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How to Choose Your Cancer Surgeon – and Measure the Quality of Robot-Assisted Surgery

Announcer:

Welcome to CME on ReachMD. This segment, entitled *How to Choose Your Cancer Surgeon – and Measure the Quality of Robert-Assisted Surgery* is provided by Prova Education and the Roswell Park Cancer Institute as well as through the generous support of BlueCross BlueShield of Western New York.

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Dr. Guru:

I'm Khurshid Guru, and I'm a robotic surgeon at Roswell Park Cancer Institute. This video presentation will offer insight into choosing a surgeon, the institution where you refer a patient, and the role that metrics play in evaluating the quality of surgery.

A compliant patient strives for well-being. An annual visit with the primary care physician allows patients to update their personalized health plan with a goal to prevent disease-based risk factors and lifestyle choices. A thorough physical examination and complete medical history can offer vital information about health issues. Laboratory tests can detect abnormalities that may indicate cancer or other medical concerns. When a tumor is suspected, imaging tests help doctors determine the cancer location and if the cancer has spread. The earlier cancer is diagnosed and treated, the better the chance of it being cured.

When a significant disease, such as cancer, is diagnosed, one of the most important things is to realize that cancer is a family disease. It impacts the entire family not just the patient. Identifying someone with the family as the patient's champion will go a long way in helping the patient and their family in preparing for the journey ahead. These champions work with the patient as a team. The champion can help the patient get their questions answered, remember what the doctor said, offer support, and be an extra set of eyes and ears for the patient.

A second opinion is generally a good idea. This involves meeting with another specialist to learn their view on the diagnosis and proposed treatment options. The patient benefits as they can reconfirm the diagnosis, make sure that there is a team of professionals specializing in this type of disease, and that the healthcare facility is dedicated to that particular problem. When a patient becomes knowledgeable about the many treatment options available, they are better able to make decisions that are best for them. According to the American Cancer Society, it is common to get a second opinion, and most doctors are comfortable with having one. For example, in bladder cancer patients, sometimes it's important to re-biopsy and re-resect the tumor as advised and recommended by the National Comprehensive Cancer Network guidelines.

Choosing a surgeon is an important and personal issue. Patients should not hesitate to ask the surgeon about his or her qualifications to perform the specific kind of surgery needed. Excellent surgeons are usually happy to explain their background and training to a patient and their family. Internet and social media have made it easy to access a vast majority of information on any topic without any prior knowledge or expertise. Public reporting of surgical outcomes is supposed to guide patients towards better understanding of disease processes and facilitate quality improvement. It is important to understand the quality of data collected, the size of the sample

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used, and if data has been adjusted based on patient risk. It is difficult to easily separate the outlier with poor performance, as it depends on the number of procedures performed, and the mortality related to that procedure. Data quality is critical as it is the source of such reports. Its accuracy in measuring the right metrics is important.

The choice of hospital also is critically important and several factors are worth considering. Within the hospital, expertise and experience in performing the specific procedure is essential. Indicators of expertise in the treatment of cancer include such credentials as designation by the National Cancer Institute. High surgical volume is often associated with lower mortality and better patient outcomes. Every disease is different, and does the surgeon have the experience and the ability to handle variation, and does the institution have lateral expertise to support this disease? Large hospitals in California were assessed by the California Cancer Registry to evaluate their compliance with NCCN guidelines and its correlation with pancreatic cancer outcomes. Only 34.5% were compliant and this status was associated with reduced risk of mortality. In 2015, regional impact of adherence to NCCN ovarian cancer guidelines was assessed utilizing data from approximately 10,000 patients. With a compliance of 36%, the institution's NCCN status was found to be an independent predictor of improved survival.

Questions for the surgeon and the hospital can include: How many of these procedures are performed at this institution? What are the potential complications they encounter and how are they managed? Is there a team that regularly works together in the operating room? How do patients receive communication before, during, and after surgery? Lastly, are patient support groups available so that patients and their family have a chance to learn from others' experience in coping with cancer?

For patients being treated for cancer, or any serious illness, it is vital to have a team of experts working together on a treatment plan tailored specifically for them. This team should follow nationally established patient-care guidelines. A study out of Cochrane Database found that the 5-year survival significantly improved for colorectal cancers treated at high-volume institutions by high-volume surgeons. It was associated with lower risk of permanent stoma formation. Utilizing a New York-based database, recently published data on major rectal surgery showed that high-volume surgeons had significantly lower rate of surgical complications.

Choosing a doctor who works with a multidisciplinary team in a dedicated treatment center is one of the most important decisions. More than 2000 robotic surgical systems have been installed across the United States. The Da Vinci Surgical System does not function on its own. It is an operator-dependent machine. Every surgery demands excellence. It is critical to measure metrics to assess quality before, during, and after surgery. We will take an example of radical cystectomy for bladder cancer. It is critical to assure a multidisciplinary approach is used for assessing newly diagnosed patients of bladder cancer. While analyzing trends and optimal use of neoadjuvant chemotherapy for bladder cancer, it was found that patients who just met the surgeon only had a 30% chance of getting consultation with a medical oncologist. Once they met the medical oncologist, and this was done together, the rates went up to 78%, and the utilization of neoadjuvant chemotherapy went from 11 to 55%. Evaluation by a medical oncologist to assess for meeting criteria to receive neoadjuvant chemotherapy is crucial for patients with muscle-invasive bladder cancer. Depending on overall health and kidney function, patients are considered for neoadjuvant chemotherapy. It is important that patients who are eligible for neoadjuvant chemotherapy with muscle-invasive bladder cancer are not directly taken to surgery. They do end up taking 4 to 6 weeks of chemotherapy, get re-evaluated, and then go to surgery. It is also important to ensure expertise of the surgeon, their team, especially if you are considering robot-assisted surgery. Robot-assisted surgery brings multiple advantages with 3D-vision magnification and precision, thereby making it able to operate in small, narrow spaces, where organs are packed together, such as the pelvis. It is very important to avoid robot-assisted surgery if a patient has a large, bulky tumor, significant previous abdominal surgery, or has considerable medical problems. During surgery, it is critical to complete the procedure safely, in a timely fashion, with minimum blood loss. Robot-assisted surgery provides huge advantage in avoiding significant blood loss.

Once the tumor is removed, it is critical to evaluate the soft tissue surgical margins. After removing the specimen, it is dipped in ink and the pathologist evaluates the edges of the tumor in comparison to the ink. The presence of tumor at the inked margin leads to the possibility of tumor being left behind or reaching the edges of the resection. It is ideal to have negative soft tissue surgical margins. The accepted soft tissue surgical margins, based on best practices in European Urology, are less than 3% in T2 disease and an overall rate of 7%.

The next key area is to evaluate the removal of regional lymph nodes. It is not only important to remove lymph nodes, but also critical to remove a certain number of lymph nodes.

Based on published data, complications of radical cystectomy can go up to 80% with a mortality rate of 4% within 90 days. The key organ systems involved are shown. GI and infectious disease take the lead. As the course of these patients runs from initial consultation, an average stay is up to 12 days and once they return for any complications they have a chance of readmission which is high, as well as a chance of returning to surgery. These metrics should all be considered when counseling patients for surgery and the surgeon and the team is requested for referral.

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So, in conclusion, choosing a patient advocate, requesting a second opinion, knowing the details of the surgeon, his or her team and their outcomes, and their openness to offering multidisciplinary approach, are critical.

I am Khurshid Guru, and thank you for listening to this presentation.

Announcer:

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