only a matter of time until a complication occurs," said Dr. Wolf, an ACS Fellow and professor of surgery at the University of Texas, San Antonio. ■



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# Pancreatic Cancer Survival Doubles With Gemcitabine

BY PATRICE WENDLING  
Elsevier Global Medical News

CHICAGO — Adjuvant chemotherapy with gemcitabine doubled 5-year survival rates, compared with surveillance alone, in pancreatic cancer patients who underwent surgery with curative intent, according to final results from a phase III international trial.

After 5 years of follow-up, 21% of patients who were given gemcitabine (Gemzar) for 6 months and 9% of patients who were not given gemcitabine after curative surgery were still alive. Gemcitabine increased disease-free survival as well as overall survival, and “should be the standard of care for adjuvant treatment of pancreatic cancer,” Dr. Helmut Oettle of Charité Medical University of Berlin said in a press conference at the annual meeting of the American Society of Clinical Oncology.

An intent-to-treat analysis from the CONKO-001 (Charité ONKOlogie Clinical Studies in GI cancer) trial enrolled 368 patients at 88 academic and community oncology centers in Germany and Austria. All had resected pancreatic cancer but no prior radiation or chemotherapy. Karnofsky performance scores were at least 50%.

Patients were randomized to receive adjuvant chemotherapy with six cycles of

gemcitabine on days 1, 8, and 15 every 4 weeks (n = 186) or observation (n = 182). The intent-to-treat analysis was based on 179 and 175 patients, respectively.

Median ages were 62 years in the gemcitabine arm and 61 years in the observation arm. A total of 86% of patients in both groups had T3-4 tumors, and 71% of patients in the gemcitabine arm and 73% in the observation arm were lymph node positive.

Median overall survival significantly improved from 20.2 months with observation to 22.8 months with gemcitabine (hazard ratio 0.72,  $P = .005$ ).

Long-term survival was comparable for the gemcitabine group vs. the observation group at 1 year (72% vs. 72.5%), but improved 8.5% at 2 years (48.5% vs. 40%), 17% at 3 years (36.5% vs. 19.5%), and 12% at 5 years (21% vs. 9%), Dr. Ulf Neumann reported at the meeting on behalf of the CONKO-001 study group.

Subgroup analyses showed a significant beneficial effect of gemcitabine in patients with R0 resections (22.8 vs. 20.3 months, HR 0.74) and T3-4 tumors (21 vs. 19 months, HR 0.74); and a nonsignificant trend toward improvement in those with R1 resections (22.1 vs. 14.1 months, HR 0.62) and T1-2 tumors (40.6 vs. 27 months, HR 0.58). The number of patients in the subgroups was too small to draw any con-

clusions, said Dr. Neumann, who is also at Charité Medical University of Berlin.

The study’s primary end point of disease-free survival remained as previously reported (JAMA 2007;297:267-77), significantly improving from 6.9 weeks with ob-

**AFTER 5 YEARS OF FOLLOW-UP, 21% OF PATIENTS WHO WERE GIVEN GEMCITABINE FOR 6 MONTHS AFTER CURATIVE SURGERY WERE STILL ALIVE.**

servation to 13.4 weeks with gemcitabine (HR 0.55,  $P < .001$ ).

Subgroup analyses showed a significant beneficial effect of gemcitabine on disease-free survival in patients with R0 and R1 resections, lymph node-negative and -positive tumors, as well as T1-2 and T3-4 tumors, all with  $P$  values below .05, Dr. Neumann said.

Discussant Dr. Robert Wolff of the University of Texas M.D. Anderson Cancer Center, Houston, said the trial’s findings support gemcitabine as a community standard for adjuvant therapy and provide the best level 1 evidence for disease-free, median overall, and 5-year survival.

But Dr. James Neifeld, who commented on the study, advised caution. “Results will need to be replicated in the U.S. before we should consider it standard of care here,” said Dr. Neifeld, an ACS Fellow and chairman of the surgery department at Virginia Commonwealth University, Richmond.

Dr. Wolff acknowledged that the overall survival results aren’t much better than those of other adjuvant therapies, and the results don’t apply to all patients who undergo up-front surgery, because some may not be resectable, some don’t recover from surgery, and some are metastatic at restaging, said Dr. Wolff, who disclosed relationships with Eli Lilly & Co., the maker of gemcitabine; Genentech; and Sanofi-Aventis.

“Are we making any progress, despite better surgery and perioperative care, better imaging, and slightly better chemotherapy?” Dr. Wolff asked.

The first results from CONKO-001 showed that postoperative gemcitabine was well tolerated; grades 3/4 toxicities occurred infrequently. Overall survival and toxicity were secondary end points of the study, which was supported in part by a grant from Lilly Deutschland. Dr. Neumann disclosed a consultant or advisory role with Lilly Oncology, Roche Pharmaceuticals, and Sanofi-Aventis. ■

# Cisplatin Does Not Improve Anal Canal Cancer Outcomes

BY MARY ANN MOON  
Elsevier Global Medical News

Cisplatin-based induction chemotherapy did not improve overall or disease-free survival rates in a randomized phase III trial assessing 644 patients with anal canal carcinoma, researchers reported. This strategy to debulk the tumor and perhaps to sensitize it to later chemoradiotherapy was not superior to standard mitomycin-based induction treatment, and in fact increased the need for colostomy, they said.

Disease-free survival rates were 61% at 3 years after diagnosis and 54% at 5 years with cisplatin-based induction chemotherapy, compared with 67% at 3 years and 60% at 5 years with standard treatment. Overall survival rates were 76% at 3 years and 70% at 5 years with cisplatin, compared with 84% at 3 years and 75% at 5 years with standard treatment. None of these differences were statistically significant.

The rates of colostomy were 16% at 3 years and 19% at 5 years with cisplatin, which was significantly higher ( $P = .02$ ) than the 10% colostomy rate at both time periods with standard treatment, the investigators said (JAMA 2008;299:1914-21).

These results “clearly demonstrate the importance of conducting phase [III] trials to test hypotheses that appear to have merit,” said Dr. Jaffer A. Ajani of the University of Texas M.D. Anderson Cancer Center, Houston, and his coauthors.

Five cooperative research groups participated in the study, which was coordinated by the Radiation Therapy Oncology Group. The investigators undertook the trial because cisplatin chemoinduc-

tion had produced “encouraging” results in preclinical trials and small pilot studies.

