

The Appropriateness in Surgery You Did Not Expect to Hear

08|ottobre|2016 a Cona

da

Giancarlo Pansini

Il tentativo di capire il significato della tendenza della natura a ripetersi, ma solo imperfettamente, anche nel mondo della chirurgia e lo sforzo di correggere la discontinuità, irregolarità ed instabilità, che sembrano proliferare, anziché diminuire, nei risultati che ancora oggi riscontriamo.



surgery OR surgical procedures, operative AND appropriateness



395.000
risultati
in 0,69 sec.

L'introduzione nel S.S.N. della *remunerazione a caso trattato* ha richiesto l'adozione da parte dei finanziatori di metodi di misura e controllo dell' **appropriatezza clinica**, perché questa influenza in maniera significativa il prezzo delle prestazioni.

Nell'utilizzo delle risorse disponibili, dovrebbero coniugarsi il rigore e l'equità insieme con il conseguimento dei livelli possibili di qualità dell'assistenza.

Si può valutare e migliorare l'**appropriatezza clinica**, attraverso l'analisi degli scostamenti fra il trattamento reale ed il trattamento clinicamente ottimale, com'è definibile sulla base delle più rigorose prove scientifiche.

L'**appropriatezza clinica** può essere definita come la piena corrispondenza, valutata in funzione delle prove di efficacia disponibili, fra le risorse impiegate, in termini di prestazioni e servizi sanitari, e lo specifico problema clinico trattato.

Costruire strumenti e metodi per la valutazione ed il miglioramento dell'appropriatezza clinica è un percorso molto complesso, che richiede una vera evoluzione culturale del “*paradigma clinico*”: migliorare l'appropriatezza clinica non significa soltanto contenere i costi, ma soprattutto allocare in modo più equo e più efficace le risorse e, al contempo, migliorare la sicurezza e l'efficacia dei trattamenti.

Metodo di adeguatezza RAND-UCLA: revisione sistematica delle evidenze

Una procedura chirurgica viene considerata **appropriata** quando i benefici chirurgici in termini di qualità o durata della vita, la riduzione del dolore postoperatorio ed il miglioramenti delle funzioni sono stati giudicati superare di un ampio margine i rischi medici e chirurgici di mortalità, morbilità ed ansietà riconducibili alla procedura adottata.

Beyond Outcomes_The Appropriateness of Surgical Care

CN Lee, CY Ko

JAMA, 2009

In the balance of too many patients having surgical procedures they do not need, and too many not being offered operations they do need, lies the problem of inappropriate care.

To realize the full benefits of surgery for the public's health, the indications for surgical procedures need to be better defined and disseminated, appropriateness evaluated, and policies that maximize therapeutic appropriateness formulated.

Il problema dei trattamenti inappropriati si trova nel bilancio dei troppi pazienti sottoposti ad interventi chirurgici di cui non avevano bisogno, e delle troppe operazioni non eseguite di cui avevano invece bisogno.

Per realizzare appieno i vantaggi di un intervento chirurgico ... devono essere meglio definite e condivise, le politiche che massimizzano l'appropriatezza terapeutica.

Unwanted Variations in the Rules of Practice

JE Wennberg
JAMA, 1991

There is little general agreement in medicine and surgery, and *group solidarity* about the standards of clinical practice seems localize to specific geographic area and medical specialty.

The strategies of dedicated care have led to the development of a **plethora of rules** to govern clinical practice.

C'è poco accordo generale in medicina e chirurgia, e *gruppi solidali* sugli standard della pratica clinica sembrano distribuirsi in aree geografiche specifiche e specialità mediche.

Le strategie di trattamenti particolari hanno portato allo sviluppo di una **plethora di regole** per governare pratica clinica.

155 H

Inscribed with great
pleasure for my old
friend Ruston.

Grey Turner
May 1929.

£5-00
RM



SOME ENCOURAGEMENTS
IN
CANCER SURGERY

BY
G. GREY TURNER, F.R.C.S., ENG.
Honorary Surgeon Royal Infirmary, Newcastle-upon-Tyne

BRISTOL: JOHN WRIGHT & SONS LTD.
LONDON: SIMPKIN, MARSHALL, HAMILTON, KENT & CO. LTD.

