LETTER TO EDITOR

Delivering better care and value in urological procedures

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We thank Dr. Harold Frazier for his comments[1] on our paper, which aimed to examine the incidence and predictors of 30-day readmissions after major urologic cancer surgery, including radical prostatectomy, radical nephrectomy, partial nephrectomy and radical cystectomy.[2]

First, we wish to clarify a misunderstanding regarding our methods that was admittedly, poorly phrased: "For RP, we also adjusted for the presence of each postoperative complication during the index admission. For the other 3 procedures (RNx, PNx and RC), due to the smaller number of readmission and complication events, we grouped all postoperative complications and adjusted for the presence of any complications." It should have read "for each of the 3 other procedures", emphasizing that we did in fact analyze each procedure separately and reported all the results in one single paper (see Table 2 of original paper).

Second, we agree with Dr. Frazier that the decision by the Center for Medicare & Medicaid Services (CMS) to determine reimbursement based on "quality metrics" such as readmission rates may be ill advised. A recent study found that prostate cancer patients receiving "best care" according to a set of 5 nationally endorsed quality measures did not have better treatment-related morbidity and improved cancer control.[3] This suggests that current quality measures – while relatively easy to capture in databases – may not necessarily be clinically relevant to patients.[4]

Finally, while we agree that the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) portends great potential for urologic health services research,[5-7] several endpoints important to urologists are lacking, for example, quality of life outcome measures following radical prostatectomy and cystectomy. While recording these urology-specific outcomes may not be in the ACS' agenda, a similarly designed quality improvement initiative from the American Urological Association (AUA) is needed to improve quality of care and value in urologic care. As such, the AUA Quality (AQUA) Registry (http://www.auanet.org/resources/aqua.cfm), a national urologic disease registry designed to measure and report healthcare quality and patient outcomes, holds much promise.

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