“We hypothesized that induction chemotherapy with fluorouracil and cisplatin would reduce the volume of the primary tumor, and that the ensuing concurrent chemoradiation (experimental group) would be more effective for local control and colostomy-free survival compared with traditional up-front concur-

rent chemoradiation with fluorouracil-mitomycin (control group),” they explained.

Dr. Ajani and associates evaluated 320 subjects in the experimental group and 324 in the control group, after following them for a median of 2.5 years. Subjects had histologically documented squamous, basaloid, or cloacogenic carcinoma of the anal canal. The tumors were stage T2-T4 (mea-

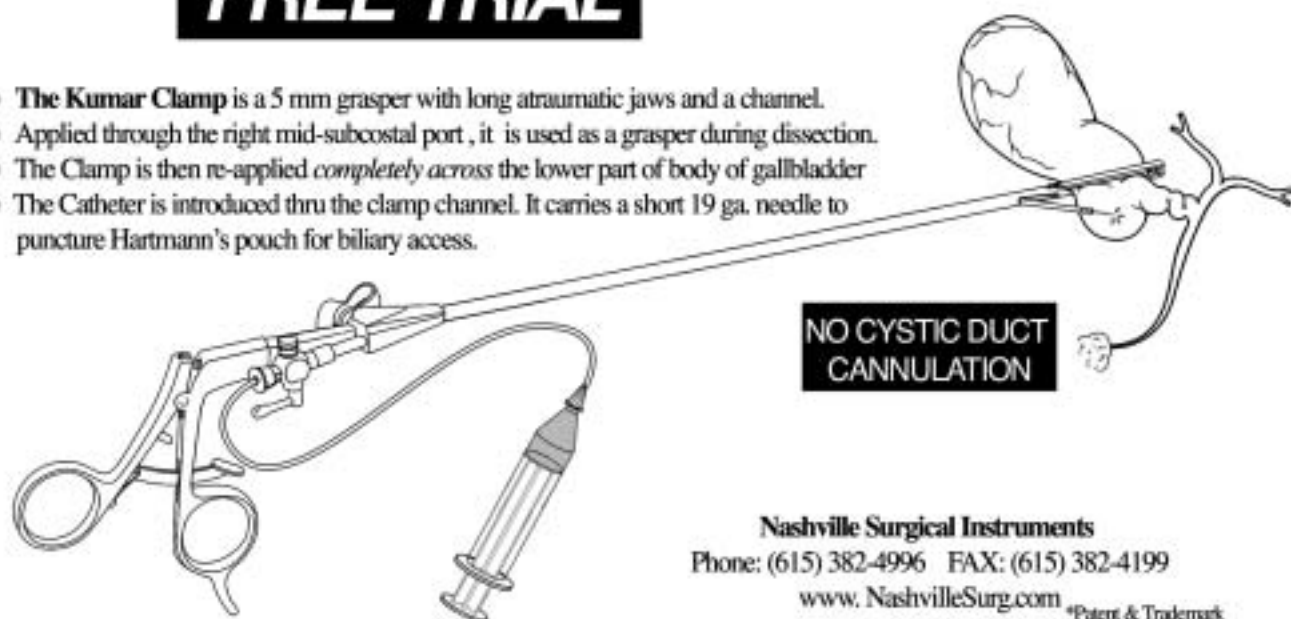
suring from 2 cm in diameter to large enough to invade adjacent organs) with a range of nodal status. Approximately 27% of patients had tumors larger than 5 cm, and 26% had positive nodes.

Cisplatin-based treatment should be used only in a clinical trial setting or in patients unable to tolerate the combination of fluorouracil and mitomycin, the investigators concluded. ■

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## NEWS FROM THE COLLEGE

# Dr. Morton Wins Jacobson Innovation Award

**D**onald L. Morton, M.D., FACS, a surgical oncologist and clinical scientist at the John Wayne Cancer Institute in Santa Monica, Calif., is the recipient of the 2008 Jacobson Innovation Award of the American College of Surgeons.

Established in 1994, the award honors living surgeons or surgical teams who have been innovative in the development of a new technique in any surgical field. The award is made possible through a donation from Julius H. Jacobson II, M.D., FACS, a general vascular surgeon who is director emeritus and the Distinguished Service Professor of Surgery at Mount Sinai School of Medicine of the City University of New York.

Dr. Morton is being recognized for his pioneering research efforts toward the development and clinical application of sentinel lymph node biopsy, which has transformed the surgical management of solid tumors, particu-

larly breast cancer and melanoma.

A medical school graduate of the University of California–San Francisco (UCSF) in 1958, Dr. Morton completed a medical internship and surgical residency at UCSF, followed by a clinical associate appointment in the surgery branch of the National Cancer Institute in Bethesda, Md., and another surgical residency and fellowship at the Cancer Research Institute at the UCSF Medical Center. From 1960 to 1969, he served in the Public Health Service of the U.S. military. He became a Fellow in 1973.

Dr. Morton introduced his lymphatic mapping technique—a surgical procedure that identifies the sentinel lymph nodes in the regional lymphatic basin—in 1990. Histopathologic examination of the sentinel node reveals the

tumor status of the entire lymphatic basin, so patients with tumor-negative sentinel nodes would not need to undergo radical lymphadenectomy. This minimally invasive procedure has been applied to neoplasms including breast, colon, and thyroid cancers.



**DONALD L. MORTON,  
M.D., FACS**

Dr. Morton has been at the Saint John's Medical Center in Santa Monica since 1991. He has also served as chief of the melanoma program and director of the fellowship program (2006 to present) as well as medical director and surgeon-in-chief (1991–2006) at the John Wayne Cancer Institute at Saint John's. He has been emeritus professor at the University of California–Los Angeles School of Medicine since 1991, after serving as professor of surgery and chief of the division of surgical oncology from 1971 to 1991.

Dr. Morton has published close to 700 research papers and more than 100 book chapters. He has received the 2005 National Cancer Fighter Award and the 2003 Heritage Award of the Society of Surgical Oncology, and is an honorary member of multiple international medical associations, such as the Polish Society of Surgical Oncology, the Japanese Cancer Association, and the H. William Scott Jr., Society.

