ADVANCED (STAGE III-IV) OVARIAN CANCER SURGERY

Quality Indicators

References
AIM: We investigated if optimal surgical debulking increases tumor responsiveness to maintenance chemotherapy and improves survival in advanced ovarian cancer patients who previously attained a clinical complete response CCR to primary chemotherapy. MATERIALS AND METHODS: We retrospectively reviewed 75 advanced ovarian cancer patients, of whom 43 and 32 underwent optimal versus suboptimal cytoreduction, respectively. All patients exhibited a CCR following 6 cycles of paclitaxel and carboplatin and subsequently received maintenance chemotherapy paclitaxel 135 mg/m2; q21 days. RESULTS: The median progression free survival PFS for the optimally debulked patients was 35 months, compared to 20 months for the suboptimal population P = 0.003. Moreover, a Cox model analysis revealed that an increased number of maintenance chemotherapy cycles and optimal surgical reduction significantly correlated with favorable patient PFS P < 0.001. In regard to overall survival OS, the patients who had optimal cytoreductive surgery exhibited improved OS results compared to the sub-optimal surgery group 42 vs. 27 months; P < 0.001. However, a Cox model analysis indicated that a greater number of maintenance chemotherapy cycles was a surrogate marker for improved OS P < 0.001, but surgery type was not P > 0.05. Duration of overall patient follow-up exceeds 41 months. CONCLUSION: In advanced ovarian cancer patients who achieve a CCR following induction chemotherapy, optimal cytoreduction may confer a greater clinical benefit from a maintenance approach compared to suboptimal cytoreduction.


OBJECTIVE: In the present study, we conducted a multicenter retrospective analysis to elucidate the prognostic factors of stage IV epithelial ovarian cancer. METHODS: In November 1999, 24 Japanese institutions received questionnaires regarding stage IV epithelial ovarian cancer patients. Eligibility criteria included all patients with stage IV epithelial ovarian cancer who were surgically confirmed and initially treated in each institution between January 1990 and December 1997. Data were collected regarding age, performance status, tumor histologic subtype, site of metastasis, preoperative CA125, cytoreductive surgery, residual disease after cytoreductive surgery, and response to primary chemotherapy. Survival analysis and comparisons were performed by univariate and multivariate methods. RESULTS: Two hundred twenty-five patients with stage IV ovarian cancer were identified. The median age of the patients was 54 years. The most common site of extraperitoneal disease was malignant pleural effusion 39.6%. Of the 225 patients who underwent an attempt at surgical debulking, 70 31.1% were optimally cytoreduced. Most patients received platinum -based combination chemotherapy for primary chemotherapy. In multivariate analysis, performance status, histology, and residual disease after cytoreductive surgery were independent prognostic predictors of outcome. The overall median survival for optimally debulked patients was 32 months compared to 16 months for suboptimally debulked patients P < 0.0001, hazard ratio: 0.415. CONCLUSION: Optimal surgical debulking, performance status, and histology appear to be important prognostic factors of survival in patients with stage IV epithelial ovarian cancer.
Epithelial ovarian cancer EOC is the major gynecologic cancer mortality cause in Sweden. The aim of the present study was to investigate the long-term survival and prognostic factors of a complete population-based 5-year cohort of 682 patients with invasive EOC in western Sweden population around 1.6 million. Data relating to residual tumor after surgery, FIGO stage, grade, histopathologic subtype, ploidy status, adjuvant chemotherapy the prepaclitaxel period, and disease state recurrence and death were reported to a quality register in a prospectively kept database and were controlled against the Swedish National Cancer Registry for completeness. The median follow-up durations for the prospectively collected data in the Cox analysis and for the survival analysis that was made for all patients were 81 months range, 52 - 109 months and 11.7 years range, 8.7 - 14.1 years, respectively. No patient was lost to follow-up. The relative 10-year survival rate was 38.4% 95% confidence interval, 34.5% - 42.8%. The median relative survival time was 4.3 years 95% confidence interval, 3.6% - 5.2%. In the univariate Cox regression analysis, prognostic significances for age, stage, residual tumor, histopathologic subtype of serous cystadenocarcinoma, grade, CA-125, and ploidy status were seen. In the multivariate analysis, age, stage, residual tumor after surgery, and postoperative CA-125 were of prognostic significance. In conclusion, 4 major prognostic factors were found for EOC in this population-based cohort study that also presents nearly accurate long-term survival owing to the nonselective nature and completeness regarding patients and follow-up of the study.

OBJECTIVE: Residual disease after initial surgery for ovarian cancer is the strongest prognostic factor for survival. However, the extent of surgical resection required to achieve optimal cytoreduction is controversial. Our goal was to estimate the effect of aggressive surgical resection on ovarian cancer patient survival. METHODS: A retrospective cohort study of consecutive patients with International Federation of Gynecology and Obstetrics stage IIIC ovarian cancer undergoing primary surgery was conducted between January 1, 1994, and December 31, 1998. The main outcome measures were residual disease after cytoreduction, frequency of radical surgical resection, and 5-year disease-specific survival. RESULTS: The study comprised 194 patients, including 144 with carcinomatosis. The mean patient age and follow-up time were 64.4 and 3.5 years, respectively. After surgery, 131 67.5% of the 194 patients had less than 1 cm of residual disease definition of optimal cytoreduction. Considering all patients, residual disease was the only independent predictor of survival; the need to perform radical procedures to achieve optimal cytoreduction was not associated with a decrease in survival. For the subgroup of patients with carcinomatosis, residual disease and the performance of radical surgical procedures were the only independent predictors. Disease-specific survival was markedly improved for patients with carcinomatosis operated on by surgeons who most frequently used radical procedures compared with those least likely to use radical procedures 44% versus 17%, P < .001. CONCLUSION: Overall, residual disease was the only independent predictor of survival. Minimizing residual disease through aggressive surgical resection was beneficial, especially in patients with carcinomatosis. LEVEL OF EVIDENCE: II-2.
used to categorize extent of operation. RESULTS: No significant differences in age, performance status, or extent of disease were observed between cohorts. Surgical complexity increased after initiation of quality improvement mean surgical complexity score, 5.5 to 7.1; p < 0.001, rates of optimal RD < 1 cm improved from 77% to 85% p=0.157, and rates of complete resection of all gross disease rose from 31% to 43% p=0.188. In the subset of patients with carcinomatosis most likely to benefit from extended surgical resection, radical procedures were used more frequently 63% versus 79%; p=0.028, rates of optimal debulking RD<1 cm increased 64% to 79%, and the rate of RD=0 increased from 6% to 24% p=0.006. When disease was noted on the diaphragm, procedures to remove the disease were more frequently used 38% to 64%; p=0.001 . The rates of major perioperative morbidity group B, 21% versus group A, 20%; p=0.819 and 3-month mortality 8% versus 6%; p=0.475 were not affected despite this more aggressive surgical approach. CONCLUSIONS: Analysis of outcomes with appropriate feedback and education is a powerful tool for quality improvement. We observed improvements in rates of cytoreduction and use of specific radical procedures, with no increase in morbidity as a result of this process.


BACKGROUND: Diaphragm involvement by ovarian cancer is often considered to be a major obstacle to successful cytoreductive surgery. Lack of evidence of survival benefit, concerns over safety and lack of experience are common justifications for this belief. In this study, we sought to evaluate the therapeutic value of diaphragmatic surgery in advanced ovarian cancer. METHODS: Relevant data from all consecutive patients with stage IIIC and IV epithelial ovarian cancer, primarily operated at Mayo Clinic from 1994 through 1998, were collected and analyzed. Statistical analyses were performed using chi2 test, Cox regression model and Kaplan -Meier curves including log rank test. For comparison of trends in performing procedures, an additional 91 consecutive patients undergoing surgery from August 1, 2002 and August 31, 2004 were analyzed. RESULTS: 244 eligible patients were identified. Mean age was 64 years range: 24-87, and 5-year overall survival OS was 31.5%. For the entire cohort, residual disease RD) was the only independent prognostic factor in multivariate analysis P < 0.0001 when considering other factors including demographic, intraoperative findings and procedures performed. For the subgroup of patients with tumor involving the diaphragm N = 181, patients who underwent diaphragm surgery stripping of the diaphragmatic peritoneum, full or partial thickness diaphragm resection, excision of nodules or CUSA had improved 5-year OS relative to those that did not 53% vs. 15%; P < 0.0001. Furthermore, in multivariate analysis of patients with diaphragm disease, both RD and performance of diaphragm surgery were independent predictors of outcome P < 0.001. Considering the subgroup of patients with RD < 1 cm, we noted a strong survival advantage for those patients who underwent diaphragm surgical procedures 5 -year survival: 55% vs. 28%; P = 0.0005. Over time, we noted a statistically significant increase in the rate of diaphragm procedures for patients with diaphragm involvement from 1994-98 relative to 2002-3 22.5% vs. 40%: P = 0.022. CONCLUSIONS: Surgical procedures to treat diaphragm disease increase the rate of complete and optimal debulking and correlate with improved survival even compared to patients optimally debulked without diaphragm surgery performed.


OBJECTIVES: Determine impact of tumor distribution and surgery on prognosis in patients with stage IV epithelial ovarian cancer EOC. METHODS: Retrospective analysis of stage IV EOC patients undergoing primary surgery between 1994 and 1998. Simple statistics, univariate and multivariable analysis were performed. RESULTS: Forty-nine patients met the inclusion criteria and entered the study. Five-year overall survival OS was 18.2%. Residual disease RD) and radical surgical procedures RSP independently predicted survival p<0.001. Optimal debulking rate RD <1 cm was 49% and median survival for optimal patients was 3.2 years. A very high risk group of patients based on extent of peritoneal disease, parenchymal liver metastases and ASA could be identified in whom the
rate of optimal debulking was less than 25% median survival 1.4 years. No patients with multiple liver metastases were optimally cytoreduced and the median survival was 1 year. CONCLUSIONS: Based on patient factors and extent of disease, a high risk group of patients can be identified with a poor prognosis and low probability of optimal debulking. It appears justified in these patients to first exclude those with unresectable pleural disease and then perform laparoscopic assessment to determine extent of disease to triage patients to alternative strategies such as neoadjuvant chemotherapy.


BACKGROUND: Advanced ovarian cancer OC is associated with impaired performance status and comorbidities for many patients. These factors have an impact on the decision to perform extended surgical cytoreduction. However, the trade-off between short-term morbidity and overall survival is complex, and few data are available analyzing the combined effects of these variables. PURPOSE: The purpose of the study was to evaluate the impact of patients’ age and American Society of Anesthesiologists ASA and surgical complexity score SCS on short-term morbidity and overall survival. STUDY DESIGN: Presurgical patient characteristics, surgical procedures performed, and outcomes were assessed in a cohort of consecutive primary OC patients. An SCS from 1 to 3 was developed to adjust for the extent of surgery simple to complex, respectively. Primary outcomes were 30 day major morbidity sepsis, thromboembolic, cardiac, or reoperation, 3 month mortality, and overall survival OS. RESULTS: Two hundred nineteen consecutive patients with stage IIIC -IV OC were included. We observed a correlation between ASA and both short-term morbidity P = .006 and 3 month mortality P = .006. Age was independently associated with both short-term morbidity P = .010 and 3 month mortality P = .005. SCS correlated directly with morbidity P < .001 but was not correlated with mortality P = .266. The independent predictors of morbidity ASA, age, and SCS were used to develop risk prediction categories: risk of expected complications ranged from 2.5% to 67.6%, depending on category. Despite the increased risk of complications, however, more complex surgery carried a survival benefit in all the risk groups, owing to the observation that residual disease RD) and SCS held a prognostic significance independent of age and ASA P < .001 and P = .001, respectively. CONCLUSION: Because of the survival benefit from lower RD, a less aggressive surgical effort results in poorer OS. However, the risk of complications are substantial for complex surgeries in the highest-risk patients: risk stratification should be used to help plan perioperative care and consider optimal treatment planning.


BACKGROUND: The peritoneum of the cul-de-sac is frequently affected in advanced ovarian cancer patients. Stripping of the pelvic peritoneum SoP combined with rectosigmoidectomy RS in patients with confluent tumor are safe techniques that can eradicate macroscopic disease. We evaluated the therapeutic value of this maximal surgical effort in advanced ovarian cancer. STUDY DESIGN: Data from all consecutive patients with stages IIIC and IV epithelial ovarian cancer, primarily operated on from 1994 through 1998, were collected and analyzed using the chi-square test, Cox regression analysis, and Kaplan-Meier curves including log-rank test. RESULTS: Two hundred forty-four eligible patients were identified; 209 patients had tumor involving the peritoneum of the cul-de-sac. For this subgroup, those who were managed with stripping of the peritoneum SoP, n=77 or rectosigmoidectomy RS, N=57 had improved 5-year overall survivals relative to those who were not n=75. SoP=37% versus RS=39% versus neither=6%; p < 0.0001. In the subgroup of patients with cul-de-sac involvement optimally cytoreduced, we noted a survival benefit for those who were managed with a maximal pelvic surgical effort 5-year overall survival, 38% [SoP] versus 38% [RS] versus 15% [neither]; p=0.02. When evaluating patients with no macroscopic residual disease, a survival advantage for patients managed with RS compared with SoP was observed 5-year overall survival, 89% RS versus 50% RS; p=0.04. CONCLUSIONS: Surgical resection of cul-de-sac disease by SoP and RS is
associated with improved survival in ovarian cancer patients. Tumor resection with en bloc RS may be preferable to allowing microscopic or infiltrative residual tumor.


OBJECTIVE: To test the feasibility and utility of a risk-adjusted, multicenter outcomes model for ovarian cancer surgery as a tool for quality improvement. METHODS: Patient characteristics, intra-operative findings, procedures, and outcomes were assessed in primary advanced stage ovarian cancer cases from 3 independent centers. A surgical complexity score SCS was developed to adjust for extent of surgery. Outcomes measures were: 30-day morbidity sepsis, thrombo-embolic, cardiac, readmission or re-operation, 3 -month mortality, length of stay LOS, and ability to receive chemotherapy. A multivariable risk-adjusted model was developed for all the outcomes. Observed-to-expected O/E outcome ratios were calculated from all data. RESULTS: 564 consecutive patients from 3 centers were analyzed. The strongest predictors of 30-day morbidity were endogenous [albumin p<0.001 and ASA p=0.008] and complexity of surgery [SCS p<0.001]. Age p=0.002 and ASA p=0.001 independently predicted mortality. LOS independently correlated with age p=0.007, albumin p=0.004, SCS p=0.002, and stage p=0.024. ASA p<0.001 and SCS p=0.003 both impacted ability to receive chemotherapy. Observed to expected O/E ratios for dependent outcome variables were similar for all 3 institutions. CONCLUSIONS: We demonstrate the benefits of a national system for studying outcomes in gynecologic surgery using a risk-adjusted model. We specifically find that endogenous patient factors and complexity of surgery are primary drivers of morbidity in ovarian cancer surgery. These data can successfully be used to formulate expected, risk-adjusted rates of complications thus providing a meaningful mechanism to identify areas ripe for quality improvement.


AIMS: To develop a means to measure the quality of care provided to women treated for urinary incontinence UI through the development of quality-of-care indicators QIs. METHODS: We performed an extensive literature review to develop a set of potential quality indicators for the management of UI. QIs were modeled after those previously described in the Assessing the Care of Vulnerable Elders ACOVE project. Nine experts ranked the indicators on a nine-point scale for both validity and feasibility. We analyzed preliminary rankings of each indicator using the RAND Appropriateness Method. A forum was then held in which each indicator was thoroughly discussed by the panelists as a group, after which the indicators were rated a second time individually using the same nine-point scale. RESULTS: QIs were developed that addressed screening, diagnosis, work-up, and both non-surgical and surgical management. Areas of controversy included whether routine screening for incontinence should be performed, whether urodynamics should be performed before non-surgical management is initiated, and whether cystoscopy should be part of the pre-operative work-up of uncomplicated stress incontinence. Following the expert panel discussion, 27 of 40 potential indicators were determined to be valid for UI with a median score of at least seven on a nine-point scale. CONCLUSIONS: We identified 27 quality indicators for the care of women with UI. Once these QIs are pilot-tested for feasibility, they will be applied on a larger scale to measure the quality of care provided to women with UI in the United States.


BACKGROUND: Initial debulking surgery followed by chemotherapy is the current treatment for International Federation of Gynecology and Obstetrics Stage III/IV ovarian carcinoma but has a limited efficacy when optimal cytoreduction is not achieved at the end of the surgical procedure. An alternative treatment for these patients could be neoadjuvant chemotherapy. The purpose of this
A retrospective study was to report the results of neoadjuvant chemotherapy in operable patients no medical contraindication to surgery presenting with primary unresectable tumors. METHODS: Between January 1996 and March 1999, operable patients presenting with Stage IIC or IV ovarian carcinoma underwent, in six French gynecologic oncology departments, surgical staging to evaluate tumor resectability. When the tumor was deemed unresectable by standard surgery, the patient received three to six cycles of platinum-based neoadjuvant chemotherapy according to the response and the center's usual protocol. Patients were surgically explored after completion of neoadjuvant chemotherapy when the tumor did not progress during treatment. Debulking was performed during this secondary surgery when a response to chemotherapy was observed. RESULTS: Fifty-four patients were treated by neoadjuvant chemotherapy. The first surgical staging procedure was laparoscopy in 33 patients 61% and laparotomy in 21 patients 39%. The median number of neoadjuvant chemotherapy cycles was 4 range, 0 - 6. Forty-four patients 80% responded to neoadjuvant chemotherapy and then tumors were debulked. Optimal cytoreduction was obtained in 39 patients 91% of the patients who underwent debulking and with standard surgery in 32 patients 82%. For patients whose tumors were optimally debulked, blood transfusions were administered to 17 patients 43%, median intensive care unit stay was 0 days range, 0 - 7 days, and median postoperative hospital stay was 10 days range, 4 - 62 days. Median overall survival for the total series was 22 months. Survival was better for patients debulked after neoadjuvant chemotherapy compared with patients with nondebulked tumors P < 0.001. CONCLUSIONS: Neoadjuvant chemotherapy for primary unresectable ovarian carcinoma leads to the selection of a subset of patients sensitive to chemotherapy in whom optimal cytoreduction can be achieved after chemotherapy by standard surgery in a high proportion of cases. Conversely, aggressive surgery can be avoided in patients with initial chemoresistance, in whom the prognosis is known to be poor regardless of treatment.


BACKGROUND: Standard chemotherapy for newly diagnosed ovarian cancer is a platinum-taxane combination. The Gynecologic Oncology Group conducted a randomized, phase 3 trial that compared intravenous paclitaxel plus cisplatin with intravenous paclitaxel plus intraperitoneal cisplatin and paclitaxel in patients with stage III ovarian cancer. METHODS: We randomly assigned patients with stage III ovarian carcinoma or primary peritoneal carcinoma with no residual mass greater than 1.0 cm to receive 135 mg of intravenous paclitaxel per square meter of body-surface area over a 24-hour period followed by either 75 mg of intravenous cisplatin per square meter on day 2 intravenous therapy group or 100 mg of intraperitoneal cisplatin per square meter on day 2 and 60 mg of intraperitoneal paclitaxel per square meter on day 8 intraperitoneal therapy group. Treatment was given every three weeks for six cycles. Quality of life was assessed. RESULTS: Of 429 patients who underwent randomization, 415 were eligible. Grade 3 and 4 pain, fatigue, and hematologic, gastrointestinal, metabolic, and neurologic toxic effects were more common in the intraperitoneal-therapy group than in the intravenous-therapy group P< or =0.001. Only 42 percent of the patients in the intraperitoneal -therapy group completed six cycles of the assigned therapy, but the median duration of progression-free survival in the intravenous-therapy and intraperitoneal-therapy groups was 18.3 and 23.8 months, respectively P=0.05 by the log -rank test). The median duration of overall survival in the intravenous-therapy and intraperitoneal-therapy groups was 49.7 and 65.6 months, respectively P=0.03 by the log -rank test). Quality of life was significantly worse in the intraperitoneal-therapy group before cycle 4 and three to six weeks after treatment but not one year after treatment. CONCLUSIONS: As compared with intravenous paclitaxel plus cisplatin, intravenous paclitaxel plus intraperitoneal cisplatin and paclitaxel improves survival in patients with optimally debulked stage III ovarian cancer.

reduce errors and improve communication. We have developed a system for grading the quality of evidence and the strength of recommendations that can be applied across a wide range of interventions and contexts. In this article we present a summary of our approach from the perspective of a guideline user. Judgments about the strength of a recommendation require consideration of the balance between benefits and harms, the quality of the evidence, translation of the evidence into specific circumstances, and the certainty of the baseline risk. It is also important to consider costs resource utilisation before making a recommendation. Inconsistencies among systems for grading the quality of evidence and the strength of recommendations reduce their potential to facilitate critical appraisal and improve communication of these judgments. Our system for guiding these complex judgments balances the need for simplicity with the need for full and transparent consideration of all important issues.

AIMS: Recommendations for the pathology reporting of breast cancer were released in Australia to ensure detailed communication of important prognostic features and good patient management. An audit of the reporting of invasive breast cancer in Queensland was conducted to determine how well these guidelines were utilised in 2004. METHODS: A random sample of reports was audited for inclusion of recommended criteria. The proportion of reports meeting each of the criteria was determined and compared across whether the report was in a synoptic report template or in a free text format. Comparison was made with published data from prior to the release of the recommendations. RESULTS: Of the 419 reports in the sample, at least 90% of reports included lesion size, histological type, histological grade, lymph node involvement, margins of excision, lymphovascular invasion, and changes in adjacent breast tissue individually, and 74% included all seven of these essential criteria. Synoptic reports accounted for 76% of the sample and were significantly more likely to have documented grade p < 0.001, quadrant p = 0.003, calcification p < 0.001, lymphovascular invasion p < 0.001, changes in non-neoplastic breast p < 0.001 and ductal carcinoma in situ criteria p < 0.001 compared with free text report format. The most notable improvements since the implementation of the recommendations were in documentation of adjacent breast tissue 92% versus 49% and lymphovascular invasion 97% versus 54%. CONCLUSION: Breast cancer reporting in Queensland has improved since the implementation of the recommendations, however further improvements would likely be seen if there is more widespread utilisation of a synoptic report format.


PURPOSE: The aim of this study was to evaluate sequential F-18-fluorodeoxyglucose positron emission tomography FDG -PET to predict patient outcome after the first and third cycle of neoadjuvant chemotherapy in advanced-stage International Federation of Gynecology and Obstetrics stages IIC and IV) ovarian cancer. PATIENTS AND METHODS: Thirty-three patients received three cycles of carboplatin-based chemotherapy, followed by cytoreductive surgery. Quantitative FDG-PET of the abdomen and pelvis was acquired before treatment and after the first and third cycle of chemotherapy. Changes in tumoral FDG uptake, expressed as standardized uptake values SUV), were compared with clinical and histopathologic response; overall survival served as a reference. RESULTS: A significant correlation was observed between FDG-PET metabolic response after the first P = .008 and third P = .005 cycle of chemotherapy and overall survival. By using a threshold for decrease in SUV from baseline of 20% after the first cycle, median overall survival was 38.3 months in metabolic responders compared with 23.1 months in metabolic nonresponders. At a threshold of 55% decrease in SUV after the third cycle median overall survival was 38.9 months in metabolic responders compared with 19.7 months in nonresponders. There was no correlation between clinical response criteria P = .7 or CA125 response criteria P = .5 and overall survival. There was only a weak correlation P = .09 between histopathologic response criteria and overall survival. CONCLUSION: Sequential FDG-PET predicted patient outcome as early as after the first cycle of neoadjuvant chemotherapy and was more
accurate than clinical or histopathologic response criteria including changes in tumor marker CA125. FDG-PET appears to be a promising tool for early prediction of response to chemotherapy.


OBJECTIVE: This study was undertaken to evaluate the role of secondary cytoreduction in patients with recurrent epithelial ovarian cancer. STUDY DESIGN: Secondarily, cytoreduced patients were retrospectively analyzed with respect to the clinicopathologic variables. RESULTS: A total of 64 patients were evaluated in this report. Multivariable analysis revealed 3 factors to be significant: optimal cytoreduction during primary P = .003, odds ratio [OR]: 0.30; 95% CI: 0.14 -0.66, secondary cytoreduction P = .04, OR: 0.47; 95% CI: 0.22 -0.99, and the endometrioid histologic type P = .005, OR: 0.09; 95% CI: 0.02-0.48. Intrinsic factors of the tumors grade, stage, age, size, and number of recurrent tumors were nonsignificant. CONCLUSION: Secondary cytoreductive surgery should be offered in selected recurrent epithelial ovarian cancer patients. Further prospective randomized series are needed to determine specific recommendations.


INTRODUCTION: Cardiovascular diseases are among the most prevalent chronic diseases leading to high degrees of mortality and morbidity worldwide and in Iran. The aim of the current study was to determine and develop appropriate indicators for evaluating provided service quality for cardiovascular patients admitted to Cardiac Care Units (CCU) in Iran. METHODS: In order to determine the indicators for evaluating provided service quality, a four-stage process including reviewing systematic review articles in premier bibliographic databases, interview, performing two rounds of Delphi technique, and holding experts panel by attendance of experts in different fields was adopted. Finally, after recognizing relevant indicators in resources, these indicators were finalized during various stages using ideas of 27 experts in different fields. RESULTS: Among 2800 found articles in the text reviewing phase, 21 articles, which had completely mentioned relevant indicators, were studied and 48 related indicators were extracted. After two interviews with a cardiologist and an epidemiologist, 32 items of the indicators were omitted and replaced by 27 indicators coping with the conditions of Iranian hospitals. Finally, 43 indicators were added into the Delphi phase and after 2 rounds of Delphi with 18 specialists, 7 cases were excluded due to their low scores of applicability. In the experts' panel stage, 6 items were also omitted and 10 new indicators were developed to replace them. Eventually, 40 indicators were finalized. CONCLUSION: In this study, some proper indicators for evaluating provided service quality for CCU admissions in Iran were determined. Considering the informative richness of these indicators, they can be used by managers, policy makers, health service providers, and also insurance agencies in order to improve the quality of services, decisions, and policies.