1925

Some Encouragements in



FIG. 24.—A large carcinoma originating in the body of the stomach near the greater curvature. It was excised together with the middle portion of the transverse colon (indicated by the glass rod), which was infiltrated by growth. The great omentum was also removed. The patient was well for eight years, when she showed signs of recurrence in the liver, which proved fatal a few months later. (Note the papilloma near the pylorus—probably the carcinoma started in the base of the growth. The stomach has been laid open along its posterior surface.)

Cancer Surgery

of the union are filled with growth. On account of their close relations with the pancreas and with the great vessels, it is not possible to make the clean sweep of these glands which the necessities of an ideal cancer operation demand.

Growths situated in the middle of the body of the stomach have often given much better results than those nearer the pylorus, and I believe the explanation is that in the mid-gastric region it is possible to remove the gland-bearing area much more thoroughly. The next picture (*Fig. 24*) is of a specimen which illustrates this point. It shows a large growth which was situated in the middle of the stomach on the greater curvature. It was advanced, for it had infiltrated the mesocolon to such an extent that a considerable portion of the latter had to be excised with the stomach, and, in addition, it will be observed that the whole of the great omentum has been taken away. The patient not only made a very good recovery from this operation, but remained alive and well until eight years afterwards, when she began to show signs of recurrence of the disease in the liver, which proved fatal nine months later.

THE BREAST.

It is a remarkable fact that the surgery of malignant disease of the breast is attended with so many disappointments. It is so conspicuous an external organ, and so frequently handled, that one would expect any abnormal condition to be detected at once, and, having been detected, to be subjected to proper treatment without delay. Again, there is no situation in the body in which it is possible to do an operation more nearly approaching the ideal. As a matter of fact a great many of the cases which reach the

Some Encouragements in

to my rule that *every case which does not show unequivocal evidence of dissemination should have the chance which only an operation offers*, I opened the abdomen and was able to remove the tumour and to make the anastomosis which resection of the overlying intestine made necessary. At first the patient made excellent progress, only to die two weeks after the operation from an unexpected secondary hæmorrhage from a branch of the superior mesenteric artery, which had been cut close to the parent trunk.

Another encouraging failure was furnished by my first gastrectomy for carcinoma. The tumour was very adherent to surrounding structures, and had directly invaded the liver, so that a portion of the latter had to be excised with the growth. Unfortunately, the man died on the eighth day from a duodenal leak. I made a very careful post-mortem, and was delighted to find that all the growth had been removed and that those glands which had been left were not infiltrated with growth, so that had the patient survived the operation he might have enjoyed a long period of immunity from recurrence. The lesson to be learnt is that neither local infiltration nor fixation by adhesions necessarily precludes successful operative interference for cancer.

A further illustration of this same rule was furnished by another of my early gastrectomies. The patient presented an enormous mass in the stomach region, and the outlook appeared most unpromising. Nevertheless, I opened the abdomen, found no dissemination, and was able to carry out what looked like a satisfactory excision. The operation was completed by joining the remnant of the stomach to the intestine with a Murphy button. All went well until two weeks later, when the man developed septic peritonitis

Some Encouragements in

to the present time justifies the belief that *the best chance for the victim of malignant disease lies in a well-executed excision of the growth together with the path of probable cancer invasion while the disease is still local*.

* * * * *

I am most anxious especially to help my younger colleagues, and I ask them to believe that if they will deal with malignant disease vigorously and thoroughly, their prowess will many times be rewarded. Millais's wonderful picture (*Fig. 40*) encourages me to hope that the experiences of the past related to-day may fire them with enthusiasm for the work of the future.

RADICAL SURGERY IN ADVANCED ABDOMINAL CANCER

By

ALEXANDER BRUNSCHWIG, M.D.

Professor of Surgery, University of Chicago



THE UNIVERSITY OF CHICAGO PRESS
CHICAGO · ILLINOIS

FOREWORD

OPERATIVE surgery was thought to have reached its full development some years ago, by which time most of the organs and tissues of the body had been subjected to successful surgical attack. In recent years the central nervous system, the contents of the thoracic cavity, and the pancreas have been brought within the scope of "current surgery." Modern research on shock, with the developments in prophylaxis and treatment, the advent of vitamin K, the introduction of continuous spinal anesthesia, the knowledge of fluid balance, a greater appreciation of nutrition for surgical patients, and the advent of chemotherapy with the sulphonamides and penicillin have contributed to the reduction in risk attendant upon a major surgical procedure. This must lead to a modification of previous concepts of "operability." The question, as concerns advanced intra-abdominal malignant neoplasms, is the subject of this essay.

