



AMERICAN COLLEGE OF SURGEONS

SURGERY NEWS

Physicians Say Imaging Cuts Would Limit Access

BY MARY ELLEN SCHNEIDER
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Policy makers are turning their attention to outpatient medical imaging services as they try to cut costs from the health care system.

But while physicians acknowledge the high price tag associated with advanced imaging modalities, some in the cardiology and radiology communities say the types of cuts being proposed could hurt access, especially in rural and underserved communities. And they argue that the proposed cuts would not address the real problem of inappropriate use.

In July, officials at the Centers for Medicare and Medicaid Services issued the 2010 Physician Fee Schedule proposed rule, which includes a plan to increase the assumed utilization rate for certain imaging equipment from 50% to 90%. The utilization rate change would apply to all equipment priced at \$1 million or more. For example, the American College of Cardiology (ACC) expects this to result in payment cuts to cardiac magnetic resonance imaging, cardiac computed tomography, and nonhospital cardiac catheterization services.

The CMS said the change will bring payment more in line with the actual costs for maintaining and operating the equipment without harming access, but opponents disagree.

Meanwhile, health reform legislation being considered in the House (H.R. 3200) would change the utilization assumption from 50% to 75% for advanced

diagnostic imaging services such as CT, magnetic resonance imaging, nuclear medicine, and positron emission tomography (PET). It would also adjust the technical component “discount” on single-session imaging to consecutive body parts from 25% to 50%. If enacted into law, the changes in the House bill would go into effect in January 2011.

As written, the proposals would not affect lower-cost imaging services such as bone density testing and ultrasound.

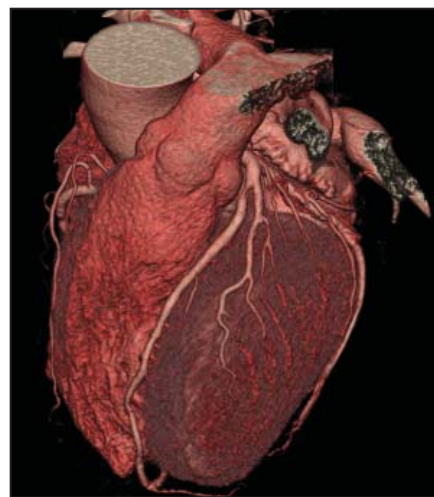
It’s appropriate for Congress and the administration to investigate how to make imaging more efficient, said Dr. Jack Lewin, CEO of the ACC, in an interview. But instead of price cutting, the ACC favors using appropriate-use criteria at the point of care so that the ordering physician can quickly see whether the current science supports the use of a particular imaging study.

“We have the science,” Dr. Lewin said. “We can give doctors who are ordering these tests for their patients the information as to which is the right test to order and when it’s really indicated.”

Appropriate-use criteria tools would save the same amount of money as the cuts proposed by Congress, Dr. Lewin said, but without some of the unintended consequences. For example, he predicted that the cuts as proposed would force some imaging centers to close and would likely have the greatest impact on poor communities and ethnic minorities.

Dr. Michael Graham, president of the Society of Nuclear Medicine, said he is particularly concerned about how these

cuts would affect access in rural areas. If the utilization assumption is significantly increased, a number of the imaging facilities in rural areas will be forced to



Officials debate cost vs. benefit of imaging like this 3-D CT angiogram.

COURTESY DR. STEPHAN ACHENBACH

close, he said in an interview. Patients may have to drive twice as far to reach a center and potentially wait twice as long to get a study. “The reality is that studies will not get done,” Dr. Graham said.

Imaging centers that stay in business and try to meet the higher utilization rates may experience their own problems, said Dr. Graham, who is a professor of radiology and director of nuclear medicine at the University of Iowa in Iowa City. If you have a small center with one PET scanner, for example, and you try to run it 90% of the time, scheduling backlogs become inevitable, further frus-

trating patients and referring physicians.

Policy makers need to get more data about what the optimal utilization rate is for advanced diagnostic imaging equipment, Dr. Graham said.

In its proposed rule, the CMS cited a study from the Medicare Payment Advisory Commission (MedPAC) showing that CT and MRI equipment was being used 90% of the time or more. However, data from the Radiology Business Management Association show that the imaging equipment in rural areas is operating about 48% of the time that an office is open, versus 56% of the time in nonrural areas.

Policy makers, who are targeting advanced imaging modalities, should also consider the impact on lower-cost imaging services, said Dr. James Borgstede, vice chairman of the department of radiology at the University of Colorado in Denver and a past chair of the small and rural practice commission at the American College of Radiology.

When performing imaging services in a rural area, physicians often use the higher-cost imaging to support lower-cost services like plain film X-rays and mammograms. If the cuts make it cost prohibitive to perform advanced imaging, these physicians may not be able to justify coming to these rural communities to provide other services, he said in an interview.