He has served as president of the International Sentinel Node Society (2003), the World Federation of Surgical Oncology Societies (1995), and the Society of Surgical Oncology (1992).

The Jacobson Innovation Award is administered by the Honors Committee of the American College of Surgeons. Original thought combined with first presentation of work that has led to a milestone in the advancement of surgical care is the main criterion for selecting a Jacobson Innovation Award recipient. ■

## Trauma Paper Competition Winners Announced

**T**he Committee on Trauma (COT) has announced the winners of this year's Resident Trauma Papers Competition for papers describing original research in the area of trauma care and/or prevention in basic laboratory research or clinical investigation.

Funded by the Eastern and Western States COTs, Region 7 (Iowa, Kansas, Missouri, and Nebraska), Wyeth Pharmaceuticals, and the ACS, the competition is open to surgical residents and trauma fellows. Papers are first submitted for state or provincial competitions. Those winners are then judged at a regional level.

Winning papers from 15 regions were presented at the scientific session of the COT meeting, and the four final winners listed below were announced on March 14.

First Place, Basic Laboratory Research: Maj. Jason M. Seery, M.D., Fort Gordon, Ga.—The Effect of Metal Fragments on Nerve Healing in Extremity Injuries Using a Rat Peroneal Nerve Model.

First Place, Clinical Investigation: Joseph F. Golob, Jr., M.D., Cleveland, Ohio—Modern Medical Informatics



**L-R: Dr. Fildes, COT Chair; Dr. Golob; Maj. Seery; Dr. Shalhub; Dr. Sailhamer; Dr. Knudson, COT Vice-Chair.**

for Intensive Care Unit Research, Quality of Care Improvement, and Daily Patient Care: The Validation of SIC-IR.

Second Place, Basic Laboratory Research: Elizabeth A. Sailhamer, M.D., Boston—Acetylation: A Novel Method for Modulation of the Immune Response Following Trauma/Hemorrhage and Inflammatory Second Hit in Animals and Humans.

Second Place, Clinical Investigation: Sherene Shalhub, M.D., MPH, Seattle—Variant IL-1 Receptor-Associated-Kinase-1 Haplotype Is Associated with Worse Clinical Outcomes in Trauma Patients and Affects Human In Vitro Response to Endotoxin.

Each regional winner received a prize of \$500; the two second-place winners received an additional \$500; and an extra \$1,000 was awarded to the two first-place winners. ■

## Sleeve Gastrectomy OK'd as Standard Bariatric Procedure

**T**he Advisory Committee of the ACS Bariatric Surgery Center Network (ACS BSCN) Accreditation Program recently voted to approve adding sleeve gastrectomy and revisional surgery to its list of standard bariatric surgery procedures. Committee members also clarified that the only gastric bypass procedure (open or laparoscopic) that is acceptable as a standard procedure is the Roux-en-Y.

For the purposes of obtaining and maintaining status as an Accredited Bariatric Center in the ACS BSCN, the following operations are defined as ACS BSCN standard surgical procedures when performed by an open or laparoscopic approach:

- ▶ Roux-en-Y gastric bypass
- ▶ Laparoscopic adjustable gastric band
- ▶ Vertical banded gastroplasty
- ▶ Biliopancreatic diversion with duodenal switch

- ▶ Biliopancreatic diversion without duodenal switch
- ▶ Sleeve gastrectomy
- ▶ Revisional surgery

The advisory committee also approved a new criterion that non standard surgical procedures may be considered toward determining a center's annual volume requirements. Non-standard surgical procedures will be recognized if a center receives and presents IRB approval for each type of non standard procedure that will be included in the count toward its annual volume requirement. This decision was made in an effort to support, strengthen, and expand the evidence base of new and emerging surgical procedures, while ensuring the delivery of high-quality patient care.

For more information about the ACS BSCN Accreditation Program, visit [www.acsbcsn.org](http://www.acsbcsn.org). ■

## Tenn. Gets Grant for Consortium

**T**he Tennessee Chapter of the ACS and the Tennessee Hospital Association, through the Tennessee Center for Patient Safety, have received a \$2.5 million grant to develop a surgical quality consortium aimed at evaluating and improving surgical care delivered by general and vascular surgeons in the state. The 3-year grant from the Blue-Cross-BlueShield of Tennessee Health Foundation will be used to support the use of the ACS National Surgical Qual-

ity Improvement Program (ACS NSQIP) in eight hospitals.

Surgeon champions at the current ACS NSQIP participating hospitals will work as mentors for the new participating hospitals and physicians. Hospitals will use aggregate reports to identify improvement opportunities, identify differences in practice between hospitals, and disseminate best practices.

To learn more, visit <https://acsnsqip.org/login/default.aspx>. ■

## NEWS FROM THE COLLEGE

## Alternative Reporting Options Added to PQRI

BY CAITLIN BURLEY

The Centers for Medicare & Medicaid Services (CMS) has extended the Physician Quality Reporting Initiative (PQRI) through the end of 2008. This voluntary pay-for-reporting program was established in the 2006 Tax Relief and Health Care Act, which mandated the development of a reporting system for professionals with a payment incentive for individuals who meet the participation criteria. Preliminary reports released by CMS in January this year showed that out of more than 631,000 professionals eligible to participate, only a little more than 99,000 professionals attempted participation from July 1 through November 2007.

This article addresses changes that have been made in the 2008 PQRI and provides information to help surgeons determine whether to participate.

**What has CMS done to encourage more participation?**

CMS has created alternative reporting, released April 15, that allows for new reporting periods and methods. CMS anticipates that the new criteria will give eligible professionals several avenues to succeed and, ultimately, to receive the bonus payment.

The two new reporting periods for 2008 PQRI participation are January 1 to December 31 and July 1 to December 31. Both include the options of claims-based reporting and registry-based reporting, and reporting with these measures groups: diabetes mellitus, end-stage renal disease, chronic kidney disease, and preventive care.

**What are the options for reporting in the full year?**

Individuals who participate in the 2008 PQRI from January to December have the following options:

- ▶ Using claims-based reporting, an eligible professional must report on three PQRI measures (one or two if less than three apply) for at least 80% of applicable claims.

- ▶ Using registry-based reporting, an eligible professional must report on at least three PQRI measures for at least 80% of applicable cases.

- ▶ Using registry-based reporting, an eligible professional must choose one measures group and report on 30 consecutive, applicable patients.