ABSTRACT Aim: In locally advanced ovarian cancer with bowel involvement appropriate surgical treatment is still controversial. Objective was to delineate factors to select those most likely to benefit from radical surgery in patients with locally advanced ovarian cancer. Methods: Therefore, we retrospectively evaluated 207 consecutive patients with primary stage IIB-IV ovarian cancer who underwent primary surgery between 2000 and 2007. Every patient received stage-related surgery and adjuvant platinum-based chemotherapy. Median follow-up was 53.5 months. Data collected included stage, histology, extent of cytoreduction and type of bowel resection. Univariate survival analyses were performed to investigate variables associated with outcome. Results: Optimal cytoreduction OCR R <= 1 cm was achieved in 76.8%. Most patients presented histologic grade 2/3 96.6%, serous ovarian cancers 84.1% and lymph node involvement 52.2%. Complete cytoreduction R = 0 mm has significant best prognostic impact in FIGO IIB-IV p = .026. Regarding bowel involvement, bowel
resection was performed in 82 patients 39.6%. In this subgroup of patients complete cytoreduction led to significant better overall survival than R > 0 mm-1 cm, even in FIGO IIIC-IV patients p = .027; this fact is independent of bowel resection. Noticeably, for survival bowel resection achieving residual tumor mass below 1 cm was also one main prognostic factor and even recurrence rate was associated with residual tumor mass. Conclusion: Our findings suggest that the major prognostic factor in patients with advanced ovarian cancer needing colorectal resection is completeness of cytoreduction. Therefore, in advanced ovarian cancer patients, multivisceral surgery is indicated to achieve OCR R <= 1 cm with or without bowel resection with best prognostic impact.


This study evaluates the 5-year outcome data for the management of advanced ovarian cancer in the South West of England. Anonymized data for 361 stage III and IV ovarian cancers registered between January 1, 1998, and December 31, 1998, were obtained from the central gynecological tumor database. The following data were identified: age at diagnosis, FIGO stage, American Society of Anesthesiologists ASA grade, tumor differentiation, treating network and surgeon, amount of residual disease after debulking surgery, current life status, and date of death if applicable. Survival analysis was performed using Kaplan-Meier crude survival for univariate analysis, and multivariate analysis was performed by Cox regression. In our data the 5-year survival for patients with stage III was 16% and with stage IV was 10%. Survival analysis demonstrated that patients in whom the disease was debulked to less than 1 cm were more likely to be alive 5 years after diagnosis than those with a 2-cm residuum P < 0.0001. There was no significant survival difference for those patients operated on by subspecialist surgeons despite these surgeons being twice as likely to achieve optimal debulking. Therefore, there must be other variables influencing survival apart from cytoreductive surgery. While there is near-complete data collection about ovarian cancer surgery, our database on chemotherapy is incomplete. This is clearly crucial for a complete view of cancer care in our region.


OBJECTIVE: To assess the routine surgical practices of consultant gynaecological oncologists CGOs in the United Kingdom in their management of primary advanced FIGO stages III and IV) epithelial ovarian cancer PAEOC. METHODS: The same anonymised questionnaire was sent twice to all consultant gynaecological oncologists CGOs working in the UK. The questions enquired about surgical practice of the previous calendar year and the respondents were asked to describe their usual or typical management of patients with PAEOC. RESULTS: 45 of 85 CGOs responded 53%. The mean number of ovarian cancer cases operated on by an individual surgeon was 47 range 6 -100. 6% of the surgeons never perform pelvic lymphadenectomy, and 22% of the surgeons never perform para-aortic lymphadenectomy in the primary surgery PS group, compared to 8% and 30% in the neoadjuvant chemotherapy NAC group. In the PS group 17% of the respondents perform pelvic lymphadenectomy routinely 80% or more of patients compared to 11% of the respondents in the NAC group. The rates of bowel surgery and surgery for upper abdominal disease were highly variable. The average operating time per case was less than 3h in 78% of the respondents. CONCLUSIONS: The mean operating times, caseload, and types of procedure undertaken in the management of advanced ovarian cancer provide compelling evidence that in many UK cancer centres the surgical goal has not been complete cytoreduction. These data have implications for the centralisation of surgical services, subspecialty training, and the lower survival of UK patients compared to other comparable countries.


OBJECTIVES: Peripheral artery disease (PAD) is a major health problem whose clinical management includes multiple options regarding risk factor control, diagnosis, and medical and surgical treatment. The aim was to generate indicators based on systematic reviews to evaluate the quality of healthcare provided in PAD. METHODS: Electronic searches were run for systematic reviews in The Cochrane Library Issue 6, 2011, MEDLINE, EMBASE, and other databases up to June 2011. Conclusive systematic reviews of high methodological quality were selected to formulate clinical recommendations. Indicators were derived from clinical recommendations with moderate to very high strength of evidence as assessed by the GRADE system. RESULTS: From 1,804 reviews initially identified, 29 conclusive and high-quality systematic reviews were selected and nine clinical recommendations were formulated with a moderate to very high strength of recommendation. Six indicators were finally generated: four on pharmacological interventions, antiplatelet agents, naftidrofuryl, cilostazol, and statins; and two lifestyle interventions, exercise and tobacco cessation. No indicators were derived for diagnostic tests or surgical techniques. Most indicators targeted patients with intermittent claudication. CONCLUSIONS: These quality indicators will help clinicians to assess the appropriateness of healthcare provided in PAD. The development of evidence-based indicators in PAD is limited by the lack of methodological quality of the research in this disease, the inconclusiveness of the evidence on diagnostic and surgical techniques, and the dynamic nature of the vascular diseases field.


OBJECTIVE: To evaluate the complication rate and its impact in patients who have undergone upper abdominal surgery for treatment of advanced ovarian cancer. METHODS: Patients who have undergone upper abdominal surgery including diaphragm surgery, splenectomy, distal pancreatectomy, gastric resection, liver resection and biliary surgery were considered for the study. Perioperative complications were evaluated and graded according to Clavien-Dindo. RESULTS: One hundred and twenty one patients were included. Two hundred and twelve surgical procedures were performed. Thirty-six patients reported at least one complication, but 61.1% of these the complication was mild. Median hospital stay for patients with and without complication was 7 vs. 13 days respectively $p<0.001$. There was a significant correlation between post-operative hospital stay and the total number of surgical procedures $R=0.445$, $p<0.001$. At multivariate analysis, diaphragmatic resection and pancreatic resection were associated with a significant increase of postoperative hospital stay, furthermore diaphragmatic resection $p=0.004$, hepatic resection $p=0.004$, pancreatectomy $p=0.011$ and biliary surgery $p=0.049$ were independent predictors of severe G3-G4 complication. CONCLUSIONS: Rate of complications of patients submitted to upper abdominal surgery for ovarian cancer is acceptable. Prediction of severe complications is the goal for its optimal management. Extensive procedures should be avoided with those patients in which optimal residual tumor could not be reached.

from 181 sources of literature, 104 were selected during the in-person meeting of CRC-WG. During the Delphi process, CRC-WG shortened the list to 89 QI. AB finally validated 27 QIs according to the phase of care: diagnosis N=6, pathology N=3, treatment N=16 and outcome N=2.

CONCLUSIONS: Using the validated Delphi methodology, including a literature review of the evidence and integration of expert opinions from local clinicians and international experts, we were able to develop a list of QIs to assess QoCC for CRC. This will hopefully guarantee feasibility of data retrieval, as well as acceptance and translation of QIs into the daily clinical practice to improve QoCC. Moreover, evidence-based selected QIs allow one to assess immediate changes and improvements in the diagnostic-therapeutic process that could be translated into a short-term benefit for patients with a possible gain both in overall and disease-free survival.


BACKGROUND: Recent data has shown that the use of neoadjuvant chemotherapy NAC significantly reduces tumor burden before optimal cytoreductive surgery CS and is associated with an improved overall survival OS. The aim of our study was to evaluate response to treatment and survival of patients with advanced epithelial ovarian cancer EOC who received NAC followed by interval cytoreductive surgery ICS.

METHODS: Fifty -two patients with advanced EOC treated with NAC followed by ICS were retrospectively analyzed. Response to NAC, progression-free survival PFS, and OS were evaluated. By using univariate and multivariate analyses, the predicted survival rates by the factors were analyzed. RESULTS: Median age of patients at diagnosis were 62 years range 33-77. The serous cell type was the most common histology 98%. The majority of patients 94% received a combination therapy of paclitaxel and carboplatin. A median of four cycles of NAC was administered. At the end of NAC, the clinical complete response CR with normal clinical examination and normal serum CA 125 level was achieved in 40 patients 77%. Moreover, a radiological CR and a radiological partial response were obtained in 35 patients 67% and in 16 patients 31%, respectively. ICS was considered standard in 45 86% patients. Optimal cytoreduction could be achieved in 43 of 52 patients 83%. After ICS, pathological CR was established in 15 of 52 patients 29%. At the median follow-up of 25 months range 9 -102, 2 -year PFS and OS were 31 and 90%, respectively. The median PFS time was 13.3 months SE 1.1, 95% CI 11.1-15 and the median OS time was 47.5 months SE 5.8, 95% CI 36.1-59. The univariate analysis showed that optimal or suboptimal cytoreduction and perioperative blood transfusion were important prognostic factors on OS for patients who received NAC. Patients treated with optimal cytoreduction had significantly better median OS 52.5 months, 95% CI 45-60 than patients who underwent suboptimal cytoreduction 24.2 months, 95% CI 11.3-37 P = 0.001. Furthermore, the cytoreduction type optimal vs. suboptimal), surgical procedure standard vs. non-standard, and perioperative blood transfusion were independent prognostic factors of OS by multivariate analysis chi 2 = 9.28, P = 0.002, HR 0.28, 95% CI 0.003 -0.37; chi 2 = 4.44, P = 0.035, HR 0.15, 95% CI 0.026-0.87; chi 2 = 9.24, P = 0.002, HR 0.75, 95% CI 0.014 -0.79, respectively.

CONCLUSIONS: This study demonstrates that NAC is associated with improved OS for patients with advanced EOC who received NAC. Additionally, our results showed that cytoreduction type, surgical procedure, and perioperative blood transfusion were independent prognostic indicators of OS for patients with advanced EOC who received NAC. Thereafter, NAC may be an alternative treatment to primary cytoreduction.


BACKGROUND: Pancreatic cancer outcomes vary considerably among hospitals. Assessing pancreatic cancer care by using quality indicators could help reduce this variability. However, valid quality indicators are not currently available for pancreatic cancer management, and a composite assessment of the quality of pancreatic cancer care in the United States has not been done.

METHODS: Potential quality indicators were identified from the literature, consensus guidelines, and interviews with experts.
A panel of 20 pancreatic cancer experts ranked potential quality indicators for validity based on the RAND/UCLA Appropriateness Methodology. The rankings were rated as valid high or moderate validity or not valid. Adherence with valid indicators at both the patient and the hospital levels and a composite measure of adherence at the hospital level were assessed using data from the National Cancer Data Base 2004 -2005 for 49,065 patients treated at 1,134 hospitals. Summary statistics were calculated for each individual candidate quality indicator to assess the median ranking and distribution.

RESULTS: Of the 50 potential quality indicators identified, 43 were rated as valid 29 as high and 14 as moderate validity. Of the 43 valid indicators, 11 25.6% assessed structural factors, 19 44.2% assessed clinical processes of care, four 9.3% assessed treatment appropriateness, four 9.3% assessed efficiency, and five 11.6% assessed outcomes. Patient-level adherence with individual indicators ranged from 49.6% to 97.2%, whereas hospital-level adherence with individual indicators ranged from 6.8% to 99.9%. Of the 10 component indicators contributing 1 point each that were used to develop the composite score, most hospitals were adherent with fewer than half of the indicators median score = 4; interquartile range = 3 -5.

CONCLUSIONS: Based on the quality indicators developed in this study, there is considerable variability in the quality of pancreatic cancer care in the United States. Hospitals can use these indicators to evaluate the pancreatic cancer care they provide and to identify potential quality improvement opportunities.


PURPOSE: There is considerable variation in the quality of cancer care delivered in the United States. Assessing care by using quality indicators could help decrease this variability. The objectives of this study were to formally develop valid quality indicators for melanoma and to assess hospital-level adherence with these measures in the United States. METHODS: Quality indicators were identified from available literature, consensus guidelines, and melanoma experts. Thirteen experts ranked potential measures for validity on the basis of the RAND/University of California, Los Angeles Appropriateness Methodology. Adherence with individual valid indicators and a composite measure of all indicators were assessed at 1,249 Commission on Cancer hospitals by using the National Cancer Data Base NCDB; 2004 through 2005. RESULTS: Of 55 proposed quality indicators, 26 measures 47% were rated as valid. These indicators assessed structure n = 1, process n = 24, and outcome n = 1. Of the 26 measures, 10 are readily assessable by using cancer registry data. Adherence with valid indicators ranged from 11.8% to 96.5% at the patient level and 3.7% to 83.0% at the hospital level. Adherence required that >OR= 90% of patients at a hospital receive concordant care. Most hospitals were adherent with 50% or fewer of the individual indicators median composite score, five; interquartile range, four to seven. Adherence was higher for diagnosis and staging measures and was lower for treatment indicators. CONCLUSION: There is considerable variation in the quality of melanoma care in the United States. By using these formally developed quality indicators, hospitals can assess their adherence with current melanoma care guidelines through feedback mechanisms from the NCDB and can better direct quality improvement efforts.


PURPOSE: The purpose of this paper is to examine the question of how official bodies, health care organisations, and professional associations deal with the absence of a methodological gold standard for the simultaneous development of clinical practice guidelines and quality indicators, what procedures they use and what they feel are major strengths and limitations of their methods. DESIGN/METHODOLOGY/APPROACH: The authors conducted a web-based survey among 90 organisational members of the Guidelines International Network G-I-N) representing 34 countries from Africa, America, Asia, Europe and Oceania. All organisational G-I-N members were invited to participate in the survey by following a link provided in the invitation e-mail. FINDINGS: The responses of 24 organisations were included in the final analysis. The results indicate a broad variability in the approaches and methods used to develop quality indicators and guidelines simultaneously. The
answers of the participants indicated a lack of formal procedures for the simultaneous development. Formal procedures exist in only about half of the participating organisations. In addition, piloting or evaluation of the procedures is almost completely missing. Significantly, respondents mainly reported that the procedure used in their organisation "could certainly be more rigorous". Besides various strengths, participants reported a considerable number of limitations of the development processes they use.

ORIGINALITY/VALUE: This survey among G-I-N members -- despite limitations -- gives helpful insights in the state of the simultaneous development of quality indicators and clinical practice guidelines and underlines the need for future activities in methodological standard development and quality improvement of these processes.


BACKGROUND: Consensus methodologies are often used to create evidence-based measures of healthcare quality because they incorporate both available evidence and expert opinion to fill gaps in the knowledge base. However, there are limited studies of the key domains that are considered during panel discussion when developing quality indicators. METHODS: We performed a qualitative content analysis of the discussions from a two-day international workshop of injury control and quality-of-care experts 19 panel members convened to create a standardized set of quality indicators for injury care. The workshop utilized a modified RAND/UCLA Appropriateness method. Workshop proceedings were recorded and transcribed verbatim. We used constant comparative analysis to analyze the transcripts of the workshop to identify key themes. RESULTS: We identified four themes in the selection, development, and implementation of standardized quality indicators: specifying a clear purpose and goal(s for the indicators to ensure relevant data elements were included, and that indicators could be used for system-wide benchmarking and improving patient outcomes; incorporating evidence, expertise, and patient perspectives to identify important clinical problems and potential measurement challenges; considering context and variations between centers in the health system that could influence either the relevance or application of an indicator; and contemplating data collection and management issues, including availability of existing data sources, quality of data, timeliness of data abstraction, and the potential role for primary data collection. CONCLUSION: Our study provides a description of the key themes of discussion among a panel of clinical, managerial, and data experts developing quality indicators. Consideration of these themes could help shape deliberation of future panels convened to develop quality indicators.


PURPOSE: To determine if incorporation of an additional cytotoxic agent improves overall survival OS and progression -free survival PFS for women with advanced -stage epithelial ovarian carcinoma EOC and primary peritoneal carcinoma who receive carboplatin and paclitaxel. PATIENTS AND METHODS: Women with stages III to IV disease were stratified by coordinating center, maximal diameter of residual tumor, and intent for interval cytoreduction and were then randomly assigned among five arms that incorporated gemcitabine, methoxypolyethylene glycosylated liposomal doxorubicin, or topotecan compared with carboplatin and paclitaxel. The primary end point was OS and was determined by pairwise comparison to the reference arm, with a 90% chance of detecting a true hazard ratio of 1.33 that limited type I error to 5% two -tail) for the four comparisons. RESULTS: Accrual exceeded 1,200 patients per year. An event-triggered interim analysis occurred after 272 events on the reference arm, and the study closed with 4,312 women enrolled. Arms were well balanced for demographic and prognostic factors, and 79% of patients completed eight cycles of therapy. There were no improvements in either PFS or OS associated with any experimental regimen. Survival analyses of groups defined by size of residual disease also failed to show experimental benefit in any subgroup. CONCLUSION: Compared with standard paclitaxel and carboplatin, addition of a third cytotoxic agent provided no benefit in PFS or OS after optimal or suboptimal cytoreduction. Dual-stage, multiarm,
phase III trials can efficiently evaluate multiple experimental regimens against a single reference arm. The development of new interventions beyond surgery and conventional platinum-based chemotherapy is required to additionally improve outcomes for women with advanced EOC.


OBJECTIVE: Delphi technique is a structured process commonly used to develop healthcare quality indicators, but there is a little recommendation for researchers who wish to use it. This study aimed 1 to describe reporting of the Delphi method to develop quality indicators, 2 to discuss specific methodological skills for quality indicators selection 3 to give guidance about this practice.

METHODOLOGY AND MAIN FINDING: Three electronic data bases were searched over a 30 years period 1978 -2009. All articles that used the Delphi method to select quality indicators were identified. A standardized data extraction form was developed. Four domains questionnaire preparation, expert panel, progress of the survey and Delphi results were assessed. Of 80 included studies, quality of reporting varied significantly between items 9% for year's number of experience of the experts to 98% for the type of Delphi used. Reporting of methodological aspects needed to evaluate the reliability of the survey was insufficient: only 39% 31/80 of studies reported response rates for all rounds, 60% 48/80 that feedback was given between rounds, 77% 62/80 the method used to achieve consensus and 57% 48/80 listed quality indicators selected at the end of the survey. A modified Delphi procedure was used in 49/78 63% with a physical meeting of the panel members, usually between Delphi rounds. Median number of panel members was 17Q1:11; Q3:31. In 40/70 57% studies, the panel included multiple stakeholders, who were healthcare professionals in 95% 38/40 of cases. Among 75 studies describing criteria to select quality indicators, 28 37% used validity and 1723% feasibility.

CONCLUSION: The use and reporting of the Delphi method for quality indicators selection need to be improved. We provide some guidance to the investigators to improve the using and reporting of the method in future surveys.


OBJECTIVE: Measuring the quality of inpatient obstetrical care using quality indicators is becoming increasingly important for both patients and healthcare providers. However, there is no consensus about which measures are optimal. We describe a modified Delphi method to identify a set of indicators for continuously monitoring the quality of maternity care by healthcare professionals. METHODOLOGY AND MAIN FINDINGS: An international French-speaking multidisciplinary panel comprising 22 obstetricians-gynaecologists, 12 midwives, and 1 paediatrician assessed potential indicators extracted from a medical literature search, using a two-round Delphi procedure followed by a physical meeting. Each panellist rated each indicator based on validity and feasibility. In the first round, 35 panellists from 5 countries and 20 maternity units evaluated 26 indicators including 15 related to the management of the overall population of pregnant women, 3 to the management of women followed from the first trimester of pregnancy, 2 to the management of low-risk pregnant women, and 6 to the management of neonates. 25 quality indicators were kept for next step. In the second round, 27 27/35: 77% panellists selected 17 indicators; the remaining 8 indicators were discussed during a physical meeting. The final set comprised 18 indicators. CONCLUSION: A multidisciplinary panel selected indicators that reflect the quality of obstetrical care. This set of indicators could be used to assess and monitor obstetrical care, with the goal of improving the quality of care in maternity units.


BACKGROUND: The regional impact of care at a National Cancer Institute Comprehensive Cancer Center NCI -CCC on adherence to National Comprehensive Cancer Network NCCN) ovarian cancer
OBJECTIVE: To examine the effect of hospital procedure volume and other prognostic variables on overall survival outcome and likelihood of receiving standard recommended care among patients with advanced-stage epithelial ovarian cancer. METHODS: The National Cancer Data Base NCDB was searched for patients undergoing primary treatment for FIGO Stage IIIC/IV epithelial ovarian cancer from 1996 to 2005. The average annual surgical procedure volume was derived for each reporting hospital. Quartile ranking discriminated four groups of hospitals based on annual surgical volume: low <9, intermediate 9 - 20, high 21 - 35, and very high >35. Cox proportional hazards modeling was used to determine the impact on overall survival of hospital surgical volume adjusted for treatment, FIGO/AJCC stage, ethnicity, age, payer status, household income, and tumor grade. Binomial multivariate logistic regression modeling was used to assess differences in patient demographic, tumor, and treatment variables between high/very high volume hospitals and low/intermediate volume hospitals. RESULTS: A total of 45,929 patients were identified. After adjusting for other factors, overall survival was significantly correlated with hospital case volume: very high reference; high HR 0.98, 95% CI=0.92-1.04; intermediate HR 1.08, 95% CI=1.01 -1.15; and low HR 1.14, 95% CI=1.07-1.22. Compared to low and intermediate volume hospitals, patients treated at very high and high-volume hospitals were less likely to receive neo-adjuvant chemotherapy OR=0.33, 95% CI=1.18 - 1.50 or surgery alone OR=0.77, 95% CI=0.73 -0.82 instead of initial surgery and adjuvant chemotherapy. CONCLUSIONS: Hospital ovarian cancer surgical volume >or=21 cases/year is associated with a higher likelihood of patients with Stage IIIC/IV epithelial ovarian cancer receiving standard treatment surgery followed by adjuvant chemotherapy. Even after adjusting for treatment paradigm and other factors, hospital volume >or=21 cases/year was significantly predictive of improved overall survival outcome.


BACKGROUND: The relationship between racial and socioeconomic status SES disparities and the quality of epithelial ovarian cancer care and survival outcome are unclear. METHODS: A population-
based analysis of National Cancer Data Base NCDB records for invasive primary epithelial ovarian cancer diagnosed in the period from 1998 to 2002 was done using data from patients classified as white or black. Adherence to National Comprehensive Cancer Network NCCN) guideline care was defined by stage-appropriate surgical procedures and recommended chemotherapy. The main outcome measures were differences in adherence to NCCN guidelines and overall survival according to race and SES and were analyzed using binomial logistic regression and multilevel survival analysis. RESULTS: A total of 47,160 patients white = 43,995; black = 3,165 were identified. Non-NCCN-guideline-adherent care was an independent predictor of inferior overall survival hazard ratio [HR] = 1.43, 95% confidence interval [CI] = 1.38 to 1.47. Demographic characteristics independently associated with a higher likelihood of not receiving NCCN guideline-adherent care were black race odds ratio [OR] = 1.36, 95% CI = 1.25 to 1.48, Medicare payer status OR = 1.20, 95% CI = 1.12 to 1.28, and not insured payer status OR = 1.33, 95% CI = 1.19 to 1.49. After controlling for disease and treatment-related variables, independent racial and SES predictors of survival were black race HR = 1.29, 95% CI = 1.22 to 1.36, Medicaid payer status HR = 1.29, 95% CI = 1.20 to 1.38, median household income less than $35,000 OR = 1.06, 95% CI = 1.02 to 1.11. CONCLUSIONS: These data highlight statistically and clinically significant disparities in the quality of ovarian cancer care and overall survival, independent of NCCN guidelines, along racial and SES parameters. Increased efforts are needed to more precisely define the patient, provider, healthcare system, and societal factors leading to these observed disparities and guide targeted interventions.


OBJECTIVE: To evaluate the impact of surgeon and hospital case volume, and other related variables, on short-term outcomes after surgery for ovarian cancer. METHODS: The Maryland Health Service Cost Review Commission database was accessed for ovarian cancer surgical cases including both oophorectomy and any staging/cytoreductive surgical procedure from 2001 to 2008. Multivariate logistic regression analyses and multiple linear regression models were used to evaluate for significant associations between surgeon and hospital case volume, as well as other independent variables, and the risk of in-hospital death, extent of surgery, length of hospital stay, and hospital-related cost of care. RESULTS: Overall, 1894 primary ovarian cancer operations were performed by 352 surgeons at 43 hospitals. After controlling for the effects of all variables, the only independently significant factors associated with the risk of in-hospital death were surgery by a high-volume surgeon and an APR-DRG mortality risk score of 4. Ovarian cancer surgery performed by a high-volume surgeon was associated with a 69% reduction in the risk of in-hospital death. Surgery at a high-volume hospital was an independent positive predictor of a cytoreductive procedure. A statistically significant negative correlation was observed between surgery at a high-volume hospital and both length of hospital stay and hospital-related cost. CONCLUSIONS: After controlling for other factors, ovarian cancer surgery performed by a high-volume surgeon is associated with a 69% reduction in the risk of in-hospital death, while high-volume hospital care is associated with increased likelihood of cytoreduction, shorter length of stay, and lower hospital-related cost of care.