“While we all want to provide health care for all of our patients, the government has to reimburse us appropriately,” Dr. Borgstede said. ■

Sphincter-Sparing Strategy Effective for Complex Fistulae

BY DAMIAN McNAMARA
Elsevier Global Medical News

HOLLYWOOD, FLA. — A new sphincter-sparing approach for repair of complex fistulae was effective in a study of 39 reoperative patients.

The Ligation of the Intersphincteric Fistula Tract (LIFT) technique is “a new tool—it’s easy, safe, and cheap, and at least as effective as other approaches ... with an almost 60% durable success rate,” Dr. Joshua I.S. Bleier said at the annual meeting of the American Society of Colon and Rectal Surgeons.

There is a lack of consensus in the literature on the best approach to complex fistulae. “We

don’t see there is one right approach to trans-sphincteric fistula. It needs to be tailored to the patient,” Dr. Bleier said.

The LIFT procedure involves secure closure of the internal opening and removal of infected cryptoglandular tissue. A seton is placed 6 to 8 weeks prior to surgery to establish the fistula tract and to rule out any active sepsis. During the procedure, the surgeon identifies and divides the fistula tract in the intersphincteric plane.

Good retraction is important; the integrity of the internal sphincter must be maintained, said Dr. Bleier, formerly at the University of Minnesota. He is now a colon and rectal surgeon

at the University of Pennsylvania Health System, Philadelphia.

He and his associates studied a prospective database of outcomes for 39 patients who had the LIFT procedure performed by a total of 11 colorectal surgeons at the University of Minnesota, Minneapolis. These complex, reoperative patients had undergone a median of two prior attempts at fistulae closure. Their mean age was 49 years, and all patients had trans- or suprasphincteric fistula confirmed by ultrasound.

Initial outcomes were in the 80% range, but success decreased to 57% at a median follow-up of 20 weeks. The medi-

an time to failure was 10 weeks (range, 2-37 weeks). “Failures were benign, and patients were no worse off,” according to Dr. Bleier. Anal fissure and persistent perianal pain, the only two reported complications, were successfully managed. The two infection-related failures in the study were managed with late open fistulotomy, he said.

“Our study was made up of patients who mostly failed other [procedures], but this is appropriate as a first-line, sphincter-sparing approach,” he said.

Dr. Bleier acknowledged that the study was limited by its heterogeneous population, the descriptive study design, minor variations in surgical technique,

and the lack of standardized assessment of quality of life and continence. However, he added that the study showed “very good success in a very complex population with multiple prior failed attempts.”

Prior to this study, this procedure had only been described in *Techniques in Coloproctology* (doi:10.1007/s10151-009-0522-2).

“This is the first U.S. study and the best study to date,” said Dr. Genevieve Melton-Meaux of the University of Minnesota, who commented on the study. She added that the university has registered and started a multicenter, prospective trial with standard quality of life and functional assessment instruments. ■



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Ileus After Colectomy Inflates Costs

BY DAMIAN McNAMARA
Elsevier Global Medical News

HOLLYWOOD, FLA. — Postoperative costs for patients who develop an ileus after undergoing colectomy are almost double those for patients without this complication, based on results of a retrospective study of 191 procedures.

"It's already established that a postoperative ileus increases length of stay, but the economic impact has been hard to quantify," Dr. Theodor Asgeirsson said at the annual meeting of

the American Society of Colon and Rectal Surgeons.

Dr. Asgeirsson and his colleagues reviewed colectomies performed at the Ferguson Clinic in Grand Rapids, Mich., starting in July 2007. The postoperative ileus incidence was 26%, including 41 primary cases (defined as three episodes of emesis in 24 hours and/or insertion of a nasogastric tube during the index admission) and 10 secondary cases (i.e., those associated with intra-abdominal complications).

Nineteen patients in the pri-

mary ileus group and one in the secondary group needed a nasogastric tube.

Development of an ileus affected more than one-quarter of patients, and was associated with 39% of total care costs in the study, said Dr. Asgeirsson, a researcher at the clinic.

During index admissions, the total cost for patients with a postoperative ileus was \$31,629 vs. \$17,626 for those without this complication, a statistically significant difference (*P* less than .005).

The total readmission cost for

postoperative ileus patients was \$8,742 vs. \$12,946 for non-ileus patients. Readmission for gastrointestinal failure, including nausea, vomiting, and/or poor oral intake was also considered ileus, unless surgical or radiologic small bowel obstruction was identified. In contrast, non-ileus patients were readmitted for more serious adverse events, he said.

The researchers bundled hospital, pharmacy, radiology, operating room, lab, and other costs. When asked whether total costs were higher only be-

cause patients with a postoperative ileus had longer stays, Dr. Asgeirsson said no.

"When these patients get readmitted for a delayed postop ileus, the team usually wants to rule out the worst, such as anastomosis," Dr. Asgeirsson said. "We are doing a lot of diagnostic tests that increase costs. Not all patients need it, but it's a security thing so the surgeon gets a better night's sleep."