- ▶ Using registry-based reporting, an eligible professional must choose one measures group to report on at least 80% of applicable patients.

**What are the options for reporting in the half-year?**

The options for participating in 2008 PQRI from July to December are:

- ▶ Using claims-based reporting, an eligible professional must choose one measures group to report on 15 consecutive, applicable patients.

- ▶ Using claims-based reporting, an eligible professional must choose one measures group to report on at least 80% of applicable claims.

- ▶ Using registry-based reporting, an eligible professional must report on at least three PQRI measures for 80% of applicable patients.

- ▶ Using registry-based reporting, an eligible professional must choose one measures group to report on 15 consecutive, applicable patients.

- ▶ Using registry-based reporting, an eligible professional must choose one measures group to report on at least 80% of patients.

**How are the measures groups used for reporting?**

Each measures group has four to nine PQRI measures, and health care professionals who choose to use one of the groups must report on all measures within that group. Patients must be applicable to the measures group used—that is, the defined measures are relevant to these patients' cases. When submitting measures groups through claims-based reporting, physicians must use the G code to signify the first of the 15 consecutive patients. G codes are only needed when using claims-based reporting.

**What are the specifications for registry-based reporting?**

On April 15, CMS announced that 12 clinical registries would take part in registry-based reporting as part of a pilot test. The registries were expected to demonstrate that they could submit PQRI data to CMS; that they were in existence on Jan. 1 of this year; and that they could fulfill CMS-specified technical requirements. Names of the qualifying registries will be posted on the CMS Web site by Aug. 31. Eligible professionals also were expected to be able to prove an established relationship with the registry through which they are reporting to CMS and confirm the validity of their data.

**Which organizations or firms house the 12 clinical registries CMS named as pilot test participants?**

The Society of Thoracic Surgeons, Cedaron, University of Wisconsin Medical Foundation, ICLOPS, The National Cardiovascular Data Registry, Cielo MedSolutions, American Osteopathic Association, Rush Health Associates, Wellcentive, Wisconsin Collaborative for Healthcare Quality, General Electric, and Phytel.

**Is there a payment incentive for participation in PQRI?**

Incentive payments for successful participation have been extended, and the cap associated with the bonus payments for the 2008 and 2009 PQRI has been removed. The incentive is 1.5% for all Medicare Part B services in the reporting period.

**Is it too late to enroll in PQRI for 2008?**

It is not too late to enroll. The half-year reporting period provides eligible professionals with opportunities to receive a bonus payment. For more information, visit [www.cms.hhs.gov/pqri/](http://www.cms.hhs.gov/pqri/) or contact Caitlin Burley at [cburley@facs.org](mailto:cburley@facs.org).

MS. BURLEY is a quality and regulatory assistant in the ACS Division of Advocacy and Health Policy.

## Clinical Scholars in Residence Program Builds on Success

BY CLIFFORD KO

The ACS Clinical Scholars in Residence Program is a 2-year fellowship in outcomes research and surgical health care policy. It was started in 2006 to offer residents a unique experience in the work of the College's Division of Research and Optimal Patient Care. The fellowship is designed to address issues in health care quality, health policy, and patient safety, and to help the Clinical Scholar in Residence prepare for a career in academic surgery.

Karl Bilimoria, M.D., M.S., the first Clinical Scholar in Residence, has produced more than 25 peer-reviewed publications, 20 national meeting pre-



KARL BILIMORIA, M.D.

sentations, and important contributions to the College's surgical quality programs (including the National Surgical Quality Improvement Program and the Commission on Cancer programs).

During his time as the Clinical Scholar in Residence, Dr. Bilimoria earned a masters of science degree in clinical investigation from Northwestern University in Chicago. He returns to his general surgery residency as a fourth-year postgraduate at Northwestern this month. His long-term interest is in surgical oncology with an emphasis on health services research.

Two new Clinical Scholars in Residence who have demonstrated great dedication to outcomes research and improvement of the quality of surgical



ANGELA INGRAHAM, M.D.

care are expected to make similarly-meaningful contributions.

Angela Ingraham, M.D., a resident at the University of Cincinnati, Ohio, joins the College this month to further her training and education in an effort to conduct meaningful research that will reduce traumatic injury incidence and improve the care of trauma patients.

Mehul Raval, M.D., a resident at Northwestern University, also joins the College in July. He aspires to obtain the skills necessary to conduct effective outcomes research that will contribute to advancements in pediatric surgery and establishing improved practice guidelines.

The College also welcomes its first Robert Wood Johnson Clinical Scholar.



MEHUL RAVAL, M.D.

Stanley Frencher, M.D., is a general surgery resident at Yale–New Haven (Conn.) Hospital who is interested in quality of surgical care, appropriateness of care, and health care disparities. Dr. Frencher, who begins work for the College this month, will be located primarily at the University of California–Los Angeles Center for Surgical Outcomes and Quality.

Applications for the next 2-year positions must be submitted by July 15, 2008. For more information, contact Karen Richards at [krichards@facs.org](mailto:krichards@facs.org) or visit [www.facs.org/ropc/clinicalscholars2009.html](http://www.facs.org/ropc/clinicalscholars2009.html).

DR. KO is director of the ACS Division of Research and Optimal Patient Care.



STANLEY FRENCHER, M.D.

# Race Alone Does Not Predict Surgical Outcomes

BY BRUCE JANCIN  
Elsevier Global Medical News

NEW YORK — African American race is not an independent predictor of worse perioperative outcomes following major general surgery, according to results of a large study that is at odds with earlier reports.

Those prior studies didn't adequately control for the greater comorbidities and other potential confounders present in African American, compared with white, general surgery patients, Dr. Nestor F.

Esnaola said at the annual meeting of the American Surgical Association. Although race is not a modifiable characteristic, many of the comorbidities that were identified in the new study as being more common in African American surgery patients certainly are. The implication is that greater access to prehospital primary care and more inpatient comanagement by hospitalists might neutralize the racial disparity in perioperative outcomes, he said.

Dr. Esnaola reported on 34,141 white and 5,068 African American patients who

underwent major general surgery at one of 14 academic medical centers during 2001-2004 while enrolled in the National Surgery Quality Improvement Program's Patient Safety in Surgery Study. The prospective study, sponsored by the American College of Surgeons with funding from the Agency for Healthcare Research and Quality, featured data collection on 97 patient variables.