OBJECTIVE: Patient chances for cure and palliation for a variety of malignancies may be greatly affected by the care provided by a treating hospital. We sought to determine the effect of volume and teaching status on patient outcomes for five gynecologic malignancies: endometrial, cervical, ovarian and vulvar carcinoma and uterine sarcoma. METHODS: The Florida Cancer Data System dataset was queried for all patients undergoing treatment for gynecologic cancers from 1990-2000. RESULTS: Overall, 48,981 patients with gynecologic malignancies were identified. Endometrial tumors were the most common, representing 43.2% of the entire cohort, followed by ovarian cancer 30.9%, cervical cancer 20.8%, vulvar cancer 4.6%, and uterine sarcoma 0.5%. By univariate analysis, although patients treated at high volume centers HVC were significantly younger, they benefited from an
improved short-term 30-day and/or 90-day survival for cervical, ovarian and endometrial cancers. Multivariate analysis MVA, however, failed to demonstrate significant survival benefit for gynecologic cancer patients treated at teaching facilities TF or HVC. Significant prognostic factors at presentation by MVA were age over 65 HR = 2.6, p<0.01, African-American race HR = 1.36, p<0.01, and advanced stage regional HR = 2.08, p<0.01; advanced HR = 3.82, p<0.01, respectively. Surgery and use of chemotherapy were each significantly associated with improved survival. CONCLUSION: No difference in patient survival was observed for any gynecologic malignancy based upon treating hospital teaching or volume status. Although instances of improved outcomes may occur, overall further regionalization would not appear to significantly improve patient survival.


OBJECTIVE: Primary cytoreductive surgery is well accepted in the initial management of ovarian cancer with a goal of maximal tumor reduction. The role of cytoreductive surgery at disease recurrence is controversial and guidelines are not standardized. We aimed to review cases of women with recurrent ovarian cancer who were collaboratively managed by two teams of oncologic surgeons with different areas of surgical expertise. METHODS: A list of 616 patients with recurrent ovarian cancer from 1995 to 2009 was generated at a single institution. 20 cases of recurrent ovarian cancer were identified that were managed collaboratively. Data collected included date of diagnosis, initial treatment, recurrence date, location and number of sites of recurrence, secondary cytoreductive procedure performed, residual disease after surgery, pre-operative status, post-operative course, and pathologic findings. RESULTS: Of the 20 cases that fit eligibility criteria, 11 were completely resected, 5 were incompletely resected, and 4 were biopsied only. Median disease-free interval following primary surgery was 18 months (range 6-147). Median interval from diagnosis to collaborative cytoreduction was 63 months (range 13-170). Our patients had metastatic disease to the liver 11, lymph nodes 8, the diaphragm 7, other locations including colon, pancreas, lung, adrenal, kidney 9. Two patients had additional miliary disease. All patients underwent joint surgical management by gynecologic and surgical oncologists. There were no deaths in the immediate post-operative period. The 5 year survival rate was 45% following the joint surgical effort, with a median post-cytoreductive surgery survival duration of 42 months. CONCLUSIONS: Previous studies document survival benefit of surgery for women with recurrent ovarian cancer when there has been a long disease-free interval, localized pelvic or intra-abdominal recurrences and an optimal performance status. Most gynecologic oncologists do not perform extensive liver or diaphragm resections or lymph node excision above the renal vessels; thus, collaboration with a surgical oncologist is a viable option. In this small descriptive study, the feasibility of this reasonably well-tolerated approach, with possible survival benefit, is documented.


AIMS: To assess the efficiency and morbidity associated with bowel resection with the initial cytoreduction procedure for advanced ovarian cancer. MATERIALS AND METHODS: A review was carried of 95 patients with ovarian cancer who underwent cytoreductive surgery between 2000 and 2003. The relationship between dichotomised preoperative, intra-operative and postoperative outcome variables were tested using SPSS software. Kaplan-Meier curves were generated to compare survival. Cox proportional hazards regression was used to determine the independent significance of factors after cytoreductive surgery. RESULTS: In patients in whom bowel resection was carried out, the largest residual tumour mass was <1cm in 66.67% of patients, compared with 45.28% of patients undergoing surgery without bowel resection P=0.038. The median survival in the optimally debulked patients was 50.38 months compared with 37.15 months in the patients who had suboptimal cytoreduction P=0.0021. The median survival in patients undergoing bowel resection was 50.70 months compared with 44.62 months in the patients who had cytoreduction without bowel resection P=0.2176. Multivariate analysis showed that optimal cytoreduction P=0.005 was found to be independently prognostic for overall survival. Major adverse events, such as ileus, intestinal fistulae, urinary tract...
fistulae, were not significantly different between groups. CONCLUSION: Bowel resection is a worthwhile endeavour in selected patients with advanced ovarian cancer to increase therapeutic efficiency. The surgical morbidity rate from these procedures is not serious and seems acceptable.


PURPOSE: To review the literature on the content and development of the sets of quality indicators used in studies on the quality of diabetes care in primary care settings. DATA SOURCES: The MEDLINE Ovid, PubMed, PsychINFO, Embase and CINAHL databases were searched for relevant articles published up to January 2011. STUDY SELECTION: and data extraction We included studies on the quality of adult diabetes care, using quality indicators. We excluded studies focusing on the hospital setting, patient subgroups, specific components of diabetes care and specific outcomes. In total, 102 studies including 1 02 sets and 1494 indicators were analyzed by two independent reviewers, using the criteria of the National Quality Measures Clearinghouse and international guidelines to document the content and selection of the identified indicators. RESULTS OF DATA SYNTHESIS: Sets varied greatly in number, content and definitions of quality indicators. Most of the indicators concerned HbA1C, lipids, blood pressure, eye and foot examination and urinalysis. Few sets included indicators on lifestyle counseling, patient experiences, healthcare structure or access to healthcare providers. Seventy sets did not specify explicit selection criteria, and 19 of these did not report the sources of the indicators. CONCLUSIONS: Sets of quality indicators are diverse in number, content and definitions. This diversity reflects a lack of uniformity in the concept of diabetes care quality and hinders the interpretation of and comparison between quality assessments. Methodology regarding defining constructs such as the quality of diabetes care and indicator selection procedures is available and should be used more rigorously.


BACKGROUND: Quality measures should be subjected to a testing protocol before being used in practice using key attributes such as acceptability, feasibility and reliability, as well as identifying issues derived from actual implementation and unintended consequences. We describe the methodologies and results of an indicator testing protocol ITP using data from proposed quality indicators for the United Kingdom Quality and Outcomes Framework QOF. METHODS: The indicator testing protocol involved a multi-step and methodological process: 1 The RAND/UCLA Appropriateness Method, to test clarity and necessity, 2 data extraction from patients' medical records, to test technical feasibility and reliability, 3 diaries, to test workload, 4 cost-effectiveness modelling, and 5 semi-structured interviews, to test acceptability, implementation issues and unintended consequences. Testing was conducted in a sample of representative family practices in England. These methods were combined into an overall recommendation for each tested indicator. RESULTS: Using an indicator testing protocol as part of piloting was seen as a valuable way of testing potential indicators in 'real world' settings. Pilot 1 October 2009 -March 2010 involved thirteen indicators across six clinical domains and twelve indicators passed the indicator testing protocol. However, the indicator testing protocol identified a number of implementation issues and unintended consequences that can be rectified or removed prior to national roll out. A palliative care indicator is used as an exemplar of the value of piloting using a multiple attribute indicator testing protocol - while technically feasible and reliable, it was unacceptable to practice staff and raised concerns about potentially causing actual patient harm. CONCLUSIONS: This indicator testing protocol is one example of a protocol that may be useful in assessing potential quality indicators when adapted to specific country health care settings and may be of use to policy-makers and researchers worldwide to test the likely effect of implementing indicators prior to roll out. It builds on and codifies existing literature and other testing protocols to create a field testing methodology that can be used to produce country specific quality indicators for pay-for-performance or quality improvement schemes.
OBJECTIVES: To determine the fraction of patients diagnosed with ovarian cancer and seen by a gynecologic oncologist and to compare outcomes with those patients and others who are not seen by a gynecologic oncologist. METHODS: The statewide, population-based Utah Cancer Registry was used to identify 848 patients diagnosed with epithelial ovarian cancer between 1992 and 1998. Differences between selected characteristics of cases seen/not seen by gynecologic oncologists were assessed with chi2 tests, and survival data were analyzed using Kaplan-Meier curves and log-rank testing. RESULTS: Of 848 incident epithelial ovarian cancer cases diagnosed in Utah residents during the period 1992-1998, 333 (39.3%) were seen by a gynecologic oncologist at some time during their cancer diagnosis and/or treatment. The percentage of ovarian cancer cases seen by a gynecologic oncologist varied with age: 35.6% of cases under 40 years of age at diagnosis were seen by a gynecologic oncologist, as were 54.5% of cases 40-59 years of age, 42.6% of cases 60-69 years, and 23.7% of women 70+ years of age chi2 test, P < 0.01. The percentage of ovarian cancer cases seen by a gynecologic oncologist increased during the study period, from 33.0% in 1992-1993 to 47.5% in 1997-1998 chi2 test for trend, P < 0.01. The vast majority of the state’s population resides within a contiguous, four-county area near the only major city where gynecologic oncology care is available. Ovarian cancer cases that resided within that geographic area were generally more likely to have been seen by a gynecologic oncologist than those who lived in more rural regions of the state 42.7 and 27.1%, respectively; chi2 test, P < 0.01. For ovarian cancer cases diagnosed with loco I or regional stages of disease, there were no significant differences in survivorship between those treated or not treated by gynecologic oncologists. Among cases diagnosed with advanced disease, those cases seen by gynecologic oncologists had a significant survival advantage when compared to those that were not median survival 26 and 15 months, respectively, P < 0.01. CONCLUSIONS: Gynecologic oncologists see less than half of ovarian cancer patients. Patients under 40 years of age, over 70 years of age, and in rural areas were significantly less likely to be seen by a gynecologic oncologist in their course of treatment. Patients with advanced disease experienced a significant survival advantage when a gynecologic oncologist was involved in their care.


PURPOSE: Medical practices in oncology are expected to be multidisciplinary, yet few articles studied how this may be concretely applied. In the present study, we evaluated the organization of two multidisciplinary committees, one for breast cancer and one for sarcoma, in a French Comprehensive Cancer Centre. METHODS: Both tumours were specifically chosen so as to emphasise substantial differences in relation with incidence, histological subtypes, management strategy, and scientific evidence. Between 2003 and 2004, 404 decision processes were observed, 210 for sarcoma 26 meetings and 194 for breast cancer 10 meetings. The number of physicians who took part in the discussions and their medical specialties were systematically noted as well as the number of contradictory discussions, medical specialties represented in these contradictory discussions and the topics of contradiction. The last measured data was whether the final committee's decision was in conformity with the referent's preferences or not. All these measures were related to the referent's medical speciality and working place, to the stage of the disease and to the disease management stage. RESULTS: Committees' specificities concerned their organization, referent's medical specialities, the number of participants in discussions and their medical specialties. Discussions in the sarcoma committee tended to be more multidisciplinary, involving more specialties. Initial strategy proposal for one patient was modified during the discussions for 86 patients out of 210 41% and for 62 out of 194 32% respectively for sarcoma and breast cancer. However, there was no significant difference in the rate of contradictory discussions between breast cancer and sarcoma committees 32% versus 41% respectively; P = 0.08. The rates of contradictory discussions were similar for localized cancers, local relapse and metastasis disease 37%, 41% and 34% respectively; P = 0.86. CONCLUSIONS: The
The present study reports more than 30% of changes concerning strategy for patient with cancer due to multidisciplinary discussions. This indicates that, providing tumour committees are adapted to the pathologies' characteristics, they can promote a collective and multidisciplinary approach to oncology.


The feasibility and validity of proposed radical prostatectomy quality indicators has not been well studied. We assessed indicator availability from treating charts. We tested the convergent construct validity of a modified subset that were available from this information source by correlating them to hospital prostatectomy volume, a variable repeatedly associated with the quality of surgical care. The study population consisted of a stratified random sample of prostate cancer patients who were: i) diagnosed between 1990 and 1998 in Ontario and ii) treated by radical prostatectomy with curative intent within 6 months of diagnosis n = 645. Of the 9 candidate quality indicators assessed, 4 were missing for 25-56% of study subjects and were not analyzed further. We discuss the implications of this missing information on feasibility of their use. For blood transfusions of 3 units or greater, length of hospital stay and use of non-nerve-sparing surgical technique, worse outcomes were generally apparent with decreasing hospital volume. Acute complication rates and positive surgical margin rates did not increase with decreasing hospital volume. We were able to demonstrate convergent construct validity for 3 quality indicators. Upon further validation, this readily available information may be applied to aid providers and quality councils to more effectively identify problems and guide change in the management of early prostate cancer.


OBJECTIVE: To estimate the influence of gynecologic oncologists on the treatment and outcome of patients with ovarian cancer. METHODS: Data were obtained from California Cancer Registry from 1994 to 1996. Kaplan-Meier and Cox proportional hazard methods were used for analyses. RESULTS: Of 1,491 patients, the median age was 65 years range: 13 -100. Only 34.1% received care by gynecologic oncologists group A while 65.9% were treated by others group B. Women in group A were more affluent P<.001, were more educated P=.036, were classified as white-collar employees P=.128, and lived in urban regions P<.001 compared with group B. Patients who saw gynecologic oncologists were more likely to have surgery as their initial treatment 91.9% versus 69.1%; P<.001, present with advanced stage III -IV) cancers 78.2% versus 70.5%; P<.001, have more grade 3 tumors 61.7% versus 39.9%; P=.048, and receive chemotherapy 90.0% versus 70.1%; P<.001. Women in group B had a fourfold higher risk of having unstaged cancers 8.0% versus 2.1%; P<.001. The 5-year disease-specific survival of group A patients was 38.6% compared with 30.3% in group B P<.001. On multivariable analysis, early stage, lower grade, and treatment by gynecologic oncologists were independent prognostic factors for improved survival. After adjusting for surgery and chemotherapy, there was no improvement in survival associated with care by gynecologic oncologists hazard ratio=0.90, 95% confidence interval 0.78-1.03; P=.133. CONCLUSION: In this study of 1,491 women, those who were treated by gynecologic oncologists were more likely to undergo primary staging surgery and receive chemotherapy. Stage, grade of disease, and treatment by gynecologic oncologists were important prognosticators.


OBJECTIVE: To compare the survival rates in younger 45 years or younger and older women over 45 diagnosed with advanced stage invasive epithelial ovarian cancer. Clinical and pathologic factors responsible for survival differences between the two groups were also determined. METHODS: All younger women with advanced-stage epithelial ovarian carcinoma diagnosed between 1984 and 2001 were identified from tumor registry databases at two hospitals. Patients with borderline tumors were
excluded. An older group of comparable controls was selected for comparison. Kaplan-Meier and Cox proportional hazards analyses were used to determine the predictors for survival. RESULTS: Of 104 women with advanced-stage epithelial ovarian carcinoma, 52 were 45 or younger and the rest were over 45. The 5-year survival rate and median survival in younger patients were 48% and 54 months, compared with 22% and 34 months in the older women \( P = .003 \). Younger women had significantly better performance status than older patients, and survival remained significantly better in younger women based on Kaplan-Meier analysis stratified by performance status 0 versus 1 to 2, \( P = .02 \). Furthermore, overall survival was significantly better in younger women after stratification by stage III versus IV, \( P = .002 \) and by cytoreductive surgery optimal versus suboptimal, \( P = .003 \). Multivariable analysis demonstrated that all these factors remained as significant independent prognostic factors for survival. CONCLUSION: Younger women with advanced-stage invasive epithelial ovarian cancer have significantly improved survival rates relative to older patients. Age, performance status, stage of disease, and extent of cytoreductive surgery are important independent prognostic factors for survival.


For millennia, food has been at the center of social events, in times of joy and in times of sorrow. Protein-energy malnutrition is associated with a significant impairment of cell-mediated immunity, phagocyte function, complement system, secretory immunoglobulin A antibody concentrations, and cytokine production. Deficiency of single nutrients also results in altered immune response; this is observed even when the deficiency state is relatively mild. Of the micronutrients, zinc, selenium, iron, copper, vitamins A, C, E and B6, and folic acid have important influences on immune responses. Overnutrition and obesity also reduce immunity. Low-birth-weight infants have a prolonged impairment of cell-mediated immunity that can be partly restored by providing extra amounts of dietary zinc. In the elderly, impaired immunity can be enhanced by modest amounts of a combination of micronutrients. These findings have considerable practical and public health significance.


BACKGROUND: Advances in the diagnosis and treatment of breast carcinoma have led to a multidisciplinary approach to management for patients with breast carcinoma. To assess the effect of this approach, the authors performed an evaluation for a cohort of patients examined in a multidisciplinary breast cancer center. METHODS: An analysis was performed for the records of 75 consecutive women with 77 breast lesions examined in consultation in a multidisciplinary breast cancer center between January and June 1998. Each patient's case was evaluated by a panel consisting of a medical oncologist, surgical oncologist, radiation oncologist, pathologist, diagnostic radiologist, and, when indicated, plastic surgeon. A comprehensive history and physical examination was performed, and the relevant mammograms, pathology slides, and medical records were reviewed. Treatment recommendations made before this evaluation were compared with the consensus recommendations made by the panel. RESULTS: For the 75 patients, the multidisciplinary panel disagreed with the treatment recommendations from the outside physicians in 32 cases 43%, and agreed in 41 cases 55%. Two patients 3% had no treatment recommendation before consultation. For the 32 patients with a disagreement, the treatment recommendations were breast-conservation treatment instead of mastectomy \( n = 13; \) 41% or reexcision \( n = 2; \) 6%; further workup instead of immediate definitive treatment \( n = 10; \) 31%; treatment based on major change in diagnosis on pathology review \( n = 3; \) 9%; addition of postmastectomy radiation treatment \( n = 3; \) 9%; or addition of hormonal therapy \( n = 1; \) 3%. CONCLUSIONS: The multidisciplinary breast cancer evaluation program provided an integrated program in which individual patients were evaluated by a team of physicians and led to a
change in treatment recommendation for 43% of 75 of the patients examined. This multidisciplinary program provided important second opinions for many patients with breast carcinoma.


BACKGROUND: To analyze the impact of radical cytoreductive surgery-as part of primary tumor debulking-on the amount of residual tumor and survival in patients with advanced ovarian cancer and to evaluate the prognostic significance of no gross residual disease (RD) after surgery. METHODS: Medical records of 203 patients with International Federation of Gynecology and Obstetrics FIGO stage IIIC-IV ovarian cancer were reviewed. All patients underwent primary cytoreductive surgery followed by taxane- and platinum-based chemotherapy. Various clinicopathologic characteristics were collected. RESULTS: Of 203 patients, 119 patients underwent simple surgery, while radical surgery was performed in 84 patients. Advanced age hazard ratio (HR) 1.04, 95% confidence interval (CI) 1.02-1.06, P < 0.01, FIGO stage IV disease HR 3.61, 95% CI 1.48 -8.83, P < 0.01, and grossly visible RD HR 3.24, 95% CI 1.90 -5.53, P < 0.01 were identified as significant factors associated with poor prognosis in the entire cohort of 203 patients. Radical surgery HR 0.56, 95% CI 0.37 -0.87, P = 0.01 was associated with improved survival. In the subgroup of patients with stage IIIIC disease with peritoneal carcinomatosis, independent prognostic factors were advanced age HR 1.04, 95% CI 1.01 -1.06, P = 0.01, radical surgery HR 0.58, 95% CI 0.35 -0.96, P = 0.03, and grossly visible RD HR 2.86, 95% CI 1.55-5.30, P < 0.01. Patients with no gross RD had the longest overall survival 86 months compared with RD 0.1-1 cm 46 months and RD >1.0 cm 37 months P < 0.01. CONCLUSIONS: No gross RD is associated with improved overall survival, and radical surgery was effective for achieving no gross RD.


OBJECTIVE: The objective of this study was to evaluate the impact of systematic pelvic and para-aortic lymphadenectomy on survival in patients with advanced ovarian cancer. METHODS: We retrospectively analyzed the data of 189 consecutive patients with FIGO stage IIIC ovarian cancer between 2000 and 2011, who underwent primary cytoreductive surgery followed by platinum- and taxane-based chemotherapy. All patients were classified into two groups - patients who underwent systematic pelvic and para-aortic lymphadenectomy and those who did not. Progression-free PFS and overall survival OS times were analyzed using Kaplan-Meier method and Cox proportional hazards model. RESULTS: Patients who underwent systematic lymphadenectomy had significantly improved PFS 22 versus 9 months, p<0.01 and OS 66 versus 40 months, p<0.01. In patients with no gross residual disease NGR or residual disease 0.1-1 cm GR-1, the median OS time of those who had lymphadenectomy was significantly longer than those who did not 86 versus 46 months, p=0.02. However, in patients with residual disease >1cm GR-B, there was no significant difference in OS according to lymphadenectomy 39 versus 40 months, p=0.50. Among patients with NGR, the median OS time of those who underwent systematic lymphadenectomy was significantly longer than those who did not undergo lymphadenectomy not yet reached [>96] and 56 months, p<0.01. No s i g n i f i c a n t difference of OS between patients with and without lymphadenectomy was observed in the subgroup of patients with GR-1 50 versus 38 months, p=0.44. The performance of lymphadenectomy was a statistically significant and independent predictor of improved OS in addition to the status of residual disease and the performance of radical cytoreductive procedures hazard ratio, 0.34; [95% CI, 0.23 -0.52]; p<0.01. CONCLUSIONS: Systematic lymphadenectomy may have a therapeutic value and be significantly associated with improved survival in stage IIIIC ovarian cancer patients with grossly no visible residual disease.

OBJECTIVE: To quantify the impact of complete cytoreduction to no gross residual disease on overall survival among patients with advanced-stage ovarian cancer treated during the platinum-taxane era.

METHODS: PubMed and Cochrane Library databases were searched for all articles on primary cytoreductive surgery for advanced-stage ovarian cancer published from 1/1996 to 7/2011. A total of 18 relevant studies 13,257 patients were identified for analysis. Simple and multiple linear regression analyses, with weighted correlation calculations, were used to assess the effect on median survival time of clinical and treatment-related factors.

RESULTS: The mean weighted median overall survival time for all cohorts was 44.4 months range, 27.6 - 66.9 months. Simple linear regression analysis revealed that residual disease, stage IV disease, and use of intraperitoneal chemotherapy were significantly associated with median survival time. After controlling for other factors on multiple linear regression analysis, each 10% increase in the proportion of patients undergoing complete cytoreduction to no gross residual disease was associated with a significant and independent 2.3-month increase 95% CI = 0.6 - 4.0, p = 0.011 in cohort median survival compared to a 1.8-month increase 95% CI = 0.6 - 3.0, p = 0.004 in cohort median survival for optimal cytoreduction residual disease ≤ 1 cm. Each 10% increase in the proportion of patients receiving intraperitoneal chemotherapy was associated with a significant and independent 3.9-month increase 95% CI = 1.1 - 6.8, p = 0.008 in median cohort survival time.

CONCLUSIONS: For advanced-stage ovarian cancer treated during the platinum-taxane era, the proportions of patients left with no gross residual disease and receiving intraperitoneal chemotherapy are independently significant factors associated with the most favorable cohort survival time.


Even with wider application of cytoreductive surgery for advanced ovarian cancer, there is still a lack of adequate documentation concerning morbidity and mortality associated with this surgery. The purpose of this paper is to provide such information. This report is based on a retrospective analysis of 60 patients with Stage III and IV disease who had maximal cytoreductive surgery at the Long Island Jewish-Hillside Medical Center between January 1975 and February 1982. This analysis was focused on variables related to morbidity and mortality associated with the procedure. The results indicated that operating time, blood loss, intraoperative and postoperative complications, postoperative morbidity, and the length of hospital stay were acceptable. Only one operative mortality was encountered. The presence of a gynecologic oncologist in the operating room was crucial in carrying out optimal cytoreductive surgery. It is concluded that morbidity and mortality in primary maximal cytoreductive surgery for advanced ovarian carcinoma are acceptable and the surgery should be performed if feasible.


Determining whether persons with multiple sclerosis MS receive appropriate, comprehensive healthcare requires tools for measuring quality. The objective of this study was to develop quality indicators for the care of persons with MS. We used a modified version of the RAND/UCLA Appropriateness Method in a two-stage process to identify relevant MS care domains and to assess the validity of indicators within high-ranking care domains. Based on a literature review, interviews with persons with MS, and discussions with MS providers, 25 MS symptom domains and 14 general health domains of MS care were identified. A multidisciplinary panel of 15 stakeholders of MS care, including 4 persons with MS, rated these 39 domains in a two-round modified Delphi process. The research team performed an expanded literature review for 26 highly ranked domains to draft 86 MS care indicators. Through another two-round modified Delphi process, a second panel of 18 stakeholders rated these indicators using a nine-point response scale. Indicators with a median rating in the highest tertile were considered valid. Among the most highly rated MS care domains were appropriateness and timeliness of the diagnostic work-up, bladder dysfunction, cognition dysfunction, depression, disease-modifying agent usage, fatigue, integration of care, and spasticity. Of the 86 preliminary indicators, 76 were rated highly enough to meet predetermined thresholds for validity. Following a widely accepted methodology, we developed a comprehensive set of quality indicators for MS care that can be used to assess quality of care and guide the design of interventions to improve care among persons with MS.
OBJECTIVE: Recent studies have suggested that the definition of optimal cytoreduction for advanced EOC should be changed from the current Gynecologic Oncology Group threshold of ≤1 cm residual disease to no gross residual disease owing to improved survival of patients pts rendered macroscopically disease-free. The objective of this study was to analyze survival rates at very specific residual disease diameters to determine the optimal goal of primary cytoreduction for bulky stage IIIC EOC.

METHODS: A prospectively kept database was used to identify and review the records of all pts with Stage IIIC EOC who underwent primary cytoreductive surgery at our institution between January 1989 and December 2003. To analyze a homogeneous cohort of cases, we excluded pts with stage IIIC disease based on nodal metastasis alone without bulky abdominal tumor, fallopian tube or primary peritoneal carcinomas, and borderline tumors. Standard statistical analyses were utilized.

