Discussion to: Postoperative day 1 discharge following robotic thoracoscopic pulmonary anatomic resections in the era of enhanced recovery protocol: A single institution experience

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Discussion to: Postoperative day 1 discharge following robotic thoracoscopic pulmonary anatomic resections in the era of enhanced recovery protocol: A single institution experience.

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Dr. M. Blair Marshall (Boston, MA):

Thank you, Dr. Gross, for that excellent presentation, and for sending me both the PowerPoint and the manuscript well in advance of the meeting. I appreciate it. And I commend you and your colleagues for continuing to push the envelope
on implementing ERAS and obtaining better outcomes for our patients. I have a few questions. Feel free to cut me off if I go over. So, as you saw, middle lobectomy was significant. Do you think that's a reflection of the number of segments? And have you considered analyzing your data to a number of segments removed, since especially you used sublobar resection? And I'm curious to know if there's a greater air leak, even though the number of segments might be lower in that patient population?

Dr. Daniel Gross (Miami, FL):

So, we did look at segments as a whole. We didn't have the power to individually analyze each segment, just because the combination is just so numerous. And middle lobectomy is probably a function of kind of the way the lung re-expands and basically covers all of your dissection plains. So that's my hypothesis, and that's really been consistently seen in every paper published about postoperative day-1 discharge.

Dr. Marshall:

Thank you. And then have you looked at the difference in ERAS compliance between those two groups? And have you looked at your own compliance, and where the failures are most frequent?

Dr. Gross:

I'm sorry. In terms of?

Dr. Marshall:

So, in our ERAS protocol, not every patient gets every metric 100% of the time.

Dr. Gross:

Oh, I see. It's funny you mention ERAS compliance because our NSAID compliance rate was actually kind of low until we started looking at our own data. And then we observed that there was a significant bias with attendings not giving Toradol if they felt the bleeding was significant. But once we pointed out to the attendings that the compliance was low, the compliance went from about 30% to about 70% now. And we've also transitioned to selective NSAIDs as well, and further increased our compliance. I would say that's been our--primarily, the one area of ERAS that we haven't had great compliance with. Beta-blockade we pretty much only hold for bradycardia.
Dr. Marshall:

Uh-huh. We have the same problem with Toradol at our institution. And yet, despite letting our faculty know that it doesn't affect bleeding rates, they still refuse to give it. Have you looked at the difference between reimbursement? It seems that it requires extra assistance to follow up with these patients at home after early discharge, which are additional costs. And when you look at patients going home on post-op day 1 versus day 2, the Medicare 2-night midnight night rule comes into play. And so, I wonder whether we should be pushing for that because once you cut the hospital reimbursement, you lose your power.

Dr. Gross:

So, it's very funny you mention that. I've been asking that question for many years, and only when I was actually starting to interview for jobs, that one of the CMOs was actually able to answer that question. And apparently, the way she explained it to me was that if you document that the patient was expected to stay longer, but will subsequently be able to be discharged earlier, then you can still qualify for the full reimbursement. And in regard to your question about—

Dr. Marshall:

Can I just follow up on that? So, you personally document the staff? How does that happen? Do you know?

Dr. Gross:

I think the attendings will discharge, and then we have a very strong medical—

Dr. Marshall:

Yeah, billing.

Dr. Gross:

--billing department that has bothered me several times, and I'm sure it's bothered Dr. Nguyen even more times than me.

Dr. Marshall:
And my last question is, have you looked at patient satisfaction between going home postop day 1 and later?

Dr. Gross:

So, that is a very good avenue for future research in terms of whether the patients like going home early. And this is somewhat of a bias group because we did have about 25% of our patients that could’ve left, decide to stay. And I know anecdotally, my own preference is whether to aggressively pull a tube is different if I know a patient tells me they’re going to potentially stay anyway, I'm much less likely to try and pull that tube at 2:00 PM versus earlier the next day.

Dr. Marshall:

Right. Great presentation. Thank you very much.

Dr. Gross:

Thank you.

Unidentified Speaker 1:

Any questions from the floor?

Unidentified Speaker 2:

So let me ask this. It builds a little bit on what Dr. Cerfolio sort of said in passing. If we can send a robotic lobectomy home the next morning, how close are we to sending them home later the same night of surgery?

Dr. Gross:

So, I mean, I think that's a very challenging question to answer. I think the ability to discern chyle leak so quickly in the postoperative period kind of represents a challenge because even if it's not chylous initially, it will often appear chylous when challenged. So that's one thing. I mean, the other thing that I've seen is that even when we have pulled tubes with patients with no air leak, you do get the intermittent subcutaneous emphysema and you have all these issues that I think-- I think these are all issues that need to be addressed before we can—
Unidentified Speaker 3:

Quickly on the chylothoraxing, Dr. Cerfolio is not here so I'll say it for him. He's just submitted an abstract STSA of giving Haagen-Dazs in the PACU [laughter].

Dr. Gross:

Yeah, we have our ice cream given very early.

Unidentified Speaker 3:

Well, it'll increase your patient satisfaction scores, so there's that. Really interesting in your model that you included the, what was it, the deprivation index and socioeconomic status. Any thoughts on, I guess do you have enough patients that are stratified by socioeconomic status and that particular index? And firstly, what variables are in that index and how is it calculated, do you know?

Dr. Gross:

It's primarily calculated due to zip code. That is what we are able to-- and there are some other determinants that get factored in from the EMR that they are able to pull, but it's primarily zip code based.

Unidentified Speaker 3:

Yeah, because this kind of geocoding and these types of things are really, I think, fascinating and are going to be important for us to look at because as we have a lot of the one-size-fits-all ERAS protocols are good for a lot of people, they're good for the most. But then what about those extra people who fall within a different category? They're going to need some extra help.

Dr. Gross:

Thank you.