Unadjusted 30-day morbidity was 14.3% in African Americans, significantly higher than the 12.4% rate in whites; 30-day mor-

tality was also higher, at 2.1% in African Americans versus 1.7% in whites, although this difference was not significant.

But this study highlighted the need for comprehensive risk adjustment, said Dr. Esnaola, an ACS Fellow with the Medical University of South Carolina, Charleston. African American patients were younger but significantly more likely to present with hypertension, diabetes, renal failure, dyspnea, anemia, a history of heart failure, and open wounds or active infection.

For example, the 6.1% prevalence of end-stage renal disease in African Americans was fivefold greater than in whites. The prevalence of diabetes was 17% in African Americans and 10% in whites. A history of hypertension was present in

49% of African Americans, compared with 34% of whites. African American patients were nearly twice as likely as whites to present for surgery with open wounds or active infection.

Particularly striking were the different rates of emergency surgery (16% in African Americans patients versus 10.5% in whites).

**Race had no independent effect on 30-day morbidity when comorbidities were controlled for.**

**DR. ESNAOLA**



African Americans and whites underwent similar types of general surgery, but African Americans had less complex operations based on relative-value units.

In a multivariate logistic regression analysis controlling for comorbidities and numerous other potentially confounding pre- and intraoperative factors, race had no independent effect on 30-day morbidity or mortality.

These findings suggest that efforts to improve perioperative outcomes in African American patients should focus on optimizing perioperative management of comorbidities and reducing the need for emergency surgery, Dr. Esnaola said. One way to do this might be to enhance reimbursement for surgeons who provide outpatient surgical consultation to minority patients.

"Additional funding to improve infrastructure of hospitals caring for a disproportionate share of minority patients may be warranted," he added.

Audience members expressed a desire to see an analysis of the data based on socioeconomic status. Dr. Esnaola said such data weren't collected in the national surgery study, although he agreed that socioeconomic status probably drives access to care, preoperative management of comorbidities, and the likelihood of emergency surgery.

"There's no biological reason to assume that African Americans would be more likely to have greater comorbidity across the board, other than the fact that they have less access to care, less access to primary care, and less opportunity to have these issues addressed preoperatively before they present for emergency surgery," he noted. ■

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# Rates of Minimally Invasive Surgery Differ by Race

BY JEFF EVANS  
Elsevier Global Medical News

PHILADELPHIA — Black patients at U.S. hospitals appear to be significantly less likely to undergo minimally invasive abdominal procedures and more likely to die or have certain complications than are white patients, according to an analysis of Nationwide Inpatient Sample data from 2004.

Although the disparities in access to minimally invasive surgery (MIS) and surgical outcomes were small, study investigator Dr. Rocco Ricciardi argued that they were both clinically and statistically significant.

To identify potential racial disparities in the use of MIS for benign surgical conditions and to determine whether any such disparities influence surgical outcomes, Dr. Ricciardi and his colleagues analyzed all primary cases of appendectomy, fundoplication, and gastric bypass with ICD-9 di-



**Rates of MIS were significantly lower among blacks (27%) than among whites (34%) or Hispanics (39%).**

DR. RICCIARDI

agnostic and procedural codes that were recorded in the Nationwide Inpatient Sample (NIS) in 2004. The NIS includes hospital discharge abstracts for about 8 million hospital stays, representing about 20% of U.S. hospital inpatients across 35 states. The investigators excluded patients with a surgical indication of malignancy, peptic ulcer disease, or GI bleeding.

MIS techniques were used in 33% of 88,545 appendectomy, fundoplication, and gastric bypass procedures in the 2004 sample, Dr. Ricciardi reported at the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons. Rates of MIS use were significantly lower among black patients (27%) than among white (34%) or Hispanic patients (39%). Black patients were 23% less likely to undergo surgery using MIS techniques than were white patients, after adjustment for age, sex, income, comorbidities (using the Charleston Comorbidity Index), hospital characteristics, surgical volume, and MIS conversion rate.

The highest-volume hospitals fell into the lowest quintile for use of MIS, and black patients sought treatment most often at such hospitals, said Dr. Ricciardi, an ACS Fellow with the department of colon and rectal surgery at the Lahey Clinic, Burlington, Mass.

Univariate analyses showed that patients who underwent MIS procedures had significantly lower mortality than did those who underwent open procedures (7 deaths/10,000 patients vs. 20/10,000). Black patients had a higher likelihood of dying in the hospital than did white patients (26 deaths/10,000 patients vs. 16/10,000).

In multivariate analyses, patients who underwent a procedure using MIS were 47% less likely to die than were patients

who underwent open procedures. Black patients also were twice as likely as white patients to die during hospitalization.

In the postoperative period, black patients were significantly more likely than white patients to experience pneumonia (odds ratio 1.5), GI ulceration and bleeding (OR 1.51), respiratory complications (OR 1.24), cardiac complications (OR 2.96), other infections (OR 1.49), and “surgical misadventures” (OR 4.39).

Dr. Yuri W. Novitsky of the University of Connecticut, Farmington, who dis-

cussed the study at the meeting, questioned whether the results were attributable to patient-level factors and presenting clinical scenarios rather than access to MIS techniques, because a laparoscopic approach would not be appropriate for all patients.

Dr. Novitsky also suggested that the “claims of racial disparities” that stem from a 0.1% overall increase in the surgical mortality of black patients vs. white patients “may be somewhat overstated.”

However, Dr. Ricciardi thought that

the 0.1% increase in mortality was clinically significant in addition to being statistically significant because it corresponded to a 63% increase in the odds of death in the univariate analysis and a doubling of the odds of death in the multivariate analysis.

Previous studies have suggested that racial differences in surgical outcomes could be accounted for by financial and insurance constraints, genetic differences, segregated health care systems, and health care worker bias, Dr. Ricciardi said. ■

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# Single-Stage Duodenal Switch: Safe and Effective

*The duodenal switch is difficult to perform but gives superior outcomes, including greater weight loss.*

BY BRUCE JANCIN  
Elsevier Global Medical News

NEW YORK — The duodenal switch can be performed with reasonable safety as a single-stage bariatric procedure even in superobese patients, according to results from a series of 190 patients.