The patients referred to in the following text were all hospitalized in the University of Chicago Clinics, and the operations were performed by the author. They represent a series of unselected cases, in which "standard" concepts as to operability of intra-abdominal cancer were purposely disregarded. The decision to proceed with excision was governed entirely by the findings, which showed whether or not all macroscopic tumor could be removed, regardless of location, type of neoplasm, and extent of involvement. Where excision of the primary growth could be carried out but liver and other metastases were present and would remain, the justification for the operation was the feeling that palliation might be afforded by the procedure when it could not be afforded by other means available. The principal objective of this investigation is to permit of some impressions as to what might be accomplished by radical extension of operative surgery for the "inoperable." A corollary to this study was the development of several radical operations such as gastrecto-spleno-pancreato-colectomy; total-gastrecto-total-pancreatectomy-splenectomy; colecto-pancreato-splenectomy; etc. Limiting the discussion to the endeavors of a single operator permits of the control of such factors as surgical judgment, manual dexterity, finer points in technique, etc. A study of this type in a significant series of patients has not been previously recorded.

Three years later, she returned to the outpatient department, complaining of "sour stomach" and epigastric pain of 3 weeks' duration. Roentgenograms revealed what appeared to be a new ulcer crater on the lesser curvature, high up near the cardiac orifice. There was no evidence of stoma ulcer. She was hospitalized on the medical service and after improvement on medical management was discharged.

As stated at the beginning of this chapter, total gastrectomy is an operation performed essentially for palliation, and the great majority of patients surviving eventually succumb from recurrences. Prolonged survivals may obtain in exceptional circumstances. Several reports dealing with survivals from total gastrectomy are cited below.

PACK AND McNEER	298 case reports in the literature, up to 1944	
	16 survivals for three or more years	
	5 lived 3-4 years	} Patients that had died
	2 lived over 4 years	
	2 lived 6 years	
	3 living 3-4 years	} Patients living at time report was made
	3 living over 4 years	
	1 living 8 years	
WALTERS <i>et al.</i> ,		
MAYO CLINIC, 1907-38	27 patients operated upon	
	9 survived operation	
	8 died of recurrences	
	2 lived 1 year	
	2 lived 2 years	
	3 lived 3 years	
	1 lived 4 years	
	1 living 2 years	
LAHEY, 1944	73 patients operated upon	
	24 operative deaths	
	3 living 1½-2 years	
	1 living over 2 years	
	1 living over 3 years	
	1 living over 4 years	
	1 living over 5 years	
UNIVERSITY OF CHICAGO CLINICS	29 patients operated upon, 1928-44 (simple total gastrectomy, with splenectomy in some instances)	
	14 operative deaths	
	1 living 1 year	
	1 living 3 years	
	1 living 3½ years (leiomyosarcoma)	
	1 living 4 years	