Dr. Asgeirsson said that future studies of enhanced recovery protocols to treat or prevent ileus are warranted. ■

CDC Prices Obesity at \$147 Billion Annually

BY HEIDI SPLETE
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WASHINGTON — The health cost of obesity in the United States jumped by 37% over the past decade, from \$74 billion in 1998 to approximately \$147 billion today, based on data from a study conducted by the Centers for Disease Control and Prevention and the Research Triangle Institute. The data were presented July 27 at the CDC's inaugural Weight of the Nation conference on obesity.

"Obesity affects every body system," Dr. Thomas R. Frieden, director of the CDC, said during opening remarks at the conference.

Obesity accounted for 6.5% of overall annual medical costs in the United States in 1998, but that proportion increased to 9.1% by 2006, said the study's lead author, Eric Finkelstein, Ph.D., of the independent Research Triangle Institute.

The annual cost of medical care per adult in the United States is 41% less for a normal-weight individual than for an obese individual, Dr. Finkelstein said. In this study, obesity was defined as a body mass index of 30 kg/m² or higher, and normal weight was defined as 18.5-25 kg/m². Prescription drugs are among the top contributors to the costs of obesity, he said. In 2006, across all insurance payers, the average annual prescription drug cost for a normal-weight individual was \$707, versus

\$1,275 for an obese individual, which represents an 80% increase in drug costs for the obese. The data were collected from annual Medical Expenditure Panel Surveys, which are national surveys of medical expenses for the civilian, noninstitutionalized U.S. population. The complete data were published online on July 27 in the journal *Health Affairs* (doi: 10.1377/hlthaff.28.5.w822).

If the obesity prevalence had remained the same between 1998 and 2006, 2006 medical costs in the United States would have been \$40 billion less, Dr. Finkelstein emphasized.

The study results were limited by the reliance on self-reports of body mass index, he noted. The study examined only aggregate health costs and not disease-specific costs, he added.

At a media briefing, Dr. Frieden said that the most effective strategies to reduce obesity and its associated costs in the United States may involve community intervention rather than clinical intervention. But physicians are responsible for promoting healthy living in their communities and for encouraging patients' weight-loss efforts in a clinical practice setting, he added.

The study was sponsored in part by the CDC. ■

➔ To watch a video interview of Dr. Finkelstein, go to: <http://www.youtube.com/watch?v=OT40TLLaJ4Q>

Early Repair No Better Than Surveillance of Small AAAs

BY BRUCE JANCIN
Elsevier Global Medical News

DENVER — Early endovascular repair provided no advantages over ultrasound surveillance for patients with small abdominal aortic aneurysms in the 4- to 5-cm range, according to an interim analysis of a large trial.

Patients had the same risk of rupture or aneurysm-related death at 20 months' follow-up regardless of whether they were randomized to repair or surveillance in the ongoing Positive Impact of Endovascular Options for Treating Aneurysms Early (PIVOTAL) trial.

"The risk of rupture is low with careful follow-up and selective intervention," Dr. Kenneth Ouriel reported at the Vascular Annual Meeting.

PIVOTAL is a multicenter trial involving 728 patients with abdominal aortic aneurysms 4-5 cm in diameter who were randomized to endovascular repair or ultrasound surveillance every 6 months with intervention in the event of aneurysm enlargement or development of symptoms.

Standard practice has been to watch aneurysms of that size. The PIVOTAL hypothesis was that endovascular repair of such aneurysms might be more beneficial. Even though prior clinical trials have failed to show an advantage for open surgical repair over surveillance of small aneurysms, endovascular repair has proved safer than open surgery in the case of large aneurysms,

thus providing a rationale for PIVOTAL, explained Dr. Ouriel, an ACS Fellow and vascular surgeon who serves as senior vice president and chief of international operations at New York-Presbyterian Hospital.

The primary composite PIVOTAL end point is rupture or aneurysm-related death, which by 20 months' follow-up had occurred in 2 patients (0.6%) in each study

arm. The secondary end point, all-cause mortality, occurred in 15 patients in each group (4.1%).

By a mean 20 months of follow-up, 112 patients in the surveillance arm had undergone aneurysm repair, a rate some

audience members considered high. Dr. Ouriel responded that this rate was in line with those reported in other studies reflective of real-world clinical practice. Although a 0.5-cm increase in aneurysm size in a 6-month period or enlargement to 5.5 cm are frequently considered to be indications for intervention, some patients who don't meet those standards request repair because they've grown uncomfortable in waiting.

Dr. Ouriel stressed that although early endovascular repair and surveillance are neck and neck in terms of key outcomes at this point, the final answer is not in. PIVOTAL follow-up will continue out to a mean of 4 years.

The study is sponsored by Medtronic Vascular. Dr. Ouriel disclosed that he has no financial conflicts of interest, as he is participating in the trial without compensation. ■



DR. OURIEL

The risk of small abdominal aortic aneurysm rupture is low with careful follow-up and selective intervention.