At 30 days after surgery, the mortality rate for patients who underwent the procedure was zero and the overall complication rate was about 20%. The rate of serious complications in superobese patients, who accounted for most of the group, was not significantly higher than that of the less obese patients.

“It has been advocated that the procedure is so difficult that you had to do it in two stages: first the sleeve gastrectomy, then the rest of the duodenal switch a year or so later. We do not think doing two operations is a good idea if you can do it in one relatively safe operation,” Dr. Henry Buchwald said at the annual meeting of the American Surgical Association.

The duodenal switch is more difficult to perform than other bariatric operations, but previous studies have shown that it gives superior outcomes, including the greatest weight loss, said Dr. Buchwald, an ACS Fellow and professor of surgery at the University of Minnesota, Minneapolis.

He reported on the 30-day safety end points for his first 190 consecutive patients to undergo a single-stage duodenal switch procedure. With a mean preoperative body mass index of 53 kg/m<sup>2</sup>, more than half of the patients were in the superobese category (BMI of 50 or greater), which prior reports by others had identified as a subgroup at markedly increased

risk for serious complications with the duodenal switch. A total of 74 patients had concurrent procedures, including cholecystectomy or repair of ventral, umbilical, or hiatal hernia.

The overall complication rate at 30 days was 19.5%, including a 10% wound infection rate. Serious complications—mild acute renal failure, gastric outlet obstruction, acute pancreatitis, leak, and duodenoileostomy requiring dilatation—occurred in 18 patients: 6 of 90 with a baseline BMI of less than 50, and 12 of 100 superobese, a nonsignificant difference.

The duodenal switch is a modified biliopancreatic diversion procedure that involves creating a common channel 75-100 cm long, performing a sleeve gastrectomy with a roughly 100-mL gastric pouch, closing the duodenal stump, performing end-to-side duodenoileostomy hand-sewn in two layers, and closing all mesenteric defects. It is a malabsorptive procedure.

Jejunioileal bypass, the prototypical malabsorptive procedure, has fallen into disfavor because of problems such as vitamin deficiencies, electrolyte imbalance, bloating, severe diarrhea, and liver failure. The duodenal switch procedure avoids such problems because of its long ileal segment and good bile flow, he explained.

Audience members asked Dr. Buchwald why surgeons should resort to the duodenal switch—the most technically difficult of all bariatric operations—when a simpler procedure, such as laparoscopic Roux-en-Y gastric bypass, gets patients home from the hospital several days sooner and with substantially less morbidity.

“The most difficult operations, unfortunately, are often the ones that are most

effective,” Dr. Buchwald said, adding that he believes the duodenal switch provides the greatest benefits of any bariatric procedure. He noted that in an earlier 22,094-patient meta-analysis, he demonstrated that the duodenal switch achieved the greatest weight loss, the highest rate of resolution of type 2 diabetes, and the greatest reductions in hyperlipidemia of all types of bariatric surgery (JAMA 2004;292:1724-37).

Complete resolution of diabetes occurred in 98.9% of diabetic patients who underwent a duodenal switch and in lesser percentages of patients following gastric bypass, gastropasty, and gastric banding. (See box.)

Diabetes often resolved within days after bariatric surgery, prior to the major weight loss. The mechanism of benefit is unclear, although researchers are focusing on changes in gut-related hormones. Italian surgeons have recently reported very high rates of diabetes resolution after performing the duodenal switch, even in patients who are far less obese (with baseline BMIs in the 30s) than is customary for bariatric surgery, so the benefit isn't dependent upon the amount of absolute weight loss, according to Dr. Buchwald.

All forms of bariatric surgery provided

similarly high rates of resolution of hypertension and obstructive sleep apnea (62% and 86%, respectively).

Dr. Philip R. Schauer, an ACS Fellow who is professor of surgery and director of the Cleveland Clinic Bariatric and Metabolic Institute, hailed Dr. Buchwald's study as “a major contribution to our field,” one of many to have come from the University of Minnesota, where the world's first bariatric operation was performed in 1953.

Noting that others have reported perioperative mortality rates of up to 5% with the duodenal switch, as well as markedly increased complications in the superobese, Dr. Schauer asked Dr. Buchwald how he gets such outstanding results.

“I think it's because we pay a lot of attention to careful surgery,” he replied. “And we don't believe in a learning curve.”

“There is an unfortunate tendency today, at least in my opinion, in all of surgery—and particularly in bariatric surgery—to use the term ‘learning curve’ to excuse deaths and significant complications. Well, the patient isn't learning from this experience. I think we should try to do our work without saying it's okay to do badly in our first 50 or 100 patients because it's a learning curve,” Dr. Buchwald said.

## Duodenal Switch Shows the Most Improvements Among Bariatric Procedures

	Significant hyperlipidemia improvement	Diabetes resolution	Excess weight loss
Duodenal switch	99.5%	98.9%	70.1%
Gastric bypass	93.6%	83.7%	61.6%
Gastropasty	80.9%	71.6%	68.2%
Gastric banding	71.1%	47.9%	47.5%

Note: Based on a 22,094-patient meta-analysis.  
Source: JAMA

ELSEVIER GLOBAL MEDICAL NEWS

# IPAA Scores High in Long-Term Retention for Crohn's Patients

BY BRUCE JANCIN  
Elsevier Global Medical News

NEW YORK — Ileal pouch anal anastomosis has an unexpectedly good long-term retention rate in highly selected Crohn's disease patients, according to a single-center study of more than 200 patients.

The 10-year pouch retention rate was 85% or higher in patients diagnosed with Crohn's disease before or immediately after the procedure, and about 50% in those whose Crohn's diagnosis was delayed 3 months or more postoperatively.

Ileal pouch anal anastomosis (IPAA) surgery also won very high patient satisfaction marks from individuals with long-term pouch retention, Dr. Genevieve B. Melton-Meaux reported at the annual meeting of the American Surgical Association.

IPAA is widely considered the procedure of choice in ulcerative colitis patients whose inflammatory bowel disease requires surgery. However, IPAA is a controversial treatment for Crohn's patients because of concerns that the pouch itself may develop active Crohn's disease, as well as a lack of long-term outcome data, said Dr. Melton-Meaux of the Cleveland Clinic Foundation.