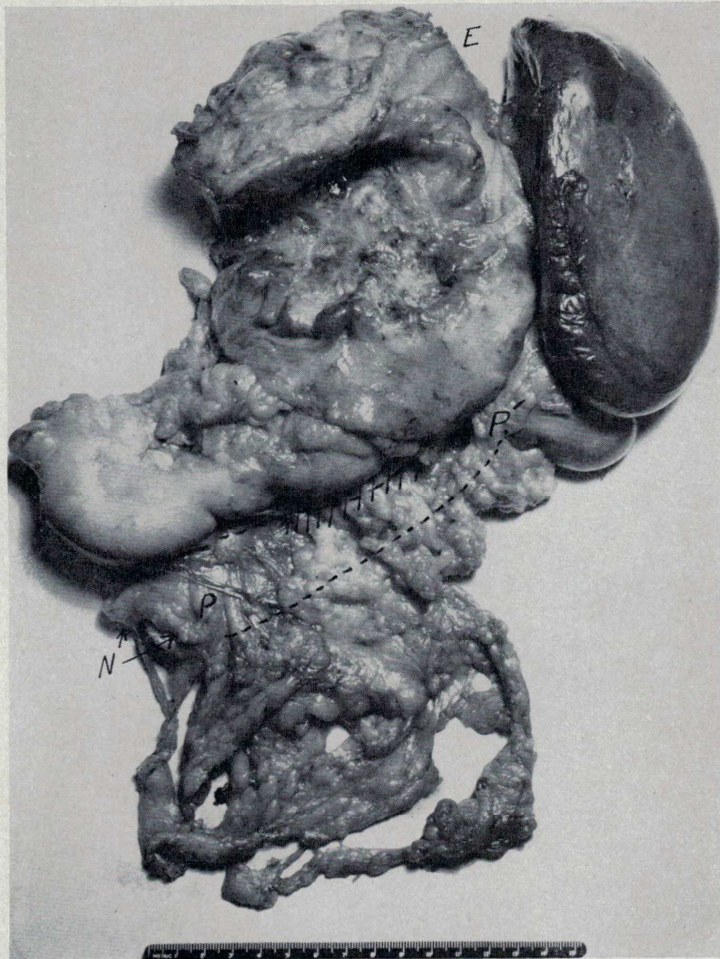


FIG. 20.—Case 59 (273781). Surgical specimen, consisting of most of cancerous stomach, spleen, and *P-P'*, body and tail of pancreas. The latter is beneath omentum, but transected neck of pancreas is seen at *N, E*, level of transection of stomach, a few centimeters below cardioesophageal orifice. The body and tail of pancreas were also resected because of carcinomatous infiltration into the stomach.

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... in the presence of advanced intra-abdominal cancer it is the **surgeon's responsibility to do what is possible to prolong life with comfort.**

... it is needless to point out that advanced cancer is invariably fatal and that **risks of immediate mortality are justifiable when benefit may be afforded** by the success of a surgical procedure.

... if surgical attack to abdominal cancer is extended, **experience is needed in achieving a low mortality .**

Medical Care After 1950

Inappropriate Surgery

A surgical operation may be inappropriate for several reasons: the surgeon involved may not be qualified to perform it; new therapies or new kinds of operations may have made the particular operation obsolete; or the patient's condition may not have warranted surgery at all or surgery at the time when it was performed.

Un intervento chirurgico può essere inappropriato per diversi motivi: il chirurgo coinvolto può non essere qualificato per eseguirlo; nuove terapie o nuovi tipi di operazioni possono aver reso l'operazione obsoleta; o le condizioni del paziente possono aver pregiudicato l'intervento chirurgico in genere o nel momento in cui è stato eseguito.

**American Medical Schools
and the Practice of Medicine**

A HISTORY

William G. Rothstein

New York Oxford
OXFORD UNIVERSITY PRESS
1987



“The surgical decision-making is a semi-exact scientific process, and it is unreasonable to expect exact answers to clinical problems.”

Il processo decisionale in chirurgia è un processo scientifico semi-esatto, ed non è ragionevole aspettarsi delle risposte esatte ai problemi clinici.

AMERICAN MEDICAL SCHOOLS

AND THE

Practice of Medicine



A History
WILLIAM G. ROTHSTEIN

When is surgical care "appropriate"? Arguably when the **benefits to the patient exceed the risks** by a wide enough margin to make it worth providing.