RESULTS: The study cohort included 465 pts. The median age was 60 years range, 25–87, and the median follow-up was 38 months range, 1–199. Univariate and multivariate analyses, which included various prognostic factors, identified amount of residual disease as a significant prognostic factor P < 0.001. Median overall survival in relation to the 5 residual disease categories was: no gross residual, 106 months; gross < or =0.5 cm, 66 months; 0.6-1.0 cm, 48 months; 1-2 cm, 33 months; >2 cm, 34 months. Statistical comparison between the 5 residual disease categories revealed 3 distinct groups with significantly different survival rates P < 0.01. These 3 groups were: 1 no gross residual; 2 gross < or =1 cm residual; and 3 >1 cm residual. Although the difference in survival did not reach statistical significance, within the gross < or =1 cm residual group, there was a trend toward improved survival in pts left with smaller volume, < or =0.5 cm residual compared with those with 0.6-1.0 cm residual P = 0.06.

CONCLUSION: Our data suggest that removal of all evidence of macroscopic disease is associated with prolonged survival and should be the goal of primary cytoreductive surgery. If complete gross resection is not feasible, however, cytoreduction to as minimal residual tumor as possible should be the focus of cytoreductive efforts, as each incremental decrease in residual disease below 1 cm may be associated with an incremental improvement in overall survival.


OBJECTIVE: The Gynecologic Oncology Group (GOG) has demonstrated that age, tumor grade, and size and number of residual lesions after primary cytoreductive surgery are significant prognostic factors in advanced ovarian carcinoma. Recent studies have reported numerous other clinical features as having prognostic value. We sought to identify the independent prognostic factors for survival in a cohort of patients with advanced ovarian cancer.

METHODS: We performed a retrospective chart review of all patients with stage III and IV ovarian carcinoma who received their primary treatment at our institution between 1987 and 1994. RESULTS: A total of 295 patients were identified, 282 of whom were evaluable. Of these 282 patients, 214 76% have died of disease or other causes. The median follow-up is 32 months range: 1-139. Eighteen factors were evaluated for prognostic significance. Significant factors in univariate analysis included patient age, gravidity 0 vs > 0, parity 0 vs > 0, preoperative albumin level, preoperative total protein level, ascites presence vs absence, disease stage IIIA/ IIIB vs IIIC vs IV), number of residual lesions < or =20 vs >20, and diameter of largest residual tumor nodule < or = 1 cm vs 1-2 cm vs > 2 cm. However, on multivariate analysis, only patient age P < 0.001, ascites P = 0.001, and size of residual disease stage IIIA/ IIIB vs IIIC vs IV), number of residual lesions < or =20 vs >20, and diameter of largest residual tumor nodule < or = 1 cm vs 1-2 cm vs > 2 cm. However, on multivariate analysis, only patient age P < 0.001, ascites P = 0.001, and size of residual disease P = 0.005 retained prognostic significance. Substage of disease was of borderline significance P = 0.086.

CONCLUSION: Although numerous clinical variables have recently been reported to have prognostic value in advanced ovarian carcinoma, only patient age, presence or absence of ascites, and diameter of the largest residual tumor nodule proved to be of statistical significance in our analysis.


BACKGROUND AND AIMS: The lack of consensus on how to define and grade adverse postoperative events has greatly hampered the evaluation of surgical procedures. A new classification of complications, initiated in 1992, was updated 5 years ago. It is based on the type of therapy needed to correct the complication. The principle of the classification was to be simple, reproducible, flexible, and applicable irrespective of the cultural background. The aim of the current study was to critically evaluate this classification from the perspective of its use in the literature, by assessing interobserver variability in grading complex complication scenarios and to correlate the classification grades with patients', nurses', and doctors' perception. MATERIAL AND METHODS: Reports from the literature using the classification system were systematically analyzed. Next, 11 scenarios illustrating difficult cases were prepared to develop a consensus on how to rank the various complications. Third, 7 centers from different continents, having routinely used the classification, independently assessed the 11 scenarios. An agreement analysis was performed to test the accuracy and reliability of the classification. Finally, the perception of the severity was tested in patients, nurses, and physicians by presenting 30 scenarios, each illustrating a specific grade of complication. RESULTS: We noted a dramatic increase in the use of the classification in many fields of surgery. About half of the studies used the contracted form, whereas the rest used the full range of grading. Two-thirds of the publications avoided subjective terms such as minor or major complications. The study of 11 difficult cases among various centers revealed a high degree of agreement in identifying and ranking complications 89% agreement), and enabled a better definition of unclear situations. Each grade of complications significantly correlated with the perception by patients, nurses, and physicians P < 0.05, Kruskal-Wallis test). CONCLUSIONS: This 5-year evaluation provides strong evidence that the classification is valid and applicable worldwide in many fields of surgery. No modification in the general principle of classification is warranted in view of the use in ongoing publications and trials. Subjective, inaccurate, or confusing terms such as “minor or major” should be removed from the surgical literature.


OBJECTIVE: The Affordable Care Act mandates the Prospective Payment System PPS -Exempt Cancer Hospitals Quality Reporting program. These 11 hospitals which are paid fee-for-service rather than on a DRG system began reporting measures 2 general safety, 2 breast, 1 colon in 2013. Given this reporting mandate, we set out to determine whether the PPS-exempt gynecologic oncology programs could identify quality measures specific to the care of our patients. METHODS: A list of 12 quality measures specific to gynecologic oncology was created from sources including the National Quality Forum and the SGO). Measures already in use were not included. The list was ranked by the gynecologic oncology program directors at the PPS-exempt hospitals. Descriptive statistics including mean and SD for rankings were utilized. RESULTS: Despite mandatory reporting of quality measures for PPS-exempt cancer hospitals, little consensus exists regarding specific gynecologic cancer measures. Documentation of debulking status, cancer survival, and offering minimally invasive surgery for endometrial cancer and intraperitoneal chemotherapy for ovarian cancer are important, but with widely variable responses when ranked 1 -12, standard deviations are 2-3. General issues regarding adherence to guidelines for the use of GCSF, documentation of functional status, and tracking of patient satisfaction scores were ranked the lowest. Three of the directors reported that their compensation is partially linked to quality outcomes. CONCLUSIONS: There is wide variability in ranking of quality measures, and may relate to provider or institutional factors. Despite the mandatory reporting in PPS-exempt cancer hospitals, work remains to define gynecologic cancer quality measures.

BACKGROUND: A set of clinical measures indicators, developed by an Australian Council on Healthcare Standards ACHS and Royal Australasian College of Surgeons RACS working party, was introduced into the accreditation programme in 1997. Although early qualitative and quantitative reporting by health-care organizations HCOs reflected their value in stimulating change, the number of HCOs reporting data on this set of clinical indicators CIs has declined, despite an increase in the number of HCOs reporting data on the CIs programme overall. Possible reasons for this decline were sought. METHODS: A retrospective review of prospectively collected surgical CI data was performed, a national survey of stakeholders in the ACHS programme was conducted and a comparison was made with published international data. RESULTS: From a maximum of 247 HCOs reporting data in 2002, the number fell to 168 by 2011. While favourable trends were evident with some CIs, for example, a decline in the rate of negative histology in childhood appendicectomy and in the rate of in-hospital infection in total hip joint replacement, there was minimal change with many of the CIs, suggesting limited responsiveness as measures of care. In the national survey, stakeholder's response was positive overall, but there was a requirement for regular review of CIs. Although some colleges viewed the CIs as simplistic and not reliable, comparisons with similar measures available in the international literature were favourable. CONCLUSIONS: Possible reasons for the declining number of HCOs reporting surgical CI data are a lack of a recent revision of the CIs and a lack of engagement of clinicians from the RACS. Revision of the surgical CI set is required.


AIMS: The standard treatment for advanced ovarian cancer consists of cytoreductive surgery associated with a platinum/paclitaxel-based chemotherapy. Nevertheless, there is still the question as to the extent and timing of the surgical debulking. The aim of this study was to evaluate the place of surgery in the therapeutic sequence. PATIENTS AND METHODS: We reviewed data from all consecutive patients with stage IIIC and IV epithelial ovarian cancer, operated on at our institution between 1990 and 2005. Patients were divided into 2 groups, according to the position of surgery in the therapeutic sequence. Patients in group 1 received initial debulking surgery. Group 2 consisted of patients having received their first debulking after initial chemotherapy. RESULTS: Two hundred and three patients were identified and frequently underwent aggressive surgery, in particular, digestive surgery with bowel resections. Perioperative mortality and morbidity rates were low 2% and 14%, respectively and there was no difference between the groups. Overall survival in group 1 for patients with complete cytoreduction residual disease RD)= 0, optimal surgery RD<1cm or sub -optimal surgery RD>1cm was 50%, 30% and 14%, respectively. In group 2, overall survival following complete surgery was 30%, and no long-term survival was observed when surgery was not complete at the time of interval surgery. Survival was worse for patients who had received more than 4 cycles of neoadjuvant chemotherapy. CONCLUSION: This study confirms the importance of surgery in the prognosis of advanced ovarian cancer. Only the patient subgroup that underwent complete initial or interval surgery was associated with a prolonged remission. Optimal surgery with controlled morbidity can be achieved in many cases, even if bowel resection is needed, at the time of primary debulking. In the interval cytoreductive surgery subgroup, the response to initial chemotherapy and surgery was found to be essential for prognosis.


BACKGROUND: Both "liberal" and "goal-directed" GD) therapy use a large amount of perioperative fluid, but they appear to have very different effects on perioperative outcomes. We sought to determine whether one fluid management strategy was superior to the others. METHODS: We selected randomized controlled trials RCTs on the use of GD or restrictive versus liberal fluid therapy LVR in major adult surgery from MEDLINE, EMBASE, PubMed 1951 to April 2011, and Cochrane controlled trials register without language restrictions. Indirect comparison between the GD and LVR strata was performed. RESULTS: A total of 3861 patients from 23 GD RCTs median sample size = 90,
interquartile range [IQR] 57 to 109 and 1160 patients from 12 LVR RCTs median sample size = 80, IQR 36 to 151 were considered. Both liberal and GD therapy used more fluid compared to their respective comparative arm, but their effects on outcomes were very different. Patients in the liberal group of the LVR stratum had a higher risk of pneumonia risk ratio [RR] 2.2, 95% confidence interval [CI] 1.0 to 4.5, pulmonary edema RR 3.8, 95% CI 1.1 to 13, and a longer hospital stay than those in the restrictive group mean difference [MD] 2 days, 95% CI 0.5 to 3.4. Using GD therapy also resulted in a lower risk of pneumonia RR 0.7, 95% CI 0.6 to 0.9 and renal complications 0.7, 95% CI 0.5 to 0.9, and a shorter length of hospital stay MD 2 days, 95% CI 1 to 3 compared to not using GD therapy. Liberal fluid therapy was associated with an increased length of hospital stay 4 days, 95% CI 3.4 to 4.4, time to first bowel movement 2 days, 95% CI 1.3 to 2.3, and risk of pneumonia RR ratio 3, 95% CI 1.8 to 4.8 compared to GD therapy. CONCLUSION: Perioperative outcomes favored a GD therapy rather than liberal fluid therapy without hemodynamic goals. Whether GD therapy is superior to a restrictive fluid strategy remains uncertain.


OBJECTIVE: Our hypothesis is that the adoption of Department of Health DH) guidance has led to an improvement in outcome in gynaecological cancer survival. SETTING: In 1999 the DH in England introduced the Improving Outcomes in Gynaecological Cancer guidance, advising case management by multidisciplinary teams with surgical concentration in specialist hospitals. This guidance was rapidly adopted in the East of England, with a population of 2.5 million. POPULATION: The population of the Anglia Cancer Network was approximately 2.3 million. METHODS: From 1996 to 2003, details of 3406 cases of gynaecological cancer were identified in the Anglia region of England. Survival analysis was performed by Cox proportional hazards regression, relative to cases diagnosed in 1996. MAIN OUTCOME MEASURE: Primary endpoint was survival. RESULTS: The survival rates for cases diagnosed between 1996 and 1999 were broadly the same across the time period, with a marked improvement taking place in 2000, and continuing to 2003 HR 0.71, 95% CI 0.64 - 0.79, comparing 2000-03 with 1996-99 diagnoses, for all gynaecological sites combined. Adjustment for treatments or method of case follow-up did not attenuate these improvements. There was a concurrent change towards major surgery being performed in specialist centres from 2000. CONCLUSIONS: The adoption of the 1999 guidance on gynaecological cancer, which included multidisciplinary case management and centralisation of surgery, resulted in a marked step-change improvement in survival of gynaecological cancer in an area of eastern England in 2000.


PURPOSE: To evaluate adherence to published recommendations for chemotherapy for ovarian cancer patients in the general community and to identify factors associated with its use. PATIENTS AND METHODS: The study population consisted of 2,150 women residing in Northern California with a first diagnosis of primary epithelial ovarian cancer between January 1994 and December 1996. Patients were identified through the California Cancer Registry and their physicians were surveyed to supplement registry treatment information. RESULTS: Almost 89% of women younger than 75 years with International Federation of Gynecology and Obstetrics stage III or IV tumors received chemotherapy, with levels of treatment highest for women diagnosed at stage III. Patients 75 years of age and older were significantly less likely than younger women to receive chemotherapy 58.2% v 86.1%; P=.001 regardless of stage at diagnosis. Approximately 20% of patients younger than 55 years with early-stage stage IC and II cancer received no chemotherapy. Treatment in an American College of Surgeons hospital and treatment by a gynecologic oncologist increased the likelihood of receiving chemotherapy. Hospitalization for comorbid illness, race/ethnicity, census-based measures of socioeconomic status, and size or teaching status of hospital were all unrelated to probability of treatment after adjustment for other factors. Reasons reported most frequently by physicians for no
treatment were lack of clinical indication and patient refusal. CONCLUSION: The results of this study suggest that, despite scientific evidence and published guidelines that advocate chemotherapy for most women with ovarian cancer, some groups of women did not receive optimum treatment.


BACKGROUND: The aim of this project was to develop a set of quality indicators to assess surgical decision making in the care of patients with non-small cell lung cancer NSCLC. METHODS: A multidisciplinary Expert Panel of 16 physicians used a modified Delphi process to identify quality indicators that evaluated the processes of care in patients with NSCLC. A systematic review identified potential indicators, which were rated on actionability, validity, usefulness, discriminability, and feasibility in two rounds of questionnaires. The first questionnaire was completed by the Expert Panel and by the larger thoracic surgical community of practice; the second questionnaire was sent to only the Expert Panel. Expert Panel members attended an in-person meeting to review the results of the two questionnaires and to compile the final list of indicators by consensus. RESULTS: From the literature review, 41 potential indicators were identified. An additional 16 indicators were suggested by the Expert Panel: 13 indicators in the two rounds of questionnaires and three after the discussion at the in-person meeting. One further indicator was identified after the in-person meeting. In the end, 17 indicators were chosen from seven domains: preoperative assessment, staging, surgical procedures, pathology, adjuvant therapy, surgical outcomes, and miscellaneous CONCLUSIONS: By use of a modified Delphi process, 17 indicators to assess the quality of processes of surgical care for patients with NSCLC were developed.


CONTEXT: In 2007, a systematic review revealed a number of quality indicators referring mostly to palliative care outcomes and processes. Psychosocial and spiritual aspects were scarcely represented. Most publications lacked a detailed description of the development process. With many initiatives and further developments expected, an update is needed. OBJECTIVES: This update gives an overview of the published quality indicators for palliative care and identifies any new developments since 2007 regarding the number and type of indicators developed and the methodology applied. METHODS: The same literature search as in the 2007 review was used to identify relevant publications up to October 2011. Publications describing development processes or characteristics of quality indicators for palliative care were selected by two reviewers independently. RESULTS: The literature search resulted in 435 hits in addition to the 650 hits found in the previous review. Thirteen new publications were selected in addition to the 16 publications selected earlier, describing 17 sets of quality indicators containing 326 indicators. These cover all domains of palliative care as defined by the U.S. National Consensus Project. Most indicators refer to care processes or outcomes. The extent to which methodological characteristics are described varies widely. CONCLUSION: Recent developments in measuring quality of palliative care using quality indicators are mainly quantitative in nature, with a substantial number of new indicators being found. However, the quality of the development process varies considerably between sets. More consistent and detailed methodological descriptions are needed for the further development of these indicators and improved quality measurement of palliative care.


AIMS: To study the role of neoadjuvant chemotherapy NACT followed by surgical cytoreduction in the management of advanced epithelial ovarian cancers. MATERIALS AND METHODS: A retrospective analysis of 82 patients with advanced epithelial ovarian cancers stage IIIC and IV) who were treated with NACT followed by surgical cytoreduction between 1995 and 2004 was performed. Response to NACT, optimal cytoreduction rate, disease-free survival and overall survival were
analyzed. RESULTS: There were 59 patients 72% with stage IIIC disease and 23 28% with stage IV disease. Diagnosis was established by imaging, ascitic fluid cytology and CA-125 estimations in 75% and by laparotomy in 25% of the patients. After NACT, complete response occurred in 17 patients 20.7%, 50 61.0% had partial response and no response was documented in 15 18.3% patients. Optimal surgical cytoreduction could be achieved in 72% of the patients. At the median follow-up of 34 months range 6 -102 months, 5 -year disease-free and overall survivals were 31 and 32% respectively. The median disease free interval was 25.4 months. On multivariate analysis, degree of optimal cytoreduction was the only factor P < 0.05 affecting survival. CONCLUSIONS: NACT followed by surgical cytoreduction is a promising treatment strategy for the management of advanced epithelial ovarian cancers. A significant number of patients exhibit response to NACT. Downstaging following NACT leads to higher optimal cytoreduction rates and improved survival in comparison to historical controls.


BACKGROUND: Because of scarce data from larger series and nonhomogeneous selection criteria, further information is needed on peritonectomy with hyperthermic intraperitoneal chemotherapy HIPEC in managing patients with ovarian peritoneal carcinomatosis. METHODS: In an open, prospective, single-center nonrandomized phase 2 study conducted from November 2000 to April 2007, 47 patients with primary advanced or recurrent ovarian cancer and diffuse peritoneal carcinomatosis were enrolled; 22 underwent primary and 25 secondary cytoreduction plus immediate HIPEC followed by systemic chemotherapy. RESULTS: The overall mean Sugarbaker peritoneal cancer index was 14.9 range, 6 -28. A mean of 6 surgical procedures were required per patient range, 4 -10. In 87.3% of the patients debulking achieved optimal cytoreduction Sugarbaker completeness of cytoreduction [CC] score 0-1, whereas in 12.7% it left macroscopic residual disease CC -2 or CC-3. Major complications developed in 21.3% of the patients and the in-hospital mortality rate was 4.2%. The mean overall survival was 30.4 months, median survival was 24 months, and mean disease-free survival was 27.4 months. Five-year survival was 16.7%. Univariate log-rank test and analysis of variance and multivariate analyses Cox proportional -hazard model) identified the CC score as the main factor capable of independently influencing survival. CONCLUSIONS: Peritonectomy procedures combined with HIPEC offer promising long-term survival in patients with diffuse peritoneal ovarian carcinomatosis. They achieve high adequate primary and secondary surgical cytoreduction rates with acceptable morbidity and mortality.


PURPOSE: There exists a significant gap between the expected and delivered level of quality received in America’s hospitals. As a result, clinical outcomes of critical services such as coronary artery bypass graft CABG) surgery have received unparalleled scrutiny. Medical information technology companies like Solucient and insurance carriers such as Blue Cross of California have identified and published a list of hospitals that demonstrate superior quality and patient outcomes for CABG procedures. These ‘benchmark’ programs serve as a reminder that closing the quality gap is possible. Unfortunately, none of these rankings report cards provide programs that fail to achieve benchmark status with detailed information on the processes or methods necessary to improve performance. METHOD: After identifying hospitals within the Fresenius Medical Care Extracorporeal Alliance FMCEA system that were judged as top performers by benchmark programs by either Solucient ‘100 Top Cardiovascular Hospitals’, Evanston, IL 60201 or Blue Cross of California ‘Centers of Expertise’, Newbury Park, CA 91320, 12 months of continuous collection of CPB -related quality indicator data were analyzed for compliance to the FMCEA evidence-based Quality Indicator Program QIP. A comparison of compliance to the FMCEA CPB indicators was made between the benchmark FMCEA hospitals and the FMCEA peer group hospitals. RESULTS: Seven CPB process indicators were compared: 1 lowest
sustained mean arterial pressure, 2 lowest sustained cardiac index, 3 lowest sustained mixed venous oxygen saturation, 4 lowest sustained hematocrit, 5 lowest activated clotting time, 6 highest sustained arterial blood temperature and 7 average sodium bicarbonate administered. Analysis of hospitals in the FMCEA system designated by Blue Cross of California as 'Centers of Expertise' revealed statistically significantly greater compliance p < 0.05 in all but one CPB indicator. Hospitals in the FMCEA system designated by Solucient's '100 Top Cardiovascular Hospitals' listing revealed statistically significantly greater compliance to all but three CPB quality indicators. CONCLUSIONS: Successful compliance with the majority of FMCEA CPB process indicators correlates with external recognition from two report card systems demonstrating superior hospital performance. Analysis of compliance to process indicators may provide useful guidelines to improve the standard of care in CABG surgery in many hospitals.


BACKGROUND: Quality assurance is increasingly acknowledged as a crucial factor for the surgical treatment of gastric cancer. The purpose of the current study was to define a minimum set of evidence-based quality of care indicators for the surgical treatment of locally advanced gastric cancer. METHODS: A systematic review of the literature published between January 1990 and May 2011 was performed, using search terms on gastric cancer, treatment, and quality of care. Studies were selected based on predefined selection criteria. Potential quality of care indicators were assessed based on their level of evidence and were grouped into structure, process, and outcome indicators. RESULTS: A total of 173 articles were included in the current study. For structural measures, evidence was found for the inverse relationship between hospital volume and postoperative mortality as well as overall survival. Regarding process measures, the most common indicators concerned surgical technique, perioperative care, and multimodality treatment. The only outcome indicator with supporting evidence was a microscopically radical resection. CONCLUSIONS: Although specific literature on quality of care indicators for the surgical treatment of locally advanced gastric cancer is limited, several quality of care indicators could be identified. These indicators can be used in clinical audits and other quality assurance programs.


OBJECTIVE: Although quality assessment is gaining increasing attention, there is still no consensus on how to define and grade postoperative complications. This shortcoming hampers comparison of outcome data among different centers and therapies and over time. PATIENTS AND METHODS: A classification of complications published by one of the authors in 1992 was critically re-evaluated and modified to increase its accuracy and its acceptability in the surgical community. Modifications mainly focused on the manner of reporting life-threatening and permanently disabling complications. The new grading system still mostly relies on the therapy used to treat the complication. The classification was tested in a cohort of 6336 patients who underwent elective general surgery at our institution. The reproducibility and personal judgment of the classification were evaluated through an international survey with 2 questionnaires sent to 10 surgical centers worldwide. RESULTS: The new ranking system significantly correlated with complexity of surgery P < 0.0001 as well as with the length of the hospital stay P < 0.0001. A total of 144 surgeons from 10 different centers around the world and at different levels of training returned the survey. Ninety percent of the case presentations were correctly graded. The classification was considered to be simple 92% of the respondents, reproducible 91%, logical 92%, useful 90%, and comprehensive 89%. The answers of both questionnaires were not dependent on the origin of the reply and the level of training of the surgeons. CONCLUSIONS: The new complication classification appears reliable and may represent a compelling tool for quality assessment in surgery in all parts of the world.
OBJECTIVES: Patients with solid tumors are at greatest risk for dying from their cancers in the five years following diagnosis. For most malignancies, deaths from other chronic diseases begin to exceed those from cancer at some point. As little is known about the causes of death among long-term survivors of ovarian cancer, we examined causes of death by years from diagnosis. METHODS: The Surveillance, Epidemiology, and End Results SEER database was used to identify women diagnosed with ovarian cancer between 1988 and 2012. We compared causes of death by stage, age, and interval time after diagnosis. RESULTS: A total of 67,385 women were identified. For stage I neoplasms, 13.6% CI, 13.0 -14.2% died from ovarian cancer, 4.2% CI, 3.8 -4.5% from cardiovascular disease, 3.6% CI, 3.3 -3.9% from other causes and 2.6% CI, 2.4 -2.9% from other tumors; ovarian cancer was the leading cause of death until 7 years after diagnosis after which time deaths are more frequently due to other causes. For those with stage III-IV tumors, 67.8% CI, 67.3 -68.2% died from ovarian cancer, 2.8% CI, 2.6 -2.9% from other causes, 2.3% CI, 2.2 -2.4% from card iovascular disease and 1.9% CI, 1.7-2.0% from other cancers; ovarian cancer was the most frequent cause of death in years 1 -15 after which time deaths were more commonly due to other causes. CONCLUSIONS: The probability of dying from ovarian cancer decreases with time. Ovarian cancer remains the most common cause of death for 15 years after diagnosis in women with stage III-IV tumors.


BACKGROUND: Very few quality indicators of care exist for surgical procedures. These may be used to both score the quality of care received, and as a method of improving the quality of care delivered quality improvement initiatives. MATERIALS AND METHODS: The goal of this study was to develop a set of evidence-based quality indicators by expert consensus for patients undergoing hepatic resection of colorectal metastases to the liver. A Delphi approach was used to develop a set of evidence-based quality indicators for patients undergoing hepatic resection of colorectal metastases to liver. A panel of experts was formed through nomination by members of the Canadian Hepatopancreatobiliary Society CHPBS. The Delphi process consisted of three iterations of questionnaires. During each round, the panel members were asked to score the potential indicators and suggest any new indicators. RESULTS: A list of 70 potential indicators was generated from the literature, of which 27 achieved consensus for inclusion in the final list of quality indicators. After consolidating similar or redundant indicators, the final list had 18 quality indicators. All of the indicators in the final list were from our original literature search. CONCLUSIONS: This Delphi process has used the best available evidence, along with a consensus methodology employing the opinion of experts in the field, to identify 18 quality indicators for patients undergoing hepatic resection for metastatic colorectal cancer. These indicators will provide a means for benchmarking quality of care among surgeons, institutions, and health regions.