She reported on 204 Crohn's disease patients who underwent IPAA at the Cleveland Clinic. These patients represent only 7% of the clinic's database of nearly 2,900 inflammatory bowel disease patients on whom the

procedure was performed. Moreover, only 10% of the 204 patients were known to have Crohn's disease at the time IPAA was scheduled.

Another 47% were diagnosed with Crohn's disease immediately after surgery, based on surgical pathology, while in 43% the diagnosis was delayed a median of 36 months postoperatively.

The overall 10-year pouch retention rate was 71%. It was 85% among patients with known Crohn's disease at the time of IPAA, 87% in those whose Crohn's was diagnosed immediately after surgery, and significantly worse (53%) in those with a delayed diagnosis.

In a multivariate analysis, pouch loss was associated with delayed diagnosis of Crohn's disease, abdominal pelvic sepsis, and pouch-vaginal fistula, but not with extraintestinal disease manifestations, smoking, postoperative infliximab or corticosteroid therapy, or preoperative pathology, Dr. Melton-Meaux said.

At follow-up, patients with pouch retention reported a median of seven bowel movements per day. In all, 72% reported perfect or near-perfect continence, and 68% reported rare or no urgency symptoms.

Postoperative manifestations of Crohn's disease were common. Perianal fistula, pouch-vaginal fistula, IPAA stricture, and pouchitis occurred in 11%-40% of patients without a delayed diagnosis of Crohn's disease and were two- to fourfold more common in those with delayed diagnosis.

Nonetheless, patients with a retained pouch at follow-up rated their quality of life as a median 9 out of a possible 10 and their happiness with the surgery as a 10.

“The functional outcomes aren't as good as for the pouch in ulcerative colitis patients, but one of the take-home messages of this study is that Crohn's patients are perhaps willing in some cases to accept less than perfect outcomes,” Dr. Melton-Meaux observed. “These patients—if they retain their pouch—are reporting a happiness with surgery of 10 out of 10.”

Why do patients with a delayed diagnosis of Crohn's disease do so much worse following IPAA? The answer is unknown, but it's likely they have a phenotypic variant of the disease that, over time, tends to include small-bowel and/or anal involvement, she said.

Audience members were eager to learn whether this study's results will prompt Cleveland Clinic surgeons, who are very experienced with IPAA, to suggest a large-scale broadening of the selection criteria for the procedure.

Negative, Dr. Melton-Meaux replied.

“We're reluctant to offer it to patients with known Crohn's disease,” she said. Their current selection criteria include Crohn's disease confined to the colon with no anal, perianal, or small bowel involvement; stable disease for several years; and a thorough patient understanding of the risks of developing recrudescing disease.

# NOTES Proves Feasible for Cholecystectomy, but Is It Safe?

BY JEFF EVANS  
Elsevier Global Medical News

PHILADELPHIA — Cholecystectomy performed transvaginally through natural orifice transluminal endoscopic surgery appears to be just as feasible as the standard four-port laparoscopic procedure, according to a small, prospective comparison of the two approaches.

In a Brazilian study, investigators compared the results of 16 patients who underwent transvaginal NOTES cholecystectomy with 15 patients who underwent laparoscopic cholecystectomy using a standard technique with four trocars. The NOTES procedure was performed with one 3-mm umbilical trocar for retraction of the gallbladder. Each patient had symptomatic, uncomplicated cholelithiasis.

The NOTES patients had a mean age of 37 years and a mean body mass index of 28 kg/m<sup>2</sup>. Patients who underwent laparoscopy had similar characteristics, Dr. Ricardo Zorrón said at the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons.

The investigators used conventional instruments to cut through the vaginal wall under direct vision. After an endoscope was inserted through the peritoneal cavity and insufflated with CO<sub>2</sub>, the investigators used endoscopic instruments from two free channels in the endoscope to dissect ducts and arteries, and used endoscopic clips and loops for ligation. They dissected and retrieved the gallbladder specimen with a polypectomy snare because they had found through previous experience that if the specimen were removed with a grasper, it could be lost in the body cavity, said Dr. Zorrón of the surgery department at University Hospital Teresópolis, Rio de Janeiro.

Compared with the laparoscopy group, the NOTES patients had significantly lower mean intra-abdominal pressure (8.8 mm Hg vs. 13 mm Hg) and significantly lower end-tidal CO<sub>2</sub> pressure (24 mm Hg vs. 42 mm Hg).

There were no complications in the laparoscopic group, but one NOTES patient had a vaginal laceration and another NOTES patient complained of vaginal discomfort. Compared with the laparoscopic procedure, NOTES cholecystectomy required a longer mean operative time (125 minutes vs. 97 minutes) and incurred greater mean blood loss (60 mL vs. 25 mL).

The patients were given postoperative analgesics only by request. Only 8 of the

16 NOTES patients asked for analgesia, compared with all 15 laparoscopic patients. Dr. Zorrón said that NOTES patients described a short duration of “general visceral pain” in the immediate postoperative period that was unrelated to the 3-mm umbilical trocar port.

Although Dr. Zorrón called the NOTES procedure “as safe and feasible as laparoscopy,” the moderator of the session cautioned that “we do need to be careful about the conclusions we can draw about safety. ... Obviously, when you’re con-

cerned about complications such as common [bile] duct injury, you have to have a series larger than 16 to say that it’s safe. It’s certainly feasible—you’ve demonstrated that. The safety, I think, is still an open question.”

He added that the safety of transvaginal NOTES cholecystectomy will be questioned until larger prospective studies comparing it with laparoscopy are conducted. But NOTES patients appear to require less postoperative analgesia and may have lower CO<sub>2</sub> insufflation and end-tidal

pressures than patients undergoing laparoscopy, according to the reactions of audience members during Dr. Zorrón’s presentation.

Dr. Zorrón and his colleagues received institutional review board approval to perform transvaginal cholecystectomies after doing experimental transgastric, transvaginal, and transcolonic retroperitoneal NOTES procedures with a flexible endoscope for about 1 year.

Dr. Zorrón reported having no conflicts of interest. ■

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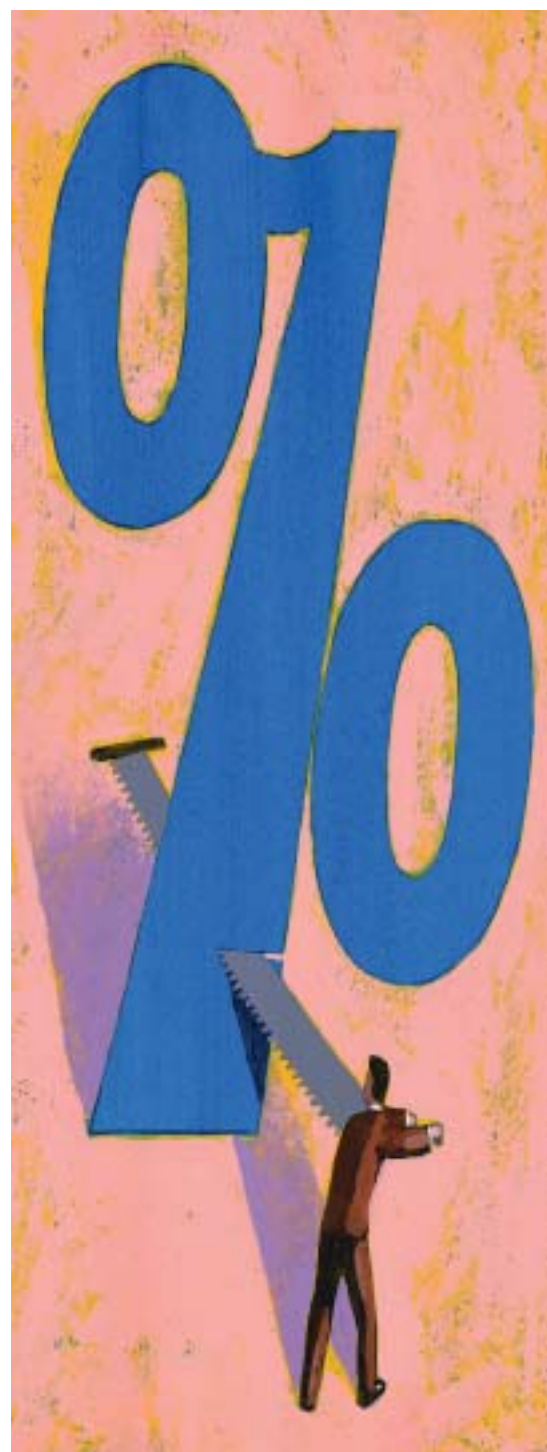
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# Thoracic Teaching Hospitals Best for Esophagectomy

BY DOUG BRUNK  
Elsevier Global Medical News

SAN DIEGO — In-hospital mortality is significantly reduced for patients undergoing esophagectomy for cancer at teaching hospitals with thoracic surgery and/or general surgery residency programs, results from a large analysis demonstrated.

However, the greatest reduction in the risk of death occurred at hospitals with thoracic surgery residency programs compared with those that have general surgery

residency programs only, Dr. Robert A. Meguid reported at the annual meeting of the American Association for Thoracic Surgery.

“Performing esophageal resections at hospitals with thoracic surgery training programs provides a source of mortality improvement, independent of hospital volume,” said Dr. Meguid of the division of thoracic surgery at Johns Hopkins Medical Institutions, Baltimore. “Research should be focused on identifying other and more specific processes of care which may

improve patient outcomes.”

He and his associates used the Nationwide Inpatient Sample of 1998-2005 to identify 4,080 patients who underwent esophagectomy for cancer at 1,508 different hospitals. Hospital teaching status was determined by NIS data and by data from the Accreditation Council for Graduate Medical Education. They used multivariate logistic regression to assess the link between hospital teaching status and postoperative in-hospital mortality, adjusting for demographics and comorbidities.

Of the 4,080 patients 2,883 were treated at teaching hospitals while 1,197 were treated at nonteaching hospitals. The median age of patients was 65 years and the majority (80%) were male.

The median Charlson Index score of patients was 3 and the median length of stay was 13 days. The median annual hospital volume was significantly higher at teaching vs. nonteaching hospitals (6 vs. 2, respectively) but the mortality rate was significantly lower at teaching hospitals (9% vs. 12%, respectively).

Dr. Meguid also reported that the median annual hospital volume was significantly higher at hospitals with thoracic surgery residency programs compared with hospitals that lacked thoracic surgery residency programs (13 vs. 3, respectively) but the mortality rate was significantly lower at hospitals with thoracic surgery residency programs (6% vs. 11%, respectively).

Multivariate regression analysis revealed that the overall risk of postoperative death was reduced by 30% at teaching vs. nonteaching hospitals (OR 0.70). With the addition of hospital esophagectomy volume to the analysis, the reduction in death persisted (13%, or an OR of 0.87), but effect of teaching hospital status was attenuated and lost statistical significance.

Multivariate regression analysis also revealed that the overall risk of postoperative death was reduced by 43% at hospitals with general surgery residency programs compared with hospitals that had no surgery residency programs. With the addition of hospital esophagectomy volume to the analysis, the reduction in death diminished slightly but remained statistically significant (a reduction of 30%).

In the final multivariate regression analysis, the researchers found that the overall risk of postoperative death was reduced by 48% at hospitals with thoracic surgery residency programs compared with those lacking thoracic surgery residency programs. With the addition of hospital esophagectomy volume to the analysis the reduction in death diminished minimally and approached statistical significance (a reduction of 36%).

“As the specificity of hospitals with thoracic surgeons increased, the odds of postoperative death decreased,” Dr. Meguid said.

Dr. Meguid noted that in 2008 it is estimated that there will be more than 16,400 new cases of esophageal cancer in the United States and more than 14,200 deaths from the disease.

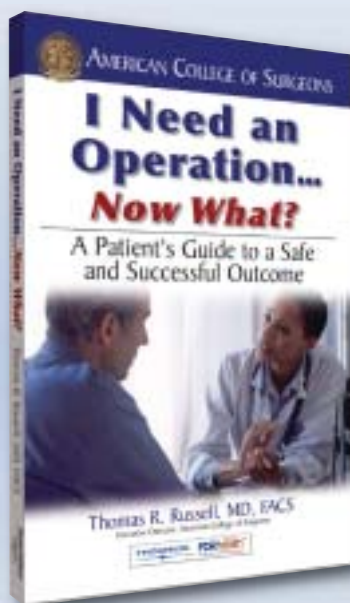
He had no conflicts of interest to disclose. ■

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