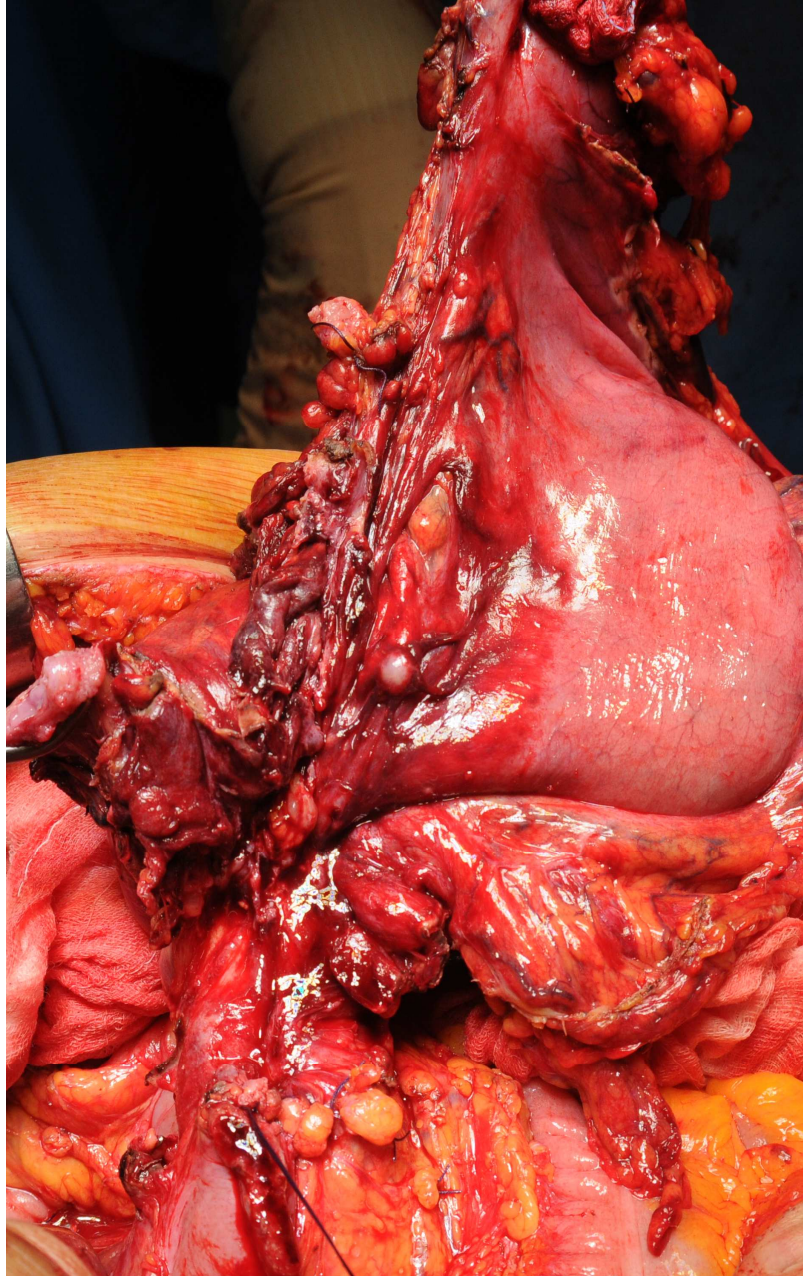
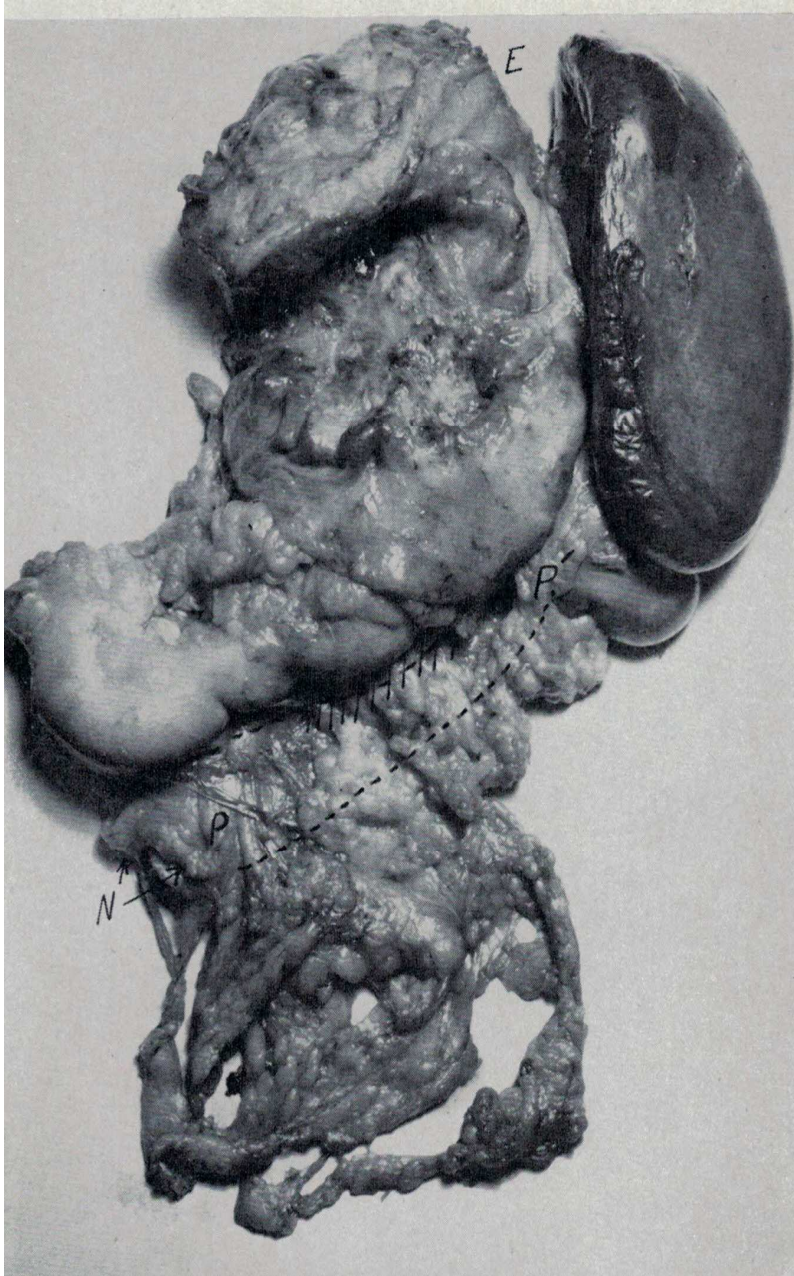
In 1986, investigators at the RAND Corporation and the University of California at Los Angeles developed explicit criteria for assessing the appropriateness of diagnostic and surgical procedures in a variety of situations. The RAND approach combines a *systematic review* of the clinical research literature with the judgment of a multidisciplinary panel of expert clinicians.