The Halstedian era of radical surgical extirpation for solid tumours dominated the first half of the 20th century. But as understanding of cancer biology increased, a paradigm shift occurred which moved the focus away from extensive surgery towards less radical procedures. Although surgery is a recognised factor in local disease control, prognosis is now believed to be predetermined at the time of diagnosis by the presence of micrometastatic deposits. Modern cancer management consists of more skilled and conservative surgery to remove the primary tumour; adjuvant therapies are also given before and after the operation to target the subclinical metastatic deposits. The most important components of high-quality care in surgical oncology are: sound clinical judgment, surgical skill, and multidisciplinary care. These prerequisites are best achieved by specialisation, but high operative volume is not essential for excision of many types of tumour. Quality assurance using several readily available tools can ensure...
that the process of care from presentation to outcome is constantly improved and that institutional variations in number of cases and quality of care are monitored.


AIMS: Prophylactic hysterectomy with bilateral salpingo-oophorectomy is being increasingly undertaken in patients with Lynch syndrome LS. The pathological features in such specimens are not well described and, unlike the SEE-FIM protocol for salpingo-oophorectomy specimens in BRCA1/2 mutation carriers and the gastrectomy grossing protocols for patients with CDH1 E-cadherin mutations, guidelines have not been devised for the grossing of prophylactic gynaecological specimens from LS patients. We aimed to review the pathological findings in a series of prophylactic gynaecological specimens from LS patients and develop guidelines for the grossing of these specimens.

METHODS AND RESULTS: We reviewed the pathological findings in 25 prophylactic gynaecological specimens from LS patients and audited the grossing protocols in different centres across Ontario, Canada. We found a 32% incidence of endometrial carcinoma or a precursor lesion; the two endometrial cancers identified were low-grade, low-stage endometrioid adenocarcinomas. To address the absence of guidelines for pathological examination, we undertook a literature review of gynaecological malignancies and incidental findings in prophylactic specimens in LS patients.

CONCLUSION: We provide recommendations regarding the grossing of such specimens which includes in-toto examination of the lower uterine segment, endometrium, ovaries and fallopian tubes with representative sampling of the cervix.


BACKGROUND: Despite considerable improvement in the treatment of advanced ovarian cancer, the optimization of efficacy and tolerability remains an important issue. Therefore, we performed a randomized, phase III non-inferiority trial comparing paclitaxel plus cisplatin PT with paclitaxel plus carboplatin TC in patients with advanced ovarian cancer. METHODS: A total of 798 patients with International Federation of Gynecology and Obstetrics stage IIB-IV were randomly assigned to receive six courses of either PT or TC at 3-week intervals. The primary endpoint was the proportion of patients without progression at 2 years. Secondary endpoints included toxicity, response to treatment, quality of life, and overall and progression-free survival time. Quality of life was evaluated using the European Organization for Research and Treatment of Cancer quality-of-life questionnaire QLQ-C30, version 2.0. Survival curves were calculated using the Kaplan-Meier method, and hazard ratios were estimated using the Cox proportional hazards model. RESULTS: The proportion of patients without progression at 2 years was not statistically significantly different between the two treatment arms 40.0% for PT versus 37.5% for TC, difference = 2.5%, one-sided 95% confidence interval [CI] = - infinity to 8.2%. Median progression-free survival time in the TC arm 17.2 months, 95% CI = 15.2 to 19.3 months and the PT arm 19.1 months, 95% CI = 16.7 to 21.5 months were also not statistically significantly different; the same was true of median overall survival time 43.3 months, 95% CI = 37.2 to 47.8 months versus 44.1 months, 95% CI = 40.2 to 49.4 months, for the TC and PT arms, respectively. The TC regimen was associated with a higher frequency of hematologic toxicity, but a lower frequency of gastrointestinal and neurologic toxicity, than the PT regimen. Mean global quality-of-life scores at the end of treatment were statistically significantly better in the TC arm than in the PT arm 65.25 versus 51.97, respectively; difference = -13.28, 95% CI = -18.88 to -7.68. CONCLUSION: The TC regimen achieved comparable efficacy to the PT regimen but was associated with better tolerability and quality of life, and should, therefore, be considered as an important alternative for standard first-line chemotherapy in patients with advanced ovarian cancer.

BACKGROUND: Primary surgery followed by platinum-taxane based chemotherapy has been the standard therapy in advanced ovarian cancer. However, the prognostic role of complete and so-called optimal and suboptimal debulking and its interaction with biological factors has not been fully defined. METHODS: Exploratory analysis was conducted of 3 prospective randomized trials AGO-OVAR 3, 5, and 7 investigating platinum-taxane based chemotherapy regimens in advanced ovarian cancer conducted between 1995 and 2002. RESULTS: A total of 3126 patients were analyzed. Approximately one-third each fulfilled criteria for complete resection group A, small residual tumor burden of 1-10 mm group B, or macroscopic residual disease exceeding 1 cm in diameter group C. Multivariate analysis showed improved progression-free and overall survival for group A with complete resection compared with groups B or C P<.0001. The impact of so-called optimal debulking as in group B showed a smaller prognostic impact compared with group C. Further independent prognostic factors for overall survival were age, performance status, grade, FIGO stage, and histology, namely the mucinous subtype. An interaction between residual tumor and some biologic factors was demonstrated. CONCLUSIONS: The goal of primary surgery should be complete resection. The prognostic impact of tumor biology seemed to be partially overruled by residual tumor and further evaluation of biologic factors should stratify for residual tumor.


The purpose of this study was to evaluate the pattern and quality of care for ovarian cancer in Germany and analyze prognostic factors with emphasis on characteristics of treating institutions, hospital volume, and participation in clinical trials. This study utilized national survey including patients with histologically proven invasive epithelial ovarian cancer diagnosed in the third quarter of 2001 including descriptive analysis of pattern of surgical care and systemic treatment in early FIGO I-IIA and advanced FIGO IIB-IV) ovarian cancer and both univariate and multivariate analysis of prognostic factors. One third of all patients diagnosed in the third quarter of 2001 in Germany, 476 patients, were included. Standard care according to German guidelines was provided to only 35.5% of patients with early ovarian cancer. Recommended chemotherapy was given to 78% in advanced disease. Multivariate analysis showed advanced stage, poor performance status, comorbidity, ascites, and treatment in an institution not participating in cooperative studies to be associated with inferior survival. Non-participation was associated with an 82% increase of risk HR = 1.82; 95% CI, 1.27 -2.61; P= 0.001. Hospital volume did not affect treatment outcome. Adherence to treatment guidelines showed remarkable variety among German hospitals, indicating options and need for improvement. Selecting an institution that participates in cooperative trials might be an option for individual patients seizing the chance for better quality of care even when individual factors might hamper enrollment in a study.


OBJECTIVE: Ovarian cancer outcome varies among different institutions, regions, and countries. This systematic review summarizes the available data evaluating the impact of different physician and hospital characteristics on outcome in ovarian cancer patients. METHODS: A MEDLINE database search for pertinent publications was conducted and reference lists of each relevant article were screened. Experts in the field were contacted. Selected studies assessed the relationship between physician and/or hospital specialty or volume and at least one of the outcomes of interest. The primary outcome was survival. Additional parameters included surgical outcome debulking, completeness of staging, and quality of chemotherapy. The authors independently reviewed each article and applied the inclusion/exclusion criteria. The quality of each study was assessed by focusing on strategies to control for important prognostic factors. RESULTS: Forty-four articles met inclusion criteria. Discipline and sub-specialization of the primary treating physician were identified as the most important variable.
associated with superior outcome. Evidence showing a beneficial impact of institutional factors was weaker, but followed the same trend. Hospital volume was hardly related to any outcome parameter. CONCLUSIONS: The limited evidence available showed considerable heterogeneity and has to be interpreted cautiously. Better utilization of knowledge about institutional factors and well-established board certifications may improve outcome in ovarian cancer. Patients and primary-care physicians should select gynecologic oncologists for primary treatment in countries with established sub-specialty training. Policymakers, insurance companies, and lay organizations should support development of respective programs.


PURPOSE: Despite the progress that has been achieved, long-term survival rates in patients with advanced ovarian cancer are still disappointing. One attempt to improve results could be the addition of non-cross-resistant drugs to platinum-paclitaxel combination regimens. Anthracyclines were among the candidates for incorporation as a third drug into first-line regimens. PATIENTS AND METHODS: We performed a prospectively randomized phase III study comparing carboplatin-paclitaxel TC; area under the curve 5/175 mg/m², respectively with epirubicin 60 mg/m² added to the same combination TEC in previously untreated patients with advanced epithelial ovarian cancer. All drugs were administered intravenously on day 1 of a 3-week schedule for a planned minimum of six courses. RESULTS: Between November 1997 and February 2000, 1,282 patients were randomly assigned to receive either TC 635 patients or TEC 647 patients, respectively. Grade 3/4 hematologic and some nonhematologic toxicities nausea/emesis, mucositis, and infections occurred significantly more frequently in the TEC arm. Accordingly, quality-of-life analysis showed inferiority of TEC versus TC. Median progression-free survival time was 18.4 months for the TEC arm and 17.9 months for the TC arm hazard ratio [HR], 0.95; 95% CI, 0.83 to 1.07; P = .3342. Median overall survival time was 45.8 months for the TEC arm and 41.0 months for the TC arm HR, 0.93; 95% CI, 0.81 to 1.08; P = .3652. Similar nonsignificant differences were observed when strata were analyzed separately. CONCLUSION: Addition of epirubicin to TC did not improve survival or time to treatment failure in patients with advanced epithelial ovarian cancer; therefore, it cannot be recommended for clinical use in this population.


BACKGROUND: For many diseases, specialized care i.e., care rendered by a specialist) has been associated with superior-quality care i.e., better outcomes. We examined associations between physician specialty and outcomes in a population-based cohort of elderly ovarian cancer surgery patients. METHODS: We analyzed the Medicare claims, by physician specialty, of all women aged 65 years or older who underwent surgery for pathologically confirmed invasive epithelial ovarian cancer between January 1, 1992, and December 31, 1999, while living in an area monitored by the Surveillance, Epidemiology, and End Results SEER program to assess important care processes i.e., the appropriate extent of surgery and use of adjuvant chemotherapy and outcomes i.e., surgical complications, ostomy rates, and survival). All statistical tests were two-sided. RESULTS: Among 3067 ovarian cancer patients who underwent surgery, 1017 patients 33% were treated by a gynecologic oncologist, 1377 patients 45% by a general gynecologist, and 673 patients 22% by a general surgeon. Among patients with stage I or II disease, those treated by a gynecologic oncologist 60% were more likely to undergo lymph node dissection than those treated by a general gynecologist 53% or a general surgeon 40%; P < .001 and were more likely to receive postoperative chemotherapy when operated on by a gynecologic oncologist 79% or a general
gynecologist 76% than by a general surgeon 62%, \( P < .001 \). Survival among patients operated on by gynecologic oncolo
gists hazard ratio [HR] of death from any cause = 0.85, 95% confidence interval [CI] = 0.76 to 0.95 or general gynecologists HR = 0.86, 95% CI = 0.78 to 0.96 was better than that among patients operated on by general surgeons. CONCLUSIONS: Ovarian cancer patients treated by gynecologic oncolo
gists had marginally better outcomes than those treated by general gynecologists and clearly superior outcomes compared with patients treated by general surgeons.


OBJECTIVE: To identify valid and feasible quality indicators for the primary care of osteoarthritis OA. DESIGN: Systematic review and narrative synthesis. DATA SOURC ES: Electronic reference databases MEDLINE, EMBASE, CINAHL, HMIC, PsychINFO), quality indicator repositories, subject experts. ELIGIBILITY CRITERIA: Eligible articles referred to adults with OA, focused on development or implementation of quality indicators, and relevant to UK primary care. An English language restriction was used. The date range for the search was January 2000 to August 2013. The majority of OA management guidance has been published within this time frame. DATA EXTRACTION: Relevant studies were quality assessed using previous quality indicator methodology. Two reviewers independently extracted data. Articles were assessed through the Outcome Measures in Rheumatology filter; indicators were mapped to management guidance for OA in adults. A narrative synthesis was used to combine the indicators within themes. RESULTS: 10 853 articles were identified from the search; 32 were included in the review. Fifteen indicators were considered valid and feasible for implementation in primary care; these related to assessment non-pharmacological and pharmacological management. Another 10 indicators were considered less feasible, in various aspects of assessment and management. A small number of recommendations had no published corresponding quality indicator, such as use of topical non-steroidal anti-inflammatory drugs. No negative 'do not do' indicators were identified. CONCLUSIONS AND IMPLICATIONS OF KEY FINDINGS: There are well-developed, feasible indicators of quality of care for OA which could be implemented in primary care. Their use would assist the audit and quality improvement for this common and frequently disabling condition.


OBJECTIVE: In advanced ovarian cancer, patients cytoreduced to no visible disease appear to have improved survival compared to patients with visible residual tumor \(< \ 10 \ 10 \ mm \) disease. It remains unresolved whether this is due to better chemotherapy response and/or simply "re-setting the clock," such that patients with less residual disease take longer to recur and succumb to their disease. METHODS: We reviewed the records of all patients who had primary surgery for stage IIIC-IV ovarian cancer at our institution from 1998-2004, followed by intravenous platinum-taxane chemotherapy. Primary outcome measures were complete response CR to initia l chemotherapy, platinum resistance at 6 months, progression-free PFS, and overall survival OS. RESULTS: A total of 296 patients met study criteria, of whom 64 22% had cytoreduction to no visible disease, 145 49% had 1 -10 mm residual disease, and 87 29% had > 10 mm residual disease. After multivariate analyses, patients cytoreduced to no visible disease demonstrated significant improvements in rates of initial complete response and incidence of platinum resistance, as well as subsequent improvement in PFS and OS, compared to the other two groups. Similarly, patients with 1-10 mm residual disease had improved outcomes compared to patients with > 10 mm residual disease for each endpoint. CONCLUSIONS: In ovarian cancer patients with < 10 mm residual disease who began platinum-taxane therapy, maximal cytoreduction to no visible residual disease was associated with improved initial chemotherapy response, less platinum resistance, and improved survival. Maximal cytoreduction may improve survival through increased sensitivity to initial chemotherapy and should be the goal of initial surgery in these patients.
OBJECTIVES: To determine the survival impact of adding extensive upper abdominal surgical cytoreduction to standard surgical techniques for advanced ovarian cancer. METHODS: The records of all patients with stages IIIIC-IV epithelial ovarian cancer who underwent primary surgery at our institution from 1998 to 2003 were reviewed. The cohort was divided into 3 groups. Group 1 patients required extensive upper abdominal surgery, such as diaphragm peritonectomy/resection, resection of parenchymal liver or porta hepatis disease and/or splenectomy with or without distal pancreatectomy, to achieve optimal cytoreduction residual disease $\leq$1 cm. Group 2 patients were optimally cytoreduced by standard surgical techniques, including hysterectomy, oophorectomy, omentectomy, and bowel resection. Group 3 patients were suboptimally cytoreduced. Primary outcome measures were response to primary chemotherapy, progression-free survival, and overall survival. RESULTS: The cohort of 262 patients was divided as follows: Group 1, 57 patients; Group 2, 122 patients; and Group 3, 83 patients. The median follow-up was 36 months range, 1-94 months. Frequency of clinical complete response in Groups 1, 2, and 3 was 82%, 78%, and 57%, respectively. The median progression-free survival for Groups 1, 2, and 3 was 24, 23, and 11 months, respectively. Progression-free survival for Groups 1 and 2 were equivalent $P=0.53$ and were significantly longer than for Group 3 $P<0.001$. The median overall survival was 84 and 38 months for Groups 2 and 3, respectively, and had not been reached for Group 1 by 68 months. Patients in Group 1 had equivalent overall survival to patients in Group 2 $P=0.74$ and improved survival over patients in Group 3 $P<0.001$. Prognostic factors significant on multivariate analysis included stage, optimal status, and ascites. CONCLUSIONS: Patients requiring extensive upper abdominal procedures to achieve optimal cytoreduction demonstrated a similar initial response, progression-free survival, and overall survival to patients optimally cytoreduced by standard surgical techniques. The presence of bulky upper abdominal disease alone did not appear to indicate poor tumor biology. This initial maximal surgical effort was associated with improved survival in patients who would have otherwise been suboptimally cytoreduced.
advanced epithelial ovarian cancer should undergo primary cytoreductive surgery with the intention of complete tumor removal.


OBJECTIVE: The purpose of this study was to determine the relative influences of the extent of disease present before surgery and completeness of cytoreduction on survival for patients with advanced ovarian cancer. METHODS: Patients 408 with stage IIIC epithelial ovarian cancer had cytoreductive surgery before systemic platinum-based combination chemotherapy. A ranking system 0 -3 was devised to prospectively quantify the extent of disease involving: 1 right upper quadrant diaphragm/hepatic, and adjacent peritoneal surfaces, 2 left upper quadrant omentum/gastro -colic ligament, spleen, stomach, transverse colon, splenic flexure of colon, 3 pelvis reproductive organs, recto-sigmoid, pelvic peritoneum, 4 retroperitoneum pelvic/aortic nodes, and 5 central abdomen small bowel, ascending/descending colon, mesentery, anterior abdomen wall, pericolic gutters. Survival was analyzed log rank and Cox regression on the basis of the rankings at these anatomic regions, the sum of intraabdominal rankings, and the cytoreductive outcome. RESULTS: Overall median and estimated 5-year survivals were 58.2 months and 49%. On univariate analysis, the central abdominal P = 0.008 and left upper quadrant P = 0.03 rankings, the sum of rankings P = 0.01, and the cytoreductive outcome P </= 0.0001 influenced survival log rank. Survival was independently stepwise Cox model) influenced by the sum of rankings 0 -5, RR 1.00; 6-10, RR 1.24; 11-15, RR 1.44; P = 0.05, and completeness of cytoreduction visibly disease -free, RR 1.00; </=1 cm residual, RR 2.32; >1 cm residual, RR 2.98; P = 0.001. CONCLUSIONS: Cytoreduction to a visibly disease-free outcome has a more significant influence on survival than the extent of metastatic disease present before surgery. Operative efforts should not be abbreviated on the hypothesis that extensive disease at specific anatomic regions precludes long-term survival.


A retrospective study was conducted to determine the influence of subspecialty training in gynecologic oncology as well as several other covariates on the feasibility, operative mortality, and survival benefits of cytoreductive surgery for 263 patients with stages IIIC and IVA epithelial ovarian cancer. Covariates most predictive of an optimal < or = 1 cm cytoreductive outcome were the diameter of the largest metastases before cytoreduction < or = 10 cm vs > 10 cm, P < 0.001 and the specialty training of the physicians present at surgery gynecologic oncologists vs other, P < 0.001. Age influenced operative mortality most < 60 vs > or = 60, P < 0.001. Covariates found to most significantly influence survival time include the specialty training of the physicians present at surgery gynecologic oncologists vs other, P < 0.0001, cytoreductive outcome complete vs optimal, P = 0.001, optimal vs suboptimal, P < 0.0001, grade of tumor grade 1 vs grades 2 and 3, P = 0.01, and pelvic disease status frozen pelvis vs mobile primary tumor, P = 0.03. We conclude that patients with advanced epithelial ovarian cancer should undergo aggressive cytoreductive surgery by gynecologic oncologists, with the objective to remove all macroscopic disease. Subsequent treatment with platinum-based chemotherapy offers the best chance for long-term survival or cure.

Gynaecologic Oncology group GOG) currently defines 'optimal' as having residual tumour nodules each measuring 1 cm or less in maximum diameter, with complete cytoreduction microscopic disease being the ideal surgical outcome. Although the size of residual tumour masses after surgery has been shown to be an important prognostic factor for advanced ovarian cancer, it is unclear whether it is the surgical procedure that is directly responsible for the superior outcome that is associated with less residual disease. OBJECTIVES: To evaluate the effectiveness and safety of optimal primary cytoreductive surgery for women with surgically staged advanced epithelial ovarian cancer stages III and IV. To assess the impact of various residual tumour sizes, over a range between zero and 2 cm, on overall survival. SEARCH STRATEGY: We searched the Cochrane Central Register of Controlled Trials CENTRAL The Cochrane Library 2010, Issue 3 and the Cochrane Gynaecological Cancer Review Group Trials Register, MEDLINE and EMBASE up to August 2010. We also searched registers of clinical trials, abstracts of scientific meetings, reference lists of included studies and contacted experts in the field. SELECTION CRITERIA: Retrospective data on residual disease from randomised controlled trials RCTs or prospective and retrospective observational studies which included a multivariate analysis of 100 or more adult women with surgically staged advanced epithelial ovarian cancer and who underwent primary cytoreductive surgery followed by adjuvant platinum-based chemotherapy. We only included studies that defined optimal cytoreduction as surgery leading to residual tumours with a maximum diameter of any threshold up to 2 cm. DATA COLLECTION AND ANALYSIS: Two review authors independently abstracted data and assessed risk of bias. Where possible, the data were synthesised in a meta-analysis. MAIN RESULTS: There were no RCTs or prospective non-RCTs identified that were designed to evaluate the effectiveness of surgery when performed as a primary procedure in advanced stage ovarian cancer. We found 11 retrospective studies that included a multivariate analysis that met our inclusion criteria. Analyses showed the prognostic importance of complete cytoreduction, where the residual disease was microscopic that is no visible disease, as overall OS and progression-free survival PFS were significantly prolonged in these groups of women. PFS was not reported in all of the studies but was sufficiently documented to allow firm conclusions to be drawn. When we compared suboptimal > 1 cm versus optimal < 1 cm cytoreduction the survival estimates were attenuated but remained statistically significant in favour of the lower volume disease group. There was no significant difference in OS and only a borderline difference in PFS when residual disease of > 2 cm and < 2 cm were compared hazard ratio HR 1.65, 95% CI 0.82 to 3.31; and HR 1.27, 95% CI 1.00 to 1.61, P = 0.05 for OS and PFS respectively. There was a high risk of bias due to the retrospective nature of these studies where, despite statistical adjustment for important prognostic factors, selection bias was still likely to be of particular concern. Adverse events, quality of life QoL and cost effectiveness were not reported by treatment arm or to a satisfactory level in any of the studies. AUTHORS' CONCLUSIONS: During primary surgery for advanced stage epithelial ovarian cancer all attempts should be made to achieve complete cytoreduction. When this is not achievable, the surgical goal should be optimal < 1 cm residual disease. Due to the high risk of bias in the current evidence, randomised controlled trials should be performed to determine whether it is the surgical intervention or patient-related and disease-related factors that are associated with the improved survival in these groups of women. The findings of this review that women with residual disease < 1 cm still do better than women with residual disease > 1 cm should prompt the surgical community to retain this category and consider re-defining it as 'near optimal' cytoreduction, reserving the term 'suboptimal' cytoreduction to cases where the residual disease is > 1 cm optimal/near optimal/suboptimal instead of complete/optimal/suboptimal).


OBJECTIVE: To assess the quality of the operative reports from cases of ovarian cancer surgery in Ontario. METHODS: We undertook a population cohort study including all newly diagnosed ovarian cancer patients treated initially with surgery from January 1996 to December 1998 in Ontario n = 1341. We abstracted charts from hospitals and cancer centres. All surgical and pathology notes were abstracted into an ACCESS database. RESULTS: A total of 1,341 women had surgery as the first step
in management of ovarian cancer. A vertical abdominal incision was used in 87.6% of these cases. Peritoneal cytology was obtained in 87.8% of cases overall, but in only 69.5% of stage 1 cases. A description of the ovaries was provided in 85% of reports, of the uterus in 70%, the diaphragm in 53%, the liver in 69%, the pelvic lymph nodes in 10%, and the para-aortic lymph nodes in 41%. In stage 1 cases, the ovaries were assessed histologically in 89% of cases, the uterus in 80%, the peritoneum in 20%, the appendix in 9%, the pelvic lymph nodes in 10%, and the para-aortic lymph nodes in 7%. Frozen section was obtained in half of the stage 1 cases, and the false negative rate for identifying malignancy was 6%. In all, 23% of women received adequate surgical staging for stage 1 disease, and 12% of women with advanced disease had optimal debulking to less than 1 cm residual disease. There are clear differences between centres with a gynaecologic oncologist on staff and other centres in the adequacy of surgical staging in women with stage 1 disease chi2 = 60.6, P < 0.0001 and in optimal debulking for advanced disease chi2 = 39.1, P < 0.0001. In 40% of cases with advanced disease, the amount of residual disease following surgery is not reported. CONCLUSION: The current approach of dictating operative notes does not provide sufficient detail in a large number of cases; this affects treatment decisions and limits our ability to assess quality indicators for operative care in ovarian cancer. This problem is pervasive but is more significant in centres without a gynaecologic oncologist. 


OBJECTIVE: The objective was to determine the relationship among hospital volume of ovarian cancer surgery, academic status of institution, surgical specialty, and outcomes of care 30 -day postoperative mortality, reoperation rate, and overall survival). METHODS: This population-based cohort study included all newly diagnosed ovarian cancer patients treated from 1992 to 1998 in Ontario, Canada. Hospitalization and surgical billing databases were used. Logistic regression was used to evaluate the importance of hospital type, hospital volume, surgical specialty, and surgeon volume of ovarian cancer operations on postoperative mortality, reoperation rates, and survival. RESULTS: Ovarian cancer surgery was performed on 3815 women between April 1992 and March 1998. When adjusted for age, comorbidity, acuity of the operation, and metastatic disease, no factors influenced postoperative mortality. The adjusted relative risk for reoperation within 3 months of the initial surgery showed that patients were less likely to have a repeat operation if the initial operation was done in a high- or intermediate-volume hospital RR 0.24 95% CI 0.12 -0.48, RR 0.29 95% CI 0.20-0.42, respectively, a hospital with a gynecologic oncologist RR 0.29 95% CI 0.15 -0.56, by a gynecologic oncologist RR 0.04 95% CI 0.01-0.12 or gynecologist RR 0.37 95% CI 0.21 -0.66, or by a high -volume surgeon RR 0.09 95% CI 0.03-0.23. The adjusted survival was improved if the initial surgery was done by a gynecologic oncologist HR 0.70 95% CI 0.57 -0.85 or gynecologist HR 0.65 95% CI 0.53-0.79. CONCLUSIONS: There is a relationship between hospital volume and reoperation rate. Institution type only influenced reoperation rate. Statistically significant associations were found between surgical specialty and all three outcome variables. The volume of surgery performed by an individual surgeon only influenced reoperation rate. Our results are preliminary but support the need for further studies examining factors such as stage. 


