COMMENTARY

# *NSQIP and urology outcomes*

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*Referring to the article published on pp. 7537-7546 in this issue*

FRAZIER II HA. NSQIP and urology outcomes. *Can J Urol* 2014;21(6):7547.

The American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) is a wonderful resource that urologic surgeons are only now beginning to fully discover. The general surgery community has already captured significant data and information that will help steer the ACS, and the Center for Medicare & Medicaid Services (CMS) in evaluating complications and hospital readmissions into the future. The current system of "value based purchasing" currently being used by CMS for determining reimbursement is a sham. I hope that the NSQIP will help us change the way CMS is evaluating surgeons and hospitals. The one shortcoming of the NSQIP dataset is that we are limited by the data captured. For example, the abstractors are not capturing a reliable scoring system of complications (i.e. no Clavian system), and there is no data on the volume of procedures performed at each of the hospitals. Hopefully these (and other) data points will be added in future iterations of NSQIP.

This particular paper authored by Leow et al[1] is a laudable initial attempt to begin to quantify the reasons for readmission following major urologic surgery, based on multiple institutions across the country. The radical prostatectomy data mirrors several of the previously published retrospective series.[2-4] The authors then proceed to group the "other three" procedures (radical nephrectomy, partial nephrectomy, and radical cystectomy) into one dataset. This decision by the authors concerned me. I do understand there is still a paucity of urology specific data in this NSQIP database. However, in my opinion this "grouping" is a broad over-generalization that could be troublesome for us in the future, because the data has the potential to be misinterpreted by CMS. The data will be more robust over the next 3-5 years, and will provide us more conclusive information. I would caution these authors and other authors from "lumping" such divergent procedures into one group when evaluating the surgical outcomes and complications. I realize that the authors hoped to identify predictors of readmission through this paper, but it probably missed achieving meaningful data for the radical nephrectomy, the partial nephrectomy and the radical cystectomy patients, simply due to the lack of data. □

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References

1. Leow JJ, Gandaglia G, Sood A et al. Readmissions after major urologic cancer surgery. *Can J Urol* 2014;21(6):7537-7546.
2. Roghmann F, Trinh QD, Braun K et al. Standardized assessment of complications in a contemporary series of European patients undergoing radical cystectomy. *Int J Urol* 2014;21(2):143-149.
3. Sugihara T, Yasunaga H, Horiguchi H et al. Comparisons of perioperative outcomes and costs between open and laparoscopic radical prostatectomy: a propensity-score matching analysis based on the Japanese Diagnosis Procedure Combination database. *Int J Urol* 2013;20(3):349-353.
4. Prasad SM, Gu X, Kowalczyk KJ, Lipsitz SR, Nguyen PL, Hu JC. Morbidity and costs of salvage vs. primary radical prostatectomy in older men. *Urol Oncol* 2013;31(8):1477-1482.