Quando la cura chirurgica è "adeguata"? Probabilmente quando i benefici per il paziente superano i rischi con un margine abbastanza ampio da renderla vantaggiosa.

Nel 1986, ricercatori presso la RAND Corporation e l'Università della California a Los Angeles hanno sviluppato criteri espliciti per valutare l'adeguatezza delle procedure diagnostiche e chirurgiche in una varietà di situazioni. L'approccio RAND combina una *revisione sistematica* della ricerca clinica in letteratura con il giudizio di un panel multidisciplinare di clinici esperti.

G.W. Von Leibnitz, Lettera a J. Bernoulli, 1703

**“.. la natura ha stabilito degli schemi che hanno origine dal ripetersi degli eventi,
ma soltanto per la maggior parte di essi. ”**



A. Einstein, Scienza e Vita. Lettere 1915-1955, Lettera a M. Born

“.. tu ritieni che Dio giochi ai dadi col mondo; io credo invece che tutto obbidisca ad una legge, in un mondo di realtà oggettive. ”

W.E. Deming, 1900-1993



“.. We have learned to live in a world of mistakes and defective products, as they were necessary to life.”

“It’s not enough to do your best, you must know what to do and then do your best”.

The Variation Theory

- Ogni variazione ha una causa
- Due tipi: cause speciali (o identificabili); comuni (o del sistema)
- Priorità: distinguere il tipo di causa che provoca una variazione
- Azione da intraprendere per una causa speciale: è in relazione agli effetti della causa
- Azione da intraprendere per una causa comune: ricorrere al “*in-depth knowlwdge*”
- **Obiettivo:** S.M.A.R.T. (Specific, Measurable, Achievable, Relevant, Time-specific)

The “Grounded Theory”

- E' un metodo qualitativo di indagine che si prefigge di studiare un fenomeno dal *basso*, cioè a partire da un'osservazione libera dei fenomeni alla ricerca di una teoria che li descriva.
- La sua specificità è quella di non essere fortemente strutturata, ma di adattarsi alla realtà.
- Prevede che ci possano essere molte verità e molti metodi per conoscerla.

A Conceptual Framework for Appropriateness in Surgical Care

Z. Cooper

Anesthesiology 2015

As our population ages and healthcare costs continue to increase, anesthesiologists and surgeons should play key roles in promoting decision making paradigms to ensure that procedural care is conducted in a manner that **adds value from the patient perspective.**

Con l'invecchiamento della popolazione ed il continuo aumento dei costi sanitari, anestesisti e chirurghi dovrebbero svolgere un ruolo chiave nella promozione di paradigmi finalizzati a garantire che l'assistenza per ogni procedura venga condotta in un modo tale da costituire **un valore aggiunto dal punto di vista del paziente.**

A Conceptual Framework for Appropriateness in Surgical Care

Z. Cooper

Anesthesiology 2015



Fig. 1. Components of high-quality surgical decision making. COE = center of excellence.

A Conceptual Framework for Appropriateness in Surgical Care

Z. Cooper

Anesthesiology 2015

Methods of Reducing Inappropriate Care

- Internal peer review
- Indications review
- External utilization review
- RAND/UCLA appropriateness method
- Payment incentives
- Specialists peer groups
- Comparison of indications
- Third-party organization
- Multidisciplinary panel
- Episode-based reimbursement

A Values-based conceptual framework for surgical appropriateness: an illustrative case report

E. J Lilley, Ann Pall Med, 2015

Old patient who experienced a decline in health, functional status, and quality of life in the months following a major surgical operation that was not clearly aligned with her personal goals and priorities.

Following surgery, she spent 41 of the 103 remaining days of her life in the hospital. For the remaining 62 days of her life, she was in post-acute institutions and mostly in pain.

Paziente anziana che ha sperimentato un declino della salute, dello stato funzionale e della qualità della vita nei mesi a seguire un importante intervento chirurgico, che **non è stato chiaramente allineato con i suoi obiettivi e le priorità personali.**

Nel nostro quadro concettuale, l'appropriatezza in chirurgia richiede: la migliore evidenza clinica, un chirurgo qualificato, una struttura sanitaria attrezzata per gestire con competenza il funzionamento e l'assistenza post-operatoria, e pazienti che sono ben informati e coinvolti nel processo-decisionale in caso di chirurgia.

Appropriateness Criteria to Assess Variations in Surgical Procedures in the United States.

E.H Lawson, UCLA-ACS-RAND Health, Arch Surg, 2011

To systematically describe appropriateness criteria developed in the United States for surgical procedures and to summarize how these criteria have been applied to identify **overuse and underuse of procedures** in US populations.

...riassumere come questi criteri sono stati applicati per identificare un **uso eccessivo e sottoutilizzo** delle procedure nelle popolazioni degli Stati Uniti.

RAND-UCLA

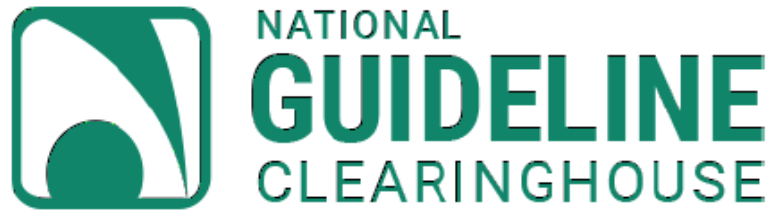
Appropriateness Method (RUAM) improves the quality of surgical care by addressing variations in the use of surgical procedures. The RUAM synthesizes the best available evidence with expert clinical judgment to produce appropriateness criteria, **which weigh the relative risks and benefits of a procedure** for specific clinical scenarios.

Appropriateness Criteria to Assess Variations in Surgical Procedures in the United States.

E.H Lawson, UCLA-ACS-RAND Health, Arch Surg, 2011

The use of **appropriateness criteria** is an intermediate step and could set the agenda for future comparative effectiveness research by identifying **gray areas where not enough is known** regarding the balance of risks and benefits of a procedure (ie, equivocal indications).

L'uso dei Criteri di Appropriatazza è un passo intermedio e potrebbe definire l'agenda per un futuro studio comparativo sull'efficacia, individuando **zone grigie in cui non si sa ancora abbastanza** per quanto riguarda l'equilibrio dei rischi e dei benefici di una procedura (ad esempio, indicazioni equivoche).



- Guideline Objectives
- Target Population
- Inclusion and Exclusion Criteria
- Major Outcome Considered
- Major Recommendations and Rating their Strength
- Evidence Supporting the Recommendations
- Benefits/harms of implementing the guidelines recommendations
- Qualifying Statements
- Implementations of the Guidelines
- Institute of Medicine National Healthcare Quality Report Categories

G.K. Chesterton, 1938

“.. il vero guaio di questo nostro mondo non è che sia irragionevole, e neppure ragionevole. Il guaio è per lo più costituito dal fatto che è quasi ragionevole, ma non lo è del tutto. La vita non è illogica; però è una trappola per i logici. Sembra solo un po' più matematica e regolare di quanto sia; la sua precisione è ovvia, ma la sua imprecisione è nascosta.

La sua sregolatezza è in agguato.”