OBJECTIVE: We sought to assess whether the specialty of the surgeon or the hospital involved in the initial management of women with ovarian cancer determined the likelihood of unnecessary repeated abdominal surgery and long-term patient survival. METHODS: We conducted a population-based study involving women in Ontario, Canada, who had epithelial ovarian cancer treated initially with abdominal surgery between January 1996 and December 1998. We documented incident surgical cases using hospital contact data and the Ontario Cancer Registry. We obtained data on patient characteristics, clinical findings, surgical techniques and perioperative care from electronic administrative data records and patient charts. We performed regression analyses to assess the influence of surgeon and hospital specialization and of case volumes on the likelihood of repeat surgery and survival. We controlled for
stage of disease and other factors associated with these outcomes. We also examined the relation between the adequacy of surgery and adjuvant chemotherapy with survival. RESULTS: A total of 1341 women met our inclusion criteria. Our analysis showed that repeat surgery was associated with the surgeon's discipline, younger patient age, well-differentiated tumours and early stage of disease. However, survival was not associated with the surgeon's discipline; rather, it was associated with advanced patient age, increasing comorbidities, advanced stage of disease, poorly differentiated tumours, urgent surgery and adjuvant chemotherapy. We observed a trend between inadequate surgery and a decreased likelihood of survival. CONCLUSION: Further study is needed to understand patterns of repeat surgery for ovarian cancer. Improved quality of operative reporting is required to classify surgical adequacy.


In summary, the AHRQ QIs are a set of readily available programs that can be downloaded without charge from the AHRQ Web site. The methodology is completely open and accessible to all users. The QI software can be applied to hospital administrative data that is available within individual institutions or from state data organizations and hospital associations and can provide valuable insights into health care quality at extremely low cost. The QIs have been incorporated into numerous quality assessment reports, including hospital-specific reports, with the aim of improving health care quality at a reasonable cost. With enhancements currently underway, the QIs will be an even more valuable part of the toolkit to improve health care quality in the United States.


BACKGROUND: Consultant gynecologic oncologists from the regional Comprehensive Cancer Center assisted community gynecologists in the surgical treatment of patients with ovarian carcinoma when they were invited. For this report, the authors evaluated the effects of primary surgery by a gynecologic oncologist on treatment outcome. METHODS: The hospital files from 680 patients with epithelial ovarian carcinoma who were diagnosed between 1994 and 1997 in the northern part of the Netherlands were abstracted. Treatment results were analyzed according to the operating physician's education by using survival curves and univariate and multivariate Cox regression analyses. RESULTS: Primary surgery was performed on 184 patients by gynecologic oncologists, and on 328 patients by general gynecologists. Gynecologic oncologists followed surgical guidelines more strictly compared with general gynecologists patients with International Federation of Gynecology and Obstetrics [FIGO] Stage I-II disease, 55% vs. 33% [P=0.01]; patients with FIGO Stage III disease, 60% vs. 40% [P=0.003] and more often removed all macroscopic tumor in patients with FIGO Stage III disease 24% vs. 12%; P=0.02. When patients were stratified according to FIGO stage, the 5-year overall survival rate was 86% versus 70% P=0.03 for patients with Stage I -II disease and 21% versus 13% P=0.02 for patients with Stage III-IV disease who underwent surgery by gynecologic oncologists and general gynecologists, respectively. The hazards ratio for patients who underwent surgery by gynecologic oncologists was 0.79 95% confidence interval [95%CI], 0.61 -1.03; adjusted for patient age, disease stage, type of hospital, and chemotherapy; when patients age 75 years and older were excluded, the hazards ratio fell to 0.71 95% CI, 0.54 -0.94 in multivariate analysis. CONCLUSIONS: The surgical treatment of patients with ovarian carcinoma by gynecologic oncologists occurred more often according to surgical guidelines, tumor removal more often was complete, and survival was improved.

BACKGROUND: Continuing medical education CME is compulsory for physicians in Iran. Recent studies in Iran show that modifications of CME elements are necessary to improve the effectiveness of the educational programmes. Other studies point to an inappropriate, even irrational drug prescribing. Based on a needs assessment study regarding CME for general physicians in the East Azerbaijan province in Iran, rational prescribing practice was recognized as a high priority issue. Considering different educational methods, outcome-based education has been proposed as a suitable approach for CME. The purpose of the study was to obtain experts’ consensus about appropriate educational outcomes of rational prescribing for general physicians in CME and developing curricular contents for this education. METHODS: The study consisted of two phases: The first phase was conducted using a two-round Delphi consensus process to identify the outcome-based educational indicators regarding rational prescribing for general physicians in primary care GPs. In the second phase the agreed indicators were submitted to panels of experts for assessment and determination of content for a CME program in the field. RESULTS: Twenty one learning outcomes were identified through a modified Delphi process. The indicators were used by the panels of experts and six educational topics were determined for the CME programme and the curricular content of each was defined. The topics were 1 Principles of prescription writing, 2 Adverse drug reactions, 3 Drug interactions, 4 Injections, 5 Antibiotic therapy, and 6 Anti-inflammatory agents therapy. One of the topics was not directly related to any outcome, raising a question about the need for a discussion on constructive alignment. CONCLUSIONS: Consensus on learning outcomes was achieved and an educational guideline was designed. Before suggesting widespread use in the country the educational package should be tested in the CME context.


Concerns about medicolegal implications of a multidisciplinary approach to cancer care may act as a barrier to the implementation of best practice approaches. While multidisciplinary meetings carry a low level of medicolegal risk, improved documentation and transparency in approach will assist in limiting liability for individual health professionals and health services. The medicolegal implications of a multidisciplinary approach are not affected by whether a health professional bills the patient for attendance at multidisciplinary meetings.


OBJECTIVE: The purpose of this study was to evaluate differences in morbidity, progression-free interval, and survival in women with advanced epithelial ovarian cancer treated with initial chemotherapy versus initial surgery. STUDY DESIGN: All women with epithelial ovarian cancer who were treated surgically at our hospital between January 1, 1995, and January 1, 2003, were eligible; the cases of 200 patients met the criteria and underwent retrospective chart review. RESULTS: Ninety-eight patients 49% had initial chemotherapy, and 102 patients 51% had initial surgery. Patients who received initial chemotherapy were more likely to have stage IV disease initial chemotherapy, 27%, vs initial surgery, 8%; P = .042 and grade 3 disease initial chemotherapy, 73%, vs initial surgery, 61%; P = .025. Optimal cytoreduction was achieved more often in patients who received initial chemotherapy initial chemotherapy, 86%, vs initial surgery, 54%; P < .001. Only optimal cytoreduction P = .022, and not treatment choice P = .089, had an impact on median survival. CONCLUSION: Initial chemotherapy is a reasonable alternative to initial surgery for the treatment of selected patients with advanced epithelial ovarian cancer.


INTRODUCTION: Cancer incidence and mortality estimates for 25 cancers are presented for the 40 countries in the four United Nations-defined areas of Europe and for the European Union EU-27 for
2012. METHODS: We used statistical models to estimate national incidence and mortality rates in 2012 from recently-published data, predicting incidence and mortality rates for the year 2012 from recent trends, wherever possible. The estimated rates in 2012 were applied to the corresponding population estimates to obtain the estimated numbers of new cancer cases and deaths in Europe in 2012.

RESULTS: There were an estimated 3.45 million new cases of cancer excluding non-melanoma skin cancer and 1.75 million deaths from cancer in Europe in 2012. The most common cancer sites were cancers of the female breast 464,000 cases, followed by colorectal 447,000, prostate 417,000 and lung 410,000. These four cancers represent half of the overall burden of cancer in Europe. The most common causes of death from cancer were cancers of the lung 353,000 deaths, colorectal 215,000, breast 131,000 and stomach 107,000. In the European Union, the estimated numbers of new cases of cancer were approximately 1.4 million in males and 1.2 million in females, and around 707,000 men and 555,000 women died from cancer in the same year. CONCLUSION: These up-to-date estimates of the cancer burden in Europe alongside the description of the varying distribution of common cancers at both the regional and country level provide a basis for establishing priorities to cancer control actions in Europe. The important role of cancer registries in disease surveillance and in planning and evaluating national cancer plans is becoming increasingly recognised, but needs to be further advocated. The estimates and software tools for further analysis EUCAN 2012 are available online as part of the European Cancer Observatory ECO) http://eco.iarc.fr.


OBJECTIVE: Geriatric population life expectancy is increasing and so is the incidence of epithelial ovarian cancer EOC in elderly women. The aim of our study was to determine the impact of radical cytoreductive surgery, the cornerstone of clinical management in primary EOC, in this population with special regard to the associated morbidity. METHODS: Through a pooled data analysis, cancer-related patient characteristics, intraoperative tumor pattern, and surgical and clinical outcomes were evaluated according to a validated documentation data collection tool. Kaplan-Meier curves were calculated for overall survival OS. The Cox regression analysis was performed to identify independent predictors of mortality. RESULTS: One hundred one EOC patients older than 69 years mean [SD] age, 75.54 [4.49] years were evaluated. The mean (SD) follow-up period was 22.63 22.92 months. Advanced International Federation of Gynecology and Obstetrics stage III 60.4% was the most common tumor stage. A complete tumor resection was achieved in 45 patients 44.6% with an associated complication rate of 40.6%. The postoperative mortality was 6%. The mean OS was 47.29 months 95% confidence interval, 36.24-58.34. The multivariate analysis identified age older than 75 years, incomplete tumor resection, and absence of adjuvant chemotherapy to negatively affect OS. CONCLUSIONS: Radical surgery for primary EOC obtaining complete tumor resection is associated with a significantly prolonged OS in elderly patients > or =70 years. The increased postoperative morbidity must be considered, underlining the high requirement for special interdisciplinary postoperative management in this special collective.


A total of 251 patients with epithelial ovarian cancer EOC treated between 2002 and 2008 was retrospectively analyzed to investigate the long-term outcomes and prognostic factors of these patients, particularly those who underwent primary debulking surgery followed by platinum-based chemotherapy. Clinicopathological parameters, including progression-free survival PFS and overall survival OS, were also analyzed. The median follow-up period from the end of initial treatment to June 2010 was 58 months. The three-year PFS rate was 61.7% for International Federation of Gynecology and Obstetrics FIGO) I-II, 19.9% for FIGO III-IV, and 33.9% for all stages. By
comparison, the five-year PFS rate was 44.6% for FIGO I-II, 17.7% for FIGO III-IV, and 28.3% for all stages. The three-year OS rate was 67.9% for FIGO I-II, 41.7% for FIGO III-IV, and 50.2% for all stages. The five-year OS rate was 52.7% for FIGO I-II, 30.8% for FIGO III-IV, and 39.2% for all stages. Univariate analysis revealed that advanced FIGO stage, serum CA125, and suboptimal debulking were significant factors affecting PFS and OS. In multivariate analysis, PFS was significantly influenced by FIGO stage and suboptimal debulking. However, OS was significantly influenced by advanced FIGO stage only. Our study confirms the efficacy of surgery followed by platinum-based chemotherapy for EOC. FIGO stage is considered as one of the most reliable predictors of the prognosis of patients with EOC.


OBJECTIVE: The aim of this retrospective multicenter study was to assess whether the pre-chemotherapy hemoglobin levels have any impact on the clinical outcome of patients with advanced epithelial ovarian cancer who received a first-line taxane/platinum-based regimen. METHODS: The study was conducted on 315 patients who underwent initial surgery followed by taxane/platinum-based chemotherapy for FIGO stage IIC-IV epithelial ovarian cancer. All the patients had ECOG performance status 0-1 at presentation. The median follow-up of survivors was 36 months range, 6 -120 months. RESULTS: The 25%, 50%, and 75% quantiles of hemoglobin levels before starting first-line chemotherapy were 10.2, 11.4, and 12.3 g/dl, respectively. Residual disease after initial surgery >1 cm versus <= 1 cm, P = 0.0013 was the only independent prognostic variable for overall survival. Conversely, hemoglobin levels <10.2 g/dl versus 10.2 -11.4 g/dl versus 11.5-12.3 g/dl versus >12.3 g/dl) were inversely related to overall survival at univariate P = 0.03 but not at multivariate analysis. CONCLUSIONS: This investigation showed that hemoglobin levels before starting first-line taxane/platinum-based chemotherapy are not an independent prognostic factor for overall survival in patients with advanced epithelial ovarian cancer.


OBJECTIVES: There is evidence of variation in both the processes and outcomes of prostate cancer care, resulting in possible harm to patients and increased costs to the health system. Care could be improved by first identifying critical, measurable indicators that correlate with quality of care. This work was conducted to develop indicators of prostate cancer care using a modified three-step Delphi approach. METHODS: A 17-member multidisciplinary panel reviewed potential indicators extracted from the medical literature through two consecutive rounds of rating followed by consensus discussion. The panel then prioritized the indicators selected in the previous two rounds. RESULTS: Of 31 possible indicators that emerged from 49 reviewed articles, 11 were prioritized by the panel as benchmarks for assessing the quality of surgical care for prostate cancer. The 11 indicators represent three levels of measurement regional, hospital, individual provider across several phases of care diagnosis, surgery, pathology, and follow-up, as well as broad measures of outcomes. CONCLUSION: A systematic evidence- and consensus-based approach was used to develop quality indicators of prostate cancer care, with a focus on pre-, peri- and post-operative care as well as outcomes. Some of the indicators selected by the panel were also recommended by a similarly structured panel process. These indicators can be used by individual providers and organizations to monitor the quality of their services, and develop interventions to address any variations.


OBJECTIVE: Little performance measurement has been undertaken in the area of oncology, particularly for surgery which is a pivotal event in the continuum of cancer care. This work was
conducted to develop indicators of quality ovarian cancer surgery using a modified three-step Delphi approach. METHODS: A multidisciplinary panel, comprised of surgical and methodologic co-chairs, nine surgeons, one medical oncologist, one radiation oncologist, a nurse, and a pathologist, reviewed potential indicators extracted from the medical literature through two consecutive rounds of rating followed by consensus discussion. The panel then prioritized the indicators selected in the previous two rounds. RESULTS: Of 33 possible indicators that emerged from 41 selected articles, 14 were prioritized by the panel as benchmarks for assessing the quality of surgical care. The 14 indicators represent three levels of measurement provincial/regional, hospital, individual provider across several phases of care diagnosis, surgery, pathology, and adjuvant therapy, as well as broad measures of access and outcomes. Some of the indicators selected by the panel were also recommended as standards of care by national initiatives in other countries. CONCLUSIONS: A systematic evidence- and consensus-based approach was used to develop quality indicators of ovarian cancer care, with a focus on pre-, peri-, and postoperative care as well as outcomes, that are applicable in any jurisdiction.


The present guidelines are the most recent data on postoperative nausea and vomiting (PONV) and an update on the 2 previous sets of guidelines published in 2003 and 2007. These guidelines were compiled by a multidisciplinary international panel of individuals with interest and expertise in PONV under the auspices of the Society for Ambulatory Anesthesia. The panel members critically and systematically evaluated the current medical literature on PONV to provide an evidence-based reference tool for the management of adults and children who are undergoing surgery and are at increased risk for PONV. These guidelines identify patients at risk for PONV in adults and children; recommend approaches for reducing baseline risks for PONV; identify the most effective antiemetic single therapy and combination therapy regimens for PONV prophylaxis, including nonpharmacologic approaches; recommend strategies for treatment of PONV when it occurs; provide an algorithm for the management of individuals at increased risk for PONV as well as steps to ensure PONV prevention and treatment are implemented in the clinical setting.


OBJECTIVE: Prognosis in women with ovarian cancer mainly depends on International Federation of Gynecology and Obstetrics stage and the ability to perform optimal cytoreductive surgery. Since ovarian cancer has a heterogeneous presentation and clinical course, predicting progression-free survival (PFS) and overall survival (OS) in the individual patient is difficult. The objective of this study was to determine predictors of PFS and OS in women with advanced stage epithelial ovarian cancer (EOC) after primary cytoreductive surgery and first-line platinum-based chemotherapy. DESIGN: Retrospective observational study. SETTING: Two teaching hospitals and one university hospital in the south-western part of the Netherlands. POPULATION: Women with advanced stage EOC. METHODS: All women who underwent primary cytoreductive surgery for advanced stage EOC followed by first-line platinum-based chemotherapy between January 1998 and October 2004 were identified. To investigate independent predictors of PFS and OS, a Cox proportional hazard model was used. Nomograms were generated with the identified predictive parameters. MAIN OUTCOME MEASURES: The primary outcome measure was OS and the secondary outcome measures were response and PFS. RESULTS: A total of 118 women entered the study protocol. Median PFS and OS were 15 and 44 months, respectively. Preoperative platelet count \(P = 0.007\), and residual disease <1 cm \(P = 0.004\) predicted PFS with an optimism corrected \(c\)-statistic of 0.63. Predictive parameters for OS were preoperative haemoglobin serum concentration \(P = 0.012\), preoperative platelet counts \(P = 0.031\) and residual disease <1 cm \(P = 0.028\) with an optimism corrected \(c\)-statistic of 0.67. CONCLUSION: PFS could be predicted by postoperative residual disease and preoperative platelet counts, whereas residual disease, preoperative platelet counts and preoperative haemoglobin serum concentration were predictive for OS. The proposed nomograms need to be externally validated.
OBJECTIVE: To evaluate the relationship between surgical specialty and survival in patients receiving initial surgical management for ovarian epithelial cancer. STUDY METHODS: An analytic framework was constructed to address the principle question 'does the type of surgeon operating on patients with newly diagnosed ovarian epithelial cancer influence survival?' A literature search addressing the components of this analytic framework was carried out using the Cochrane Library, Medline, EMBASE, and HealthSTAR databases. Relevant articles were selected and graded using U.S. Preventive Services Task Force and Canadian Task Force guidelines. Results were summarized by quality as well as level of evidence. RESULTS: Eighteen studies were reviewed. The quality of evidence was good in 3, fair in 8, and poor in 7 of the studies. The most common study flaws encountered were 'failure to account for confounders' and 'incompleteness of data'. In studies focusing on advanced disease, there was good quality evidence to support a 6- to 9-month median survival benefit for patients operated on by gynecologic oncologists rather than general gynecologists and/or general surgeons P values 0.009 to 0.01. Studies focusing on early stage disease found gynecologic oncologists more likely to carry out optimal staging P values 0.001 to 0.01. Increased survival could be explained by improved identification of true stage I patients. CONCLUSION: Patients receiving initial surgical management for ovarian epithelial cancer should be operated on by gynecologic oncologists.

BACKGROUND: Child health care is an important part of the UK general practice workload; in 2009 children aged <15 years accounted for 10.9% of consultations. However, only 1.2% of the UK's Quality and Outcomes Framework pay-for-performance incentive points relate specifically to children. AIM: To improve the quality of care provided for children and adolescents by defining a set of quality indicators that reflect evidence-based national guidelines and are feasible to audit using routine computerised clinical records. DESIGN AND SETTING: Multi-step consensus methodology in UK general practice. METHOD: Four-step development process: selection of priority issues applying nominal group methodology, systematic review of National Institute for Health and Care Excellence NICE and Scottish Intercollegiate Guidelines Network SIGN) clinical guidelines, translation of guideline recommendations into quality indicators, and assessment of their validity and implementation feasibility applying consensus methodology used in selecting QOF indicators. RESULTS: Of the 296 national guidelines published, 48 were potentially relevant to children in primary care, but only 123 of 1863 recommendations 6.6% met selection criteria for translation into 56 potential quality indicators. A further 13 potential indicators were articulated after review of existing quality indicators and standards. Assessment of the validity and feasibility of implementation of these 69 candidate indicators by a clinical expert group identified 35 with median scores 8 on a 9-point Likert scale. However, only seven of the 35 achieved a GRADE rating >1 were based on more than expert opinion. CONCLUSION: Producing valid primary care quality indicators for children is feasible but difficult. These indicators require piloting before wide adoption but have the potential to raise the standard of primary care for all children.
Advanced Stage III-IV Ovarian Cancer Surgery - Quality Indicators

Based on National Institutes of Health Consensus Panel recommendations, surgeries were categorized as comprehensive by using ICD-9 diagnosis and procedure codes. Logistic regression analysis using data from 5 states with a full set of variables n = 6854 patients was used to identify factors that were associated with the receipt of comprehensive surgical care. RESULTS: Overall, 66.9% of admissions range, 46.3-80.8% of admissions received comprehensive surgery. Factors that were associated independently with comprehensive surgical care included age < 21 years vs ages 21-50 years or ages 71-80 years or > or = 81 years, race Caucasian vs African American or Hispanic, payer private insurance vs Medicaid, cancer stage advanced vs early, annual surgeon volume low/medium [2 - 9 surgeries per year] or high [>10 surgeries per year] vs very low [1 surgery per year], and surgeon specialty gynecologic oncologists vs obstetrician gynecologists or general surgeons. Among nonteaching hospitals, medium-volume hospitals 10 -19 ovarian cancer surgeries per year and high-volume hospitals > or = 20 surgeries per year had significantly higher comprehensive surgery rates than low-volume facilities 1 -9 surgeries per year. Volume did not influence comprehensive surgery rates in teaching hospitals. CONCLUSION S: Many women with ovarian cancer, especially those in poor, elderly, or minority groups, are not receiving recommended comprehensive surgery. Efforts should be made to ensure that all women with ovarian cancer, especially those in vulnerable populations, have the opportunity to receive care from centers or surgeons with higher comprehensive surgery rates.


OBJECTIVE: To describe the primary surgical procedures and procedures for intraoperative and postoperative complications, and factors associated with these procedures, in women with ovarian cancer. METHODS: Using hospital discharge data from nine states, obtained from the Heath Care Cost and Utilization Project from 1999 to 2002, we evaluated 10,432 women with a primary diagnosis of ovarian cancer who underwent at least an oophorectomy for additional procedural ICD-9 codes during their initial hospitalization. RESULTS: Surgical procedures performed in addition to oophorectomy included: omentectomy/debulking 81.9%, hysterectomy 73.4%, lymph node dissection 41.4%, appendectomy 23.8%, bowel procedures 19.8%, laparoscopy 5.6%, diaphragmatic procedures 4.9%, colostomy 3.5%, and splenectomy 1.2%. Transfusions were given to 15.5% of patients. Intraoperative and postoperative procedures for complications were coded in 7.4% of patients, including repair of surgical injury 3.5%, procedures for cardiopulmonary complications 2.8%, reoperation 1.1%, and infection treatment 0.3%. In early stage disease 21.4% of women received no additional staging procedures and 46.8% did not have nodal sampling. In bivariate analysis of crude rates, factors associated with lymph node dissection were patient age, race, payer, teaching hospital status, hospital and surgeon volume, and surgeon specialty, p<.01. for all observations. Colostomies were performed by general surgeons in 23.1% of cases, by gynecologic oncologists in 2.7% of cases, and by obstetrician/gynecologists in no cases, p<.001. Complications were associated with age, payer, median household income, and stage, p<.001 for all observations. Complication rates were similar for low- and high-volume hospitals and surgeons. However, in higher volume settings, significantly more patients received debulking procedures, lymph node dissections, and additional surgical procedures, p<.001 for all observations. CONCLUSIONS: A significant percentage of women with ovarian cancer did not receive recommended surgical procedures. Almost 50% of women with early stage disease were not adequately staged and in women with advanced disease, the percentage who had additional surgical procedures such as bowel resections was much lower than in institutions that report high optimal cytoreduction rates.


OBJECTIVES: The Society of Gynecologic Oncologists has developed two measures to assess and improve the surgical care of patients with ovarian cancer 1 description of residual disease following cytoreduction and 2 adequacy of surgical staging. Our aim was to establish baseline surgeon
compliance with these two measures. METHODS: A retrospective review of patients with ovarian, fallopian tube or peritoneal cancer undergoing surgery between 7/1/2006 and 7/1/2011 for the purposes of staging and/or cytoreduction was performed at the University of Washington and Geisinger Medical Center. Operative and pathology reports were reviewed to obtain information pertaining to stage, histology, residual disease after surgery and the extent of surgical staging. RESULTS: 537 cases were identified; 91% with ovarian cancer. 61% of patients had at least stage IIIIC disease; 15% had recurrent disease and 16% had neoadjuvant therapy. For patients with stages I-IIIB disease, 74% had full surgical staging. 10% did not have full surgical staging but documented the reason for this in the operative report; 15% did not have full surgical staging, no reason was noted. 25% of all operative reports lacked documentation of residual disease with 40% documenting no gross residual disease, 18% with residual disease <1cm and 18% had suboptimal debulking with >1 cm disease remaining. There was a statistically significant increase in appropriate documentation of amount of residual disease over time p<0.001. CONCLUSIONS: Our study sets benchmarks for evaluation of documentation in gynecologic oncology centers. Improved documentation and staging will allow for equivalent standards of care across institutions.


In 2006, under the auspices of The Spanish Research Group for Ovarian Cancer Spanish initials GEICO), the first "Treatment Guidelines in Ovarian Cancer" were developed and then published in Clinical and Translational Oncology by Poveda Velasco et al. Clin Transl Oncol 95:308 -316, 2007. Almost 6 years have elapsed and over this time, we have seen some important developments in the treatment of ovarian cancer. Significant changes were also introduced after the GCIG-sponsored 4th Consensus Conference on Ovarian Cancer by Stuart et al. Int J Gynecol Cancer 21:750 -755, 2011. So we decided to update the treatment guidelines in ovarian cancer and, with this objective, a group of investigators of the GEICO group met in February 2012. This study summarizes the presentations, discussions and evidence that were reviewed during the meeting and during further discussions of the manuscript.


Ovarian cancer is the leading cause of death due to gynecological cancer and the 5th cause of death for cancer in women in Europe. Optimal management of patients with ovarian cancer needs the participation of a well-trained multidisciplinary team. In the last few years, we have observed a significant improvement in the knowledge of the molecular biology of the different histotypes of ovarian cancer that will probably change our standard of care in the forthcoming years. In this Guideline, we summarize the most current evidence for the medical management of ovarian cancer.


BACKGROUND: Quality indicators QI have been developed to measure quality of colorectal cancer care in the Netherlands. The aim of this study is to evaluate if these QI consistently assess the quality of colorectal cancer care in a hospital internal consistency and if these QI correlate with each other construct validity. METHODS: The performance of 85 hospitals participating in the Dutch Surgical Colorectal Audit between the 1st of January 2010 and 31st of December 2010, were evaluated on nine QI: three process indicators for colon cancer, three process indicators for rectal cancer and three outcome indicators. Consistency between all process indicators was assessed, and correlations between all process and outcome indicators were evaluated for colon and rectal cancer care separately. RESULTS: Hospital performance on the nine QI ranged widely. There was little consistency between the process indicators in assessing hospital performance. Most evaluated process indicators for colorectal cancer care did not correlate with each other, but were associated with better hospital specific
patient outcomes. CONCLUSION: QI on colorectal cancer care do provide complementary information. Individual QI are not suitable as a surrogate measure for the quality of colorectal cancer care. More comprehensive measures are needed for true assessment of hospital performance.


The Canadian Cardiovascular Society CCS is implementing the Canadian Heart Health Strategy and Action Plan recommendation to build knowledge infrastructure, through its Data Definitions and Quality Indicator QI project. The CCS selected cardiac rehabilitation CR and secondary prevention as a content area for QI development. In accordance with the CCS QI Best Practice Methodology, rapid reviews of the literature were conducted. A long list of 37 QIs, in the areas of structure, process, and outcome were developed. Through an online survey, 26 42% of all contacted external experts rated each QI on importance, scientific acceptability, and feasibility, using a 7-point scale. The overall mean rating was 5.4 +/- 1.4. Through a consensus process, the working group excluded 8 QIs based on this feedback, and several others were revised. A 30-day Web consultation was then undertaken, to solicit input from the broader CCS and CR community. A "top 5" list of QIs was requested by the CCS, which were: 1 inpatients referred to CR; 2 wait times from referral to CR enrollment; 3 patient self -management education; 4 increase in exercise capacity; and 5 emergency response strategy. Knowledge translation activities are now under way to promote utilization of the QIs and ultimately improve CR care.


OBJECTIVE: To assess the adequacy of treatment of gynaecological cancer in a public hospital and to determine the influence of referral patterns on patient outcome. DESIGN: A retrospective analysis of clinical histories. SETTING: A tertiary-level general public hospital. PATIENTS: 89 patients admitted between 1 January 1979 and 31 December 1987 for primary treatment of a gynaecological malignancy. MAIN OUTCOME MEASURES: The primary study parameter was patient survival. During data analysis, the study parameters were altered to include the adequacy of initial surgery and survival time in relation to the involvement of the Gynaecology Unit. RESULTS: Initial presenting symptoms had a major influence on the referral patterns of patients with a gynaecological malignancy. All patients who presented with abnormal vaginal bleeding were managed by the Gynaecology Unit. Patients with ovarian cancer who presented with non-specific abdominal symptoms and ascites were often managed by other units. There was a statistically significant difference in the adequacy of initial surgery depending on whether the patient was managed by the Gynaecology or the Surgical Unit P < 0.05. The median survival time of patients managed by the Gynaecology Unit was 20 months; this was considerably longer than the figure of 14 months for other units P < 0.05. CONCLUSIONS: Patients with ovarian cancer who are managed by a specialised gynaecology unit are more likely to have adequate initial surgery and a longer median survival time. Female patients presenting with non-specific abdominal symptoms, ascites and other signs of intra-abdominal malignancy should be reviewed by a gynaecology unit before initial surgery.


BACKGROUND: To select a set of quality indicators QI in order to test them in a panel of 36 French hospitals METHODS: The COMPAQH COordination for Measuring Performance and Assuring Quality in Hospitals project is coordinated by the French National Institute for Medical Research and supported by the French Ministry of Health and the French National Evaluation and Accreditation Agency. This project has four objectives: 1 to select a set of QI -2003- 2 to implement them in 2004 -2005 in a volunteer panel of hospitals 3 to compare the hospitals anonymously 4 to explore quality management implications. QI were selected with a four-step process: 1 Establishment of a list of
national priorities for Quality Improvement in relation with the Ministry of Health. 2 setting up a potential list of QI regarding these priorities. The COMPAQH staff determined a preliminary set of 81 QI, based on data in the literature and evidence about the scientific soundness of quality measures and the effectiveness of methods for improving quality. 3 Evaluation of the preliminary list. Each QI was presented in a pamphlet describing its operational definition, rationale, methodology, workload and responsibility of data collection. The hospital panel representatives ranked the 81 QI with a validated evaluation tool which contained four dimensions: Importance, Scientific acceptability, Feasibility, and Usability. 4 Development of a consensus on a final selection. Based on a structured voting process Delphi method, two rounds, the hospital panel selected a comprehensive set of 42 QI among the 81.

RESULTS: 1 Eight national priorities were defined: pain management, continuity of care, management of nutritional disorders, iatrogenic risks including nosocomial infections, patient satisfaction, follow-up of practice guidelines, management of human resources, accessibility. 2 A set of 42 QI were selected: a set of 6 core QI and 7 to 18 specific QI according to the hospital type.

CONCLUSION: Such a set of QI provides a foundation for developing a quality measurement system in French hospitals. It requires a pragmatic view for implementing them and a coherence between the different objectives of use internal and external use.


OBJECTIVE: To describe the management of and outcomes in patients with newly diagnosed ovarian cancer during 1993, 1994 and 1995 in Victoria. DESIGN AND SETTING: Retrospective cohort study conducted by surveying doctors involved in managing incident ovarian cancer cases identified from the population-based Victorian Cancer Registry. The survey was conducted in 1997 and the cohort was followed up until the end of 1999 to obtain at least four years of follow-up data on all patients. PATIENTS: All women with invasive epithelial ovarian cancer diagnosed during 1993, 1994 and 1995. MAIN OUTCOME MEASURES: Reported management in terms of staging, treatment and survival. RESULTS: Management details were obtained for 84.5% 562/665 of eligible patients. Median age at diagnosis was 66 years range, 22 -98 years. Surgery was the primary therapy in 77.2% of women 434/562. Only one in three women had adequate surgery, which was less likely to be performed by general gynaecologists and general surgeons than gynaecological oncologists 21.3% [35/164] v 13.3% [8/60] v 52% [105/202]. After surgery 78.6% of women 434/562 received chemotherapy, usually with platinum-based regimens. The overall five-year relative survival was 46% for women treated surgically; poor survival was related to increasing age, later tumour stage, presence of ascites, residual disease > 2 cm and poorer histological differentiation of the tumour. CONCLUSIONS: For optimal care a preoperative carcinoma antigen CA -125 assay, chest x-ray and pelvic ultrasound should be performed, and early referral to a multi-disciplinary unit for definitive surgery is advised. Every effort should be made to adequately stage or debulk the tumour. Women with high-risk early-stage and advanced disease should be considered for platinum-based chemotherapy.


OBJECTIVE: The study objective was to develop quality indicators for coronary artery bypass graft surgery that relate to quality of care, associate with preventable death, and could be reported on performance reports. METHODS: A comprehensive list of quality indicators was collected from quality improvement organizations including the Society For Thoracic Surgery, Northern New England Cardiovascular Disease Study Group, and Veteran's Affairs System. Indicators were collated from practice guidelines from the American College of Cardiology and the American Heart Association. A MEDLINE search using the keywords “quality indicators” and "coronary bypass" was completed. A 17-member multidisciplinary international expert panel was assembled, who voted using a 2-step Delphi process regarding association with quality of care, risk adjustment, association with preventable death, and inclusion on performance reports. RESULTS: A total of 149 quality indicators were examined. This list was distilled to 33 indicators related to quality of care, 10 indicators that could be adequately risk
adjusted, 34 indicators related to preventable death, and 18 indicators to be included on performance reports. These selected indicators consisted of 19 outcome variables, 23 process of care variables, and 4 structure variables. The quality indicators believed to be useful on a Canadian institutional coronary artery bypass graft surgery report card included the following: 30-day mortality, in-hospital mortality, electrocardiographic myocardial infarction, red cell transfusion, allogeneic blood product transfusion, deep sternal wound infection, postoperative stroke, postoperative dialysis, intensive care unit readmission, intensive care unit length of stay, ventilation time, repeat cardiac operation, repeat surgery with cardiopulmonary bypass, repeat revascularization, waiting time to surgery, completion of surgery within a recommended waiting time, use of left internal thoracic artery graft, and institutional volume.

CONCLUSIONS: This set of consensus quality indicators can be used as a standard list to be monitored by providers of coronary artery bypass graft surgery in an effort to continuously evaluate and improve their performance.


OBJECTIVES: This study sought to develop quality indicators QIs for outpatient management of adult congenital heart disease (ACHD) patients. BACKGROUND: There are no published QIs to promote quality measurement and improvement for ACHD patients. METHODS: Working groups of ACHD experts reviewed published data and United States, Canadian, and European guidelines to identify candidate QIs. For each QI, we specified a numerator, denominator, period of assessment, and data source. We submitted the QIs to a 9-member panel of international ACHD experts. The panel rated the QIs for validity and feasibility in 2 rounds on a scale of 1 to 9 using the RAND/University of California-Los Angeles modified-Delphi method, and final QI selection was on the basis of median scores. RESULTS: A total of 62 QIs were identified regarding appropriateness and timing of clinical management, testing, and test interpretation. Each QI was ascertainable from health records. After the first round of rating, 29 QIs were accepted, none were rejected, and 33 were equivocal; on the second round, 55 QIs were accepted. Final QIs included: 8 for atrial septal defects; 9 for aortic coarctation; 12 for Eisenmenger; 9 for Fontan; 9 for D-transposition of the great arteries; and 8 for tetralogy of Fallot. CONCLUSIONS: This project resulted in development of the first set of QIs for ACHD care based on published data, guidelines, and a modified Delphi process. These QIs provide a quality of care assessment tool for 6 ACHD conditions. This rigorously designed set of QIs should facilitate measuring and improving the quality of care for this growing group of patients.


This study is a literature review of papers in the English language dealing with quality control for ovarian cancer surgery. Quality control in surgery has long been a neglected area of medicine. Initial attempts were limited to cardiac surgery, but only very recently has there been any attempt to look at quality control in ovarian cancer surgery. Investigators from Hesse, Germany were the first to document the surgical quality of patients with ovarian cancer. Subsequently, investigators in the United States and other European countries have demonstrated that patients treated by gynaecological oncologists in large-volume tertiary institutions had the best outcomes. The Gynaecological Cancer Group of the European Organisation for Research and Treatment of Cancer has developed a series of process quality indicators for ovarian cancer surgery that could be used by surgeons or units to audit and improve their practice. These and or other initiatives are important, because pressure is coming from consumers, government, health care insurers and medical risk insurers for surgeons and hospitals to provide transparent patient outcome data. If the profession does not institute adequate internal regulation of the quality of ovarian cancer surgery, regulation is likely to be imposed by government.
OBJECTIVE: Surgical outcome in advanced ovarian cancer AOC is an important prognostic factor and the only factor amendable to improvement by optimization. Therefore, introduction of quality management programs QM regarding the surgical therapy in ovarian cancer may help to improve outcome. METHODS: We introduced a specific ovarian cancer quality management program in 2001 in our gynecologic oncology center. Analysis of 396 consecutive patients with primary surgery for advanced ovarian cancer FIGO stages IIIB-IV operated before the introduction of the quality management program 1997-2000, or during the introduction years 2001-2003, or after establishing 2004-2008. RESULTS: Thirty-three percent had complete debulking to no macroscopic residual disease from 1997 to 2000. This rate increased to 47% in 2001-2003 n = 86 and 62% in 2004 -2008 n = 259. The utilization of extended surgical procedures increased over time. Patients with complete resection had 5-YSR of 55% compared to 16% in patients with residuals 1-10 mm, and 13% in patients with residuals >1 cm p < 0.001. The median OS increased from 26 months 1997 -2000 to 37 months 2001-2003 and 45 months in 2004-2008 p < 0.003. CONCLUSIONS: Optimizing surgical skills, infrastructure, and introduction of quality management programs may improve both surgical and overall outcome in advanced ovarian cancer.


BACKGROUND: The purpose of this study was to compare the completeness and reproducibility of data extracted from a standardized operative report SOR with the non-standardized operative report NSOR. METHODS: Between July and December 2003, operative data were collected from all laparoscopic cholecystectomy procedures performed at the Peter Lougheed Centre Hospital. A standardized format for dictating laparoscopic cholecystectomy operative reports was introduced on October 1, 2003. Non-standardized operative reports dictated in the first 3 months of the study period were compared with SORs dictated in the final 3 months. Two physicians independently extracted data from each operative report into a surgical database. RESULTS: During the study period, 221 cholecystectomy reports were analyzed 119 SOR and 102 NSOR. Completeness of data extraction for identifying variables eg, patient name, age, and date of procedure was similar in the 2 types of reports. However, most other operative and perioperative details were more completely reported in the SOR 95% to 100% when compared to the NSOR 14% to 100% complete. Furthermore, interobserver agreement between 2 independent data extractors was better for the SOR than the NSOR 0.9972 vs 0.9809, P < .0001. CONCLUSIONS: Standardized operative reports result in more complete and reliably interpretable operative data compared with NSORs.


BACKGROUND: Patients with advanced ovarian cancer should be treated by radical debulking surgery aiming at complete tumor resection. Unfortunately about 70% of the patients present with advanced disease, when optimal debulking can not be obtained, and therefore these patients gain little benefit
from surgery. Neoadjuvant chemotherapy NACT has been proposed as a novel therapeutic approach in such cases. In this study, we report our results with primary surgery or neoadjuvant chemotherapy as treatment modalities in the specific indication of operable patients with advanced ovarian carcinoma no medical contraindication to debulking surgery. PATIENTS AND METHODS: A total of 59 patients with stage III or IV epithelial ovarian carcinomas were evaluated between 1998 and 2003. All patients were submitted to surgical exploration aiming to evaluate tumor resectability. Neoadjuvant chemotherapy was given in 27 patients where optimal cytoreduction was not feasible. Conversely primary debulking surgery was performed when we considered that optimal cytoreduction could be achieved by the standard surgery 32 patients. RESULTS: Optimal cytoreduction was higher in the NACT group 72.2% than the conventional group 62.4%, though not statistically significant P = 0.5. More imp ortant was the finding that parameters of surgical aggressiveness blood loss rates, ICU stay and total hospital stay were significantly lower in NACT group than the conventional group. The median overall survival time was 28 months in the conventional group and 25 months in NACT group with a P value of 0.5. The median disease free survival was 19 months in the conventional group and 21 months in NACT group P = 0.4. In multivariate analysis, the pathologic type and degree of debulking were found to affect the disease free survival significantly. Overall survival was not affected by any of the study parameters. CONCLUSION: Primary chemotherapy followed by interval debulking surgery in select group of patients doesn’t appear to worsen the prognosis, but it permits a less aggressive surgery to be performed.


OBJECTIVE: The Gynecologic Oncology Group has divided patients with advanced epithelial ovarian cancer into those with optimal residual cancer, in which the maximum diameter of residual is < or = 1 cm, and suboptimal residual cancer, in which the residual disease is > 1 cm. Within the optimal group of patients there is a survival difference between patients with microscopic residual disease and those with any macroscopic disease < or = 1 cm. No analysis of the effect of various residual disease diameters in patients with residual disease > or = 1 cm has been performed. This study evaluates the effect of residual disease diameter in patients with suboptimal disease entered on a randomized trial of intense versus standard chemotherapy. STUDY DESIGN: Gynecologic Oncology Group protocol 97 compared cisplatin 50 mg/m2 and cyclophosphamide 500 mg/m2 for eight courses with the same drugs at 100 mg/m2 and 1000 mg/m2 for four courses, respectively. There was no difference in progression-free interval or survival between the two arms. Of the 458 stage III with residual disease > 1 cm and stage IV patients entered in this study, 294 stage III patients comprise the current analysis. Surgical reporting forms, operation reports, and pathology reports were reviewed to determine initial greatest tumor diameter and residual tumor diameter. Patients were grouped by residual diameter. Multivariate analysis considered residual diameter of disease, age, histologic characteristics, performance status, and ascites. An adjusted relative hazard of dying of ovarian cancer was calculated for each residual disease group. RESULTS: Patients ranged in age from 20 to 80 years, with a median of 60 years. All patients were Gynecologic Oncology Group performance status 0 to 2. Fifty-two percent had grade 3 tumors, and 39% and 9%, respectively, had grade 2 or 1 tumors. All patients had stage III disease. Ninety percent had serous, endometrioid, or mixed epithelial cell type tumors. Multivariate analysis revealed a relative risk of dying as follows: residual disease < 2 cm, relative risk 1.00; 2 to 2.9 cm, relative risk 1.90; 3 to 3.9 cm, relative risk 1.91; 4 to 5.9 cm, relative risk 1.74; 6 to 7.9 cm, relative risk 1.85; 8 to 9.9 cm, relative risk 2.16; > or = 10 cm, relative risk 1.82. The difference in survival between those with < 2 cm residual disease and those with > or = 2 cm residual disease was significant p < 0.01. There is no significant difference in the risk of dying between groups with residual disease > or = 2 cm. CONCLUSIONS: Among patients with suboptimal > 1 cm residual disease epithelial ovarian cancer, those who have small diameter residual disease < 2 cm tend to survive longer than those who have larger residual disease. Among those with larger residual disease, size does not affect prognosis appreciably.
OBJECTIVES: To compare the survival and peri-operative morbidities of patients with advanced epithelial ovarian cancer EOC, stage IIIC and IV) who were treated with primary debulking surgery PDS followed by adjuvant platinum-based chemotherapy, or neoadjuvant chemotherapy followed by cytoreductive surgery NAC. METHODS: 172 patients with advanced EOC diagnosed at YNHH 1998 -2005 were retrospectively reviewed. 109 patients were treated with PDS and 63 patients were treated with NAC [37 received carboplatin/paclitaxel CP, 26 received carboplatin/cyclophosphamide CC]. RESULTS: NAC patients had significantly less intra-operative blood loss, operating time, units of transfusion, and shorter hospital stay p<0.05. Optimal cytoreduction was achieved in 95% NAC patients, versus 71% of PDS group p<0.001. Three patients in the NAC group 5% versus 27 patients 25% in the PDS group required aggressive surgery in addition to standard cytoreduction. Within the NAC group, overall survival OS is improved in patients who received CP compared to CC 83 vs. 26 months, p=0.008. Patients with extra-abdominal disease who received CP as NAC had improved progression-free survival PFS and OS when compared to the PDS group with stage IV disease 15 vs. 9 months, p=0.015; 31 vs. 20 months, p=0.032, respectively. CONCLUSION: This study demonstrates that NAC is associated with less peri-operative morbidity, less need for further aggressive surgery, and similar survival. Additionally, in patients with extra-abdominal disease, NAC is associated with an improved PFS and OS. Therapy with platinum and taxane should be the treatment of choice in NAC.


Quality indicators in postoperative pain management: a validation study. In a previous study, strategic and clinical quality indicators were developed from a tentative model to assess high quality in postoperative pain management. The aim of the present study was to investigate the content validity of these 15 indicators. The indicators were compiled in a questionnaire, and two groups of nurses n=210, n=321 scored each indicator on a 5-point scale strongly disagree to strongly agree from three different standpoints: whether it was essential for achieving high quality, whether it was realistic to carry out, and whether it was possible for nurses to influence management. The respondents were also asked to choose the most crucial indicators for the quality of care. The results showed that both groups of nurses judged the 15 indicators to have content validity from all three standpoints. Both groups also found the same six indicators to be the most crucial. These indicators concerned detecting and acting on signs and symptoms, performing prescriptions, informing and educating, acting on behalf of patients, competence/knowledge, and attitudes. The validated indicators should be useful to consider when implementing a strategy for postoperative pain management and when planning to evaluate the quality of care.


BACKGROUND: There is a lack of clinical data on the validity of neoadjuvant chemotherapy in the treatment of ovarian cancer. The aim of this study was to compare the impact of the adjuvant and neoadjuvant chemotherapy regimens on the clinical outcomes in patients with advanced ovarian cancer. METHODS: We performed a retrospective analysis of 574 patients with advanced ovarian cancer admitted to four Lithuanian oncogynaecology departments during 1993-2000. The conventional combined treatment of cytoreductive surgery and platinum-based chemotherapy was applied to both the group that underwent neoadjuvant chemotherapy n = 213 and to the control group n = 361. The selection criterion for neoadjuvant chemotherapy was large extent of the disease. Overall and
progression-free survival rates and survival medians were calculated using life tables and the Kaplan-Meier method. RESULTS: There was no difference in median overall survival between stage III patients treated with adjuvant chemotherapy and neoadjuvant chemotherapy 25.9 months vs. 29.3 months, p = 0.2508 and stage IV patients 15.4 months vs. 14.9 months, p = 0.6108. Similarly, there was no difference in median progression-free survival between stage III patients treated with adjuvant chemotherapy and neoadjuvant chemotherapy 15.7 months vs. 17.5 months, p = 0.1299 and stage IV patients 8.7 months vs. 8.2 months, p = 0.1817. There was no difference in the rate of the optimal cytoreductive surgery between patients who underwent the neoadjuvant chemotherapy and patients primarily treated with surgery n = 134, 63% vs. n = 242, 67%, respectively. CONCLUSION: There was no difference in progression-free or overall survival and in the rate of optimal cytoreductive surgery between the neoadjuvant and adjuvant chemotherapy groups despite the fact that patients receiving neoadjuvant chemotherapy had a more extensive disease. Multivariate analysis failed to prove that neoadjuvant chemotherapy could be considered as an independent prognostic factor for survival, and the findings need to be investigated in the future prospective randomised studies.


The survival of ovarian cancer patients has been reported to be superior at hospitals with a high volume of operations. A population-based study was carried out to assess whether this is true in Japan, where the incidence rate is relatively low as compared with other developed countries. The Osaka Cancer Registry's data were used to investigate associations between hospital procedure volume and survival of ovarian cancer patients. Hospitals were ranked according to the number of operations for ovarian cancer performed per year high/medium/low/very low. Survival analysis was restricted to the reported 2450 cases who lived in Osaka Prefecture except for Osaka City diagnosed in 1975 -1995, or those who resided in Osaka City in 1993-1995, since active follow-up data on vital status 5 years after the diagnosis were available. The relative 5-year survival for all ovarian cancer cases was 38.8%, and the survival was higher with greater hospital volume 22.3% / 34.2% / 46.2% / 55.0%. After adjustment for age, histologic type and cancer stage by the Cox regression model, patients receiving care in very-low-volume hospitals were seen to have a 60% higher risk of death than patients receiving care in high-volume hospitals P < 0.01. Although some limitations existed in this study, the results indicated that further centralization of operative treatment in high-volume hospitals might improve survival of ovarian cancer patients in Japan.


BACKGROUND: Recent studies reported that hospital procedure volume i.e. volume of patients per hospital receiving a particular treatment was directly proportional to cancer survival; however the degree of association might be different according to the primary tumor site, extent of disease and year of diagnosis. We performed a systematical examination of survivals by hospital procedure volume according to the primary site with inclusion of latest cases in Osaka, Japan. METHODS: Individual data on reported cancer cases with active follow-up information and diagnosis between 1994 and 1998 were retrieved from Osaka Cancer Registry's database. The analysed primary sites included oesophagus, stomach, large bowel, liver, gall bladder, pancreas, lung, breast, uterus, ovary, prostate, bladder and lymphoma. Hospitals were ranked as high-, medium-, low- and very low-volume hospitals for every primary site by dividing the number of cancer patients who received treatment in hospitals into four quartiles. RESULTS: The primary sites could be classified into three categories based on the association between hospital procedure volume and cancer survival: In type 1, a better survival was associated with a higher procedure volume as for oesophagus, liver, lung, ovary, prostate, or lymphoma; in type 2, a better survival was associated with a higher procedure volume but there was no significant difference in survival between high- and medium-volume hospitals as for uterus; and in type 3, there was no significant difference in survival among high-, medium- and low-volume hospitals as for stomach, large bowel, gall bladder, pancreas, breast, or bladder sites. CONCLUSIONS: A higher
procedure volume was generally associated with a better survival; however, this association could be classified into three types according to the primary site.


BACKGROUND: Health-care-associated infections are a major threat to the safety of patient care. Control of such problem is a major criterion for hospital accreditation. This study was aimed to determine the developing use of chemical class 6 products and biological indicators in Tabriz district hospitals since 1997 to 2011. METHODS: We conducted this time-trend interventional study with all of the public and private hospitals, which counted to 21 in Tabriz district as a sample. The situations of indicator use were presented for each time in the base of indicator groups. Furthermore, the results were showed in the base of hospital groups. RESULTS: All of district hospital n=21 with 74 autoclave machine and 22 central sterilization room were studied. The result of second time study in 2008 showed a markedly improvement in the control of sterilization processes. Furthermore, we continued our intervention results 6 month later in 2009 and 2 years later in 2011. The most striking result were use of chemical indicator in 100% of hospitals. However, there are defects in the use of biological indicators 63.65%. CONCLUSION: The most obvious finding was significant improvement in sterilization control especially in development the use of chemical indicators. The finding of this study has a number of important implications for hospital managers and infection control practitioners such as continuous practical training of CSSD personnel in hospitals and mandating of indicator using in all sterilization process with controlling of this subject in evaluation and accreditation of hospital programs.


A retrospective matched-control study was conducted to review our experience with FIGO stage III and IV epithelial ovarian cancer in patients referred after initial laparotomy and biopsy only. The study group comprised 22 patients; planned treatment was two to four cycles of chemotherapy, interval debulking surgery, six more chemotherapy cycles, and second-look laparotomy. Two control groups were matched with the study group according to FIGO stage, histologic type, and grade 2 or 3 and patient age +/- 5 years. The first control group 22 patients had greater than 2 cm residual disease after initial surgery; their planned treatment was a minimum of six cycles of chemotherapy plus second-look laparotomy. The second control group 18 patients was referred after initial laparotomy and biopsy only; their disease was immediately reexplored and debulked. Subsequent planned treatment was a minimum of six cycles of chemotherapy plus second-look laparotomy. All patients received cisplatin-based chemotherapy. Optimal cytoreduction to less than or equal to 2 cm was achieved for 77% of the study group vs 39% of the immediate-reexploration group P = 0.02. Median survival times for the three groups were not different 16 vs 19.3 vs 18 months, respectively P = 0.58. Within the study group, patients who were optimally debulked survived significantly longer than those who were not 18.1 vs 7.5 months P = 0.02. Morbidity of the interval debulking procedure was acceptable. Study findings suggest that patients with bulky residual disease have a uniformly poor prognosis regardless of the timing of further surgery.


OBJECTIVE: To determine whether specialist gynaecological surgeons improved survival in women with ovarian cancer when compared with general gynaecologists. DESIGN: Retrospective case note review. POPULATION: All women diagnosed with ovarian cancer in Scotland in 1987, 1992, 1993 and 1994. METHODS: Data on prognostic factors and surgical and post-operative management was extracted from case notes. Surgeons were classified as specialist gynaecologists, general gynaecologists or general surgeons by an independent committee with no knowledge of an individual's outcome. Cox's proportional hazards model was used to determine the relative risk of a patient dying, if managed by...
specialist and general gynaecologists, after adjustment for age, histology, tumour differentiation, presence of ascites and socio-economic status. Analysis was performed separately for each FIGO stage. **MAIN OUTCOME MEASURES:** Relative hazard ratios for survival up to three years. **RESULTS:** Survival benefit for specialists varied according to the stage of the disease. The greatest benefit was observed among women with Stage III disease 44% of women presented at this stage where there was a 25% relative hazard ratio = 0.75, $P = 0.005$ reduction in the rate of dying for women operated on by specialist gynaecologists, compared with women operated on by general gynaecologists. Differential use of platinum chemotherapy did not explain this survival advantage. Specialist gynaecologists more often debulked tumour to < 2 cm than general gynaecologists in Stage III cases 36.3% vs 28.7%, $P = 0.07$. In women with Stage III carcinoma with > 2 cm remaining, survival was significantly improved for women treated by specialist gynaecologists relative hazard ratio = 0.71, $P = 0.007$. No significant differences were observed for patients with Stages I, II and IV disease, although there were fewer deaths in women with early stage disease. **CONCLUSIONS:** Specialist gynaecologists improve survival for some women with ovarian cancer.


The aim of the study was to determine if biomarker expression could help discriminate between short-term and long-term survivors in women with advanced ovarian cancer. Fifty-one patients with stage III ovarian cancer were selected for the study, which included 28 short-term survivors death from ovarian cancer within 18 months and 23 long-term survivors alive for more than 5 years. There was no difference between the two groups with respect to FIGO substage, age, World Health Organization score, and first-line platinum therapy. Classic clinical pathologic parameters were examined together with p53, Bcl-2, Ki-67, PDGFRalpha, P-glycoprotein, BRCA1, and DNA ploidy. Immunohistochemistry was used for scoring biomarker expression and image cytometry for DNA ploidy. All patients had primary debulking surgery followed by first-line platinum therapy. On multivariate analysis, the presence of ascites, debulking surgery and repeat laparotomy, clear-cell histology, elevated CA125, and high Ki-67 score were all found to be of prognostic importance. The long-term survivors were characterized by primary optimal cytoreduction surgery <1 cm residual disease, attempt at maximal tumor debulking by experienced gynecological oncologic surgeons, and the absence of ascites. Normal CA125 level before platinum therapy and negative Ki-67 expression also predicted a more favorable prognosis.


**BACKGROUND:** The purpose of the current study is to analyze the existing data regarding neoadjuvant chemotherapy NAC in advanced epithelial ovarian cancer EOC using a random-effects model and to determine whether NAC can improve the rate of optimal cytoreduction. **METHODS:** Between 1989 and 2008, data of 21 studies were retrieved via a MEDLINE search. Meta-regression analysis based on a random-effects model was performed to assess the prognostic value of clinical variables. **RESULTS:** The patients who received NAC had a lower risk of suboptimal cytoreduction than the patients with favorable conditions pooled odds ratio, 0.50; 95% confidence interval, 0.29-0.86; $P = 0.012$ with DerSimonian-Laird model). Meta-regression analysis revealed that heterogeneity in year of publication, taxane use, and optimal cytoreduction rate influenced median overall survival significantly $P = 0.002$, $P = 0.007$, and $P = 0.012$, respectively. However, the between-studies variation of the number of NAC cycles did not influence survival $P = 0.701$. **CONCLUSION:** The current meta-analysis showed that NAC helped the gynecologic oncologist achieve an increased rate of optimal cytoreduction.

Neoadjuvant chemotherapy has been proposed as an alternative approach to conventional surgery as initial management of bulky ovarian cancer, with the goal of performing adequate debulking in the interval surgery. Two hundred five consecutive patients with advanced ovarian cancer were divided into two groups. Neoadjuvant chemotherapy followed by interval surgery was performed in 45 of 205 patients. The remaining 158 patients received primary surgery plus adjuvant chemotherapy. Optimal cytoreductive surgery rates were significantly higher in the neoadjuvant CT group \( P<0.001 \). In multivariate analysis, only residual tumor diameter and appendix involvement were found to affect total survival significantly in both groups. Five-year survival and median survival were not statistically different when all patients treated conventionally were compared with all patients treated with neoadjuvant chemotherapy. Primary chemotherapy followed by interval debulking surgery in a selected group of patients does not appear to worsen prognosis, but it permits less aggressive surgery and improves patients' quality of life.

KCE 2011. "Indicateurs de qualité en oncologie: Pré-requis pour l'élaboration d'un système de qualité." [Link to the publication]

KCE 2011. "Quality of care in oncology. Can we use quality indicators?" [Link to the publication]


BACKGROUND: The ability to measure health system quality has become a priority for governments, the private sector, and the public. Quality indicators QIs refer to clear, measurable items related to outcomes. The use of QIs can initiate local quality improvement and track changes in quality over time as interventions are implemented. QUESTIONS/PURPOSES: We identified existing evidence-based indicators of quality pediatric orthopaedic care and evaluated published QIs that may be applicable to pediatric orthopaedic care. SEARCH STRATEGY: Using five standard search engines we searched the literature using terms such as "quality indicators," "orthopaedic surgery," and "pediatric." Study selection was performed in a stepwise manner, first by title, then abstract, and then full-text review. Of the 604 citations identified, 13 articles were selected for inclusion. Eight papers included only pediatric patients. RESULTS: The most commonly reported indicator was mortality followed by postoperative complications. Reoperation and readmission rates were also reported along with patient-centered QIs, although with less frequency. CONCLUSION: Although mortality and postoperative complications were the most frequently reported QIs, concern for their applicability was raised because of their relative infrequency in pediatrics. Patient-centered QIs appear to be the most useful tools reported, although their use is somewhat limited in the published literature. Although there are benefits and drawbacks to all reported QIs, patient-centered and surgeon-defined outcomes along with cost-effectiveness have important roles in evaluating the quality of pediatric orthopaedic care.


BACKGROUND: Systemic sclerosis SSc is associated with a marked economic burden, high treatment costs and decreased productivity. Although treatment strategies for SSc can have a substantial effect on patients' outcomes, it is not known whether patients with SSc consistently receive such care. Evaluation of process-of-care quality requires specification of quality indicators QIs, clinically detailed statements of the eligible patients and the care they should receive to achieve a minimal level of quality of care. Our objective was to develop QIs for patients with SSc. METHODS: We performed a comprehensive literature review of diagnosis and treatment of SSc and proposed QIs that were evaluated by a national Expert Panel \( n=9 \) who were asked to review the supporting literature and individually rank the validity of each QI. These rankings formed the basis of discussion at a face-to-face meeting following the RAND/UCLA method to integrate expert opinion with literature review to
identify a set of final QIs. We then presented these QIs to members of the Scleroderma Clinical Trials Consortium SCTC. RESULTS: Thirty-two QIs for SSc care were judged valid by the Expert Panel. The QI set includes 9 QIs for newly diagnosed with SSc, 12 follow-up QIs for management of SSc, and 11 treatment QIs. The SCTC experts agreed with the validity of each of the 32 QI and agreed that for all but one QI the specified tests, procedures and treatments recommended in the QI were generally available. CONCLUSIONS: We have developed 32 QIs for SSc using a rigorous methodology that can be employed to evaluate and improve care for patients with SSc, as well as inform policy decisions supporting appropriate care for SSc patients.


BACKGROUND: Currently there is no standardized head and neck pathology reporting system in Victoria, Australia. The aim of this study was to document deficiencies in head and neck pathology reports at our institution. METHODS: The pathology reports of all patients with head and neck squamous cell carcinoma HNSCC who presented to Peter MacCallum Cancer Centre for postoperative radiotherapy PORT between January 1, 2004, and March 31, 2006, were critically assessed for 16 key pathological items. RESULTS: Only 37% reports contained all the 16 items. The most commonly missing items were "diameter of the largest involved lymph node" 38%, "presence/absence of lymphovascular space invasion" 30%, "presence/absence of peri-neural invasion" 28%, "clearance of margins in millimeters" 27%, and "presence/absence of extracapsular extension" 27%. The most variable item was the clearance in millimeters used to determine "clear margins". CONCLUSIONS: Several of the most important pathological factors predicting locoregional relapse in HNSCC are currently the least reliably reported items in head and neck pathology reports.


In the clinical setting, diagnosis and treatment of venous leg ulcers can vary considerably from patient to patient. The first step to reducing this variation is to document venous leg ulcer care through use of quantitative scientific documentation principles. This requires the development of valid and reliable evidence-based quality indicators of venous leg ulcer care. A Scandinavian multidisciplinary, cross-sectional panel of wound healing experts developed clinical quality indicators on the basis of scientific evidence from the literature and subsequent group nominal consensus of the panel; an independent medical doctor tested the feasibility and reliability of these clinical indicators, assessing the quality of medical technical care on 100 consecutive venous leg ulcer patients. Main outcome measures were healing, recurrence, pain, venous disease diagnosis, differential diagnosis and treatment, and inter- and intra-rater reliability. The indicators proved feasible and reliable to measure inter-rater kappa = 0.79, P < 0.01 and intra-rater kappa = 0.89, P < 0.1. Within 3 months of initial examination, venous etiology was verified by duplex in 61 of the 98 participating patients 62% and 31 32% were assessed for venous surgery. Distal arterial pressure was measured following initial examination in 33 of the patients 34%. All patients 100% were prescribed compression therapy. Of the 98 patients, 11 11% had ulcers recur in 3 months and 72 73% healed in 12 months, which is in line with the literature. It is feasible to reliably measure the quality of medical technical venous leg ulcer care in the clinical setting using a few strategic clinically relevant indicators of quality.


BACKGROUND: Quality indicators QIs are used in many healthcare settings to measure, compare, and improve quality of care. For the efficient development of high-quality QIs, rigorous, approved, and evidence-based development methods are needed. Clinical practice guidelines are a suitable source to derive QIs from, but no gold standard for guideline-based QI development exists. This review aims to identify, describe, and compare methodological approaches to guideline-based QI development.
METHODS: We systematically searched medical literature databases Medline, EMBASE, and CINAHL and grey literature. Two researchers selected publications reporting methodological approaches to guideline-based QI development. In order to describe and compare methodological approaches used in these publications, we extracted detailed information on common steps of guideline-based QI development topic selection, guideline selection, extraction of recommendations, QI selection, practice test, and implementation to predesigned extraction tables. RESULTS: From 8,697 hits in the database search and several grey literature documents, we selected 48 relevant references. The studies were of heterogeneous type and quality. We found no randomized controlled trial or other studies comparing the ability of different methodological approaches to guideline-based development to generate high-quality QIs. The relevant publications featured a wide variety of methodological approaches to guideline-based QI development, especially regarding guideline selection and extraction of recommendations. Only a few studies reported patient involvement. CONCLUSIONS: Further research is needed to determine which elements of the methodological approaches identified, described, and compared in this review are best suited to constitute a gold standard for guideline-based QI development. For this research, we provide a comprehensive groundwork.


BACKGROUND: Quality indicators QI are used in many health care areas to measure, compare, and improve the quality of care. Ideas of quality differ between health care providers and patients, yet patients are not regularly involved in QI development nor does a methodological standard for patient involvement in QI development exist. In this study we systematically reviewed the medical journal articles and gray literature for published approaches for involving patients in QI development. METHODS: We searched medical literature databases Medline, Excerpta Medica database, and Cumulative Index to Nursing and Allied Health Literature, screened websites, and contacted experts in the field of QI development for publications on approaches to patient involvement in QI development. RESULTS: Eleven relevant journal articles and four web-published documents were included. Four major approaches to patient involvement were extracted from the literature: 1 focus group interviews, 2 self-administered questionnaires, 3 individual interviews, and 4 participation in panels during systematic consensus processes. Patients' views were collected by involving patients, patient representatives, or family members. CONCLUSION: Although there is a large body of literature on QI, publications that describe approaches to patient involvement in QI development are scarce. In principle, indirect and direct methods of patient involvement can be distinguished, and it seems most promising to combine different approaches. However, the limited number of publications identified clearly shows that further research in this field is overdue and that the quality of reporting found in studies within this field needs to be improved.


BACKGROUND: Patients with advanced ovarian carcinoma of International Federation of Gynecology and Obstetrics FIGO Stage IIIC should be treated by radical surgical tumor debulking with the goal of complete tumor resection. Prolonged median survival can be achieved in those patients entirely free of tumor after surgery by the administration of postsurgical platinum/taxane-based chemotherapy regimens. However, residual tumor is present in the majority of patients, which limits survival prognosis. Different therapy approaches should be utilized to improve prognosis in these patients. Neoadjuvant chemotherapy could induce "downstaging" of the tumor and thus improve operability. Here, evidence of large ascites volume >500 mL can be used to identify those patients who could benefit from neoadjuvant chemotherapy. METHODS: In a prospective, nonrandomized Phase II study, 31 patients with advanced FIGO Stage IIIIC ovarian carcinoma and large ascites volume >500 mL received 3 cycles of platinum/taxane-based combination chemotherapy, followed by tumor debulking surgery and 3 additional cycles of platinum/taxane-based combination chemotherapy. During the same
period, 32 patients with advanced FIGO Stage IIIC ovarian carcinoma and large ascites volume >500 mL received conventional therapy tumor debulking surgery followed by 6 cycles of platinum/taxane-based combination chemotherapy. The two groups were investigated and compared with respect to tumor resection rates, blood transfusion requirements, morbidity, and mortality during surgery, duration of surgery, and median survival. RESULTS: The tumor resection rate in the patient group receiving neoadjuvant chemotherapy was significantly higher \( P = 0.04 \) than that of the conventionally treated group; the median survival time of 42 months versus 23 months also was significantly longer \( P = 0.007 \). Time spent in surgery, blood transfusion requirements, morbidity, and mortality during surgery were not significantly different. CONCLUSIONS: Patients with advanced ovarian carcinoma of FIGO Stage IIIC who will benefit only marginally from conventional therapy can be identified by evidence of large ascites volume. Higher tumor resection rates and longer median survival can be achieved in these patients by the use of neoadjuvant chemotherapy. A prospective randomized multicenter study currently is being performed by the Society for Gynecological Oncology in Germany to confirm these findings.


To assess the effect of different hospital types or surgical volume on the survival of ovarian cancer patients, a nationwide and population-based analysis was carried out in Finland. The study included all 3,851 ovarian cancer patients operated from 1983-94. The patients were classified according to the hospital of the first surgery. The hospitals were categorized by type university, central or other hospital) and, separately, into quartiles by the number of operated patients surgical volume. The patients operated at university hospitals had better survival than those operated in central hospitals, the 5-year relative survival rates RSR being 45% 95% CI = 42 -48% and 37% 34 -40%, respectively. RSR in the ‘other hospital’ category was 45% 42 -48%. The RSR for the patients operated in the highest volume hospitals was 47% 43 -50%, and by decreasing volume quartile the RSR was 40% 36 -43%, 40% 36 -43% and 42% 38 -45%, respectively. After controlling for potential confounding by stage and age using regression models, the results remained practically the same. The results indicate that further centralizing of operative treatment of ovarian cancer may still improve survival rates on a population level in Finland.


This prospective nationwide study was performed to evaluate the effect of hospital category and subspeciality training on surgical treatment of ovarian cancer. Data were obtained from a questionnaire filled in by the operating unit, and from the surgical and histopathology reports. The survey included 307 patients. Half of them were operated in the university hospitals where gynaecologic oncologists performed 72% of the operations. This was the case in only 4% and 19% in the central and district hospitals, respectively. In university hospitals, pelvic lymphadenectomy was performed in 88%, and para-aortic lymphadenectomy in 73%, of the patients with stage I disease. The corresponding figures ranged from 11% to 21% in central and district hospitals. For stage III patients operated by gynaecologic oncologists, the estimated odds ratio for no macroscopic tumour was 3.0 times higher 95% CI 1.2 -7.5 than for those operated by general gynaecologists. These results favour centralisation of surgical treatment of ovarian cancer.


OBJECTIVE: Our recent prospective, nation-wide study indicated better surgical outcome in ovarian cancer patients operated at university hospitals compared to other hospitals. Here we report how this is reflected in 5-year cancer-specific survival CSS. METHODS: Detailed 5 -year follow-up data were obtained on 275 patients by using a special questionnaire, and the data were verified from the Finnish
Cancer Registry data. The hospitals were categorized to university and other hospitals and by the number of operations performed in 1999 <10, 10 -20, or >20 operations. Data were analyzed using the Cox's proportional hazards regression analysis. RESULTS: The study population covered 90% of the epithelial ovarian cancer patients operated in 1999, in Finland. Eighty-two percent of the patients received platinum-based chemotherapy. The percentage of patients treated with a platinum-taxane combination was higher in university hospitals 63% vs. 49%, P=0.037. The 5-year CSS was 56% and the median disease-free survival DFS was 33 months. In multivariate analysis prognostic factors for CSS were stage P=0.0027, residual tumor P=0.0001, and primary chemotherapy P<0.0001. Hospital operative volume was associated with residual tumor P=0.027. When hospital operative volume increased with ten patients per year, the odds ratio for no residual disease was 1.203 95% CI 1.022-1.417. CONCLUSION: FIGO stage, residual tumor, and primary chemotherapy are significant prognostic factors for ovarian cancer. Hospital volume is associated with residual tumor. The results favor performance of ovarian cancer surgery in hospitals with higher operative volumes.


BACKGROUND: Few studies have assessed global nutritional assessment tools and body-composition measurements in gynecologic cancer patients. OBJECTIVE: We aimed to assess the convergent validity of different nutritional tools such as the scored Patient-Generated Subjective Global Assessment PG-SGA, serum albumin, skinfold-thickness measurements, and total-body potassium TBK) and body density measurements to identify gynecologic cancer patients at risk of malnutrition. DESIGN: We assessed the nutritional status of 194 patients with suspected or proven gynecologic cancer according to the SGA and the scored PG-SGA, and skinfold-thickness n = 145, TBK n = 51, and body density measurements n = 42 before primary treatment. RESULTS: According to the SGA and the scored PG-SGA global rating, 24% of gynecologic cancer patients were classified as malnourished. The prevalence of malnutrition was highest in ovarian 67% and lowest in endometrial 6% cancer patients. The ability of the PG-SGA score P < 0.001 and albumin P < 0.001, triceps skinfold-thickness P = 0.041, and TBK P = 0.005 measurements to predict the SGA was significantly better than chance. TBK significantly correlated with measurements associated with protein depletion, including age P < 0.001, arm muscle area P < 0.001, fat-free mass P < 0.001, and the PG -SGA score F = 0.009. Multiple regression analysis showed that, together, the PG-SGA score and arm muscle area adjusted for age accounted for 66% of total TBK variance. CONCLUSIONS: The PG-SGA is significantly associated with subjective and objective parameters and is a widely recognized, clinically relevant method of evaluating nutritional status. It therefore seems most appropriate for identifying malnourishment in gynecologic cancer patients.


The European Organization for Research and Treatment of Cancer EORTC has a long history in the development of quality assurance, in particular in radio- and chemotherapy. Quality assurance in surgical oncology is considered to be more complicated, because it is a multistep procedure depending on the individual. Because of the growing importance of the quality of surgical intervention in the multi-modality treatment approach of most cancers, the EORTC recently decided to investigate the current status of quality assurance programmes, both outside and within, the EORTC. The review of EORTC involvement in this area has been conducted on the basis of interviews with subcommittee chairmen and Data Center teams of the EORTC clinical research groups. In addition, clinical trial protocols, case report forms CRFs and publications by the EORTC groups related to this field were considered as possible sources of information. Several methods have been used or are currently under investigation to ensure the quality of surgery within clinical trials. These include review of reported data, standardisation of surgery and pathology forms, training sessions and site visits. However, there
has been no attempt to harmonise these initiatives across the different medical specialties. The EORTC will have to address this problem within its short-term scientific strategy.


AIMS: The aims were to review the existing methods of quality assurance in surgical oncology and to determine a relationship between surgery-related factors and the variety in outcomes in the treatment of solid cancers. METHODS: The literature was reviewed by searching Medline and Cancerlit databases. RESULTS: Wide variations were found in virtually all tumour types. Clear evidence was found that an improvement in the quality of the surgical procedure could have major implications for the prognosis and quality of life of cancer patients. CONCLUSIONS: These findings emphasize the need for strict quality control procedures in surgical oncology and might imply a considerable change in cancer treatment strategies, because the routine use of adjuvant therapies could be questioned.


OBJECTIVES: To determine prognostic factors for survival in ovarian cancer patients treated with intraperitoneal IP chemotherapy using ancillary data from cooperative group clinical trials. METHODS: Data were collected from 428 patients with stage III ovarian cancer who underwent optimal surgical cytoreduction <1 cm followed by IP paclitaxel/platinum chemotherapy. Primary endpoints were progression free survival PFS and overall survival OS. Potential prognostic variables were included in Cox proportional hazard regression models. Multivariate analysis was conducted to identify independent prognostic factors. RESULTS: Median PFS was 24.9 months 95% CI, 23.0 -29.2 and median OS was 61.8 months 95% CI, 55.5 -69.8. Predictors for PFS were histology, surgical stage and residual disease. Age, histology, and residual disease were prognostic for OS. There were no differences in the hazard ratio for death or progression between patients with positive, negative, or unknown lymph node status. For patients receiving IP chemotherapy n=428, 36% of patients had no residual disease with median PFS of 43.2 months 95% CI 32.5 -60.4 and median OS of 110 months 95% CI, 60.0 -161.3. CONCLUSIONS: Age, histology, and extent of residual disease were predictors of OS in stage III patients treated with IP chemotherapy following optimal cytoreduction. Patients with no residual disease following primary surgery that are treated with adjuvant platinum based IP chemotherapy have survival measures that exceed any rates previously seen in this population.


The aim of this article was to review the experience with neoadjuvant chemotherapy and interval surgical debulking in patients with metastatic epithelial ovarian cancer. A retrospective chart review was carried out to identify patients treated with neoadjuvant platinum/Taxol chemotherapy and interval debulking. Cox regression modeling was used to identify significant predictors of progression-free interval. The Kaplan-Meier method was used to estimate the survival statistic for the study group. Sixty-one patients were identified after being treated with neoadjuvant chemotherapy and interval debulking surgeries. All surgeries were performed after three cycles of platinum/Taxol combination chemotherapy. Eighty percent of patients had a residual disease status of 2 cm or less after surgery. Suboptimal debulking was statistically associated with tumor involvement of the upper abdominal organs P < 0.001 and non-normalization of CA125 before surgery P= 0.03. The perioperative complication rate was 7%. At a mean follow-up time of 19 months, 77% of patients were still alive. Cox regression modeling identified the microscopic tumor residual status as the only significant predictor of progression-free interval. The estimated median survival for the group was 41.70 months 95% confidence interval = 13.84 -69.56 months. Neoadjuvant chemotherapy with interval debulking surgery appeared to be safe and feasible in patients with metastatic epithelial ovarian carcinoma.
AIM: This study was performed to evaluate the efficacy of neoadjuvant chemotherapy NAC with paclitaxel and cisplatin in patients with advanced epithelial ovarian cancer who were inadequate for primary optimal surgery. METHODS: Patients with histologically confirmed epithelial ovarian cancer at International Federation of Gynecology and Obstetrics stages IIIc/IV that was unresectable according to computed tomography findings were eligible for this study. Three cycles of paclitaxel plus cisplatin NAC were administered and the response was evaluated. Patients were then selected for interval debulking surgery or three cycles of additional chemotherapy with the same regimen according to the resectability and response. Interval debulking surgery followed by second-line chemotherapy was applied to patients with no response to NAC. During the same period, patients who did not agree to the protocol were treated by the conventional method of tumor debulking surgery followed by adjuvant chemotherapy, and served as the control group. A comparison of both groups of patients was carried out. RESULTS: A total of 40 patients were involved in the study. All patients were evaluable. Eighteen patients underwent NAC and 22 patients were treated by conventional therapy. Optimal debulking was possible in 14 patients 77.8% in the NAC group and in 10 patients 45.5% in the conventional therapy group P = 0.04. The mean estimated blood loss was 620 cc range: 300 -1500 cc in the NAC group and 1061 cc range: 300 -3500 cc in the conventional therapy group P = 0.04. However, no significant differences were found in the disease-free and overall survival rates between the two groups P = 0.48 and P = 0.61, respectively. CONCLUSION: NAC provided a higher rate of optimum cytoreduction and equivalent survival with less invasive surgery and reduced morbidity compared with conventional therapy in patients with advanced epithelial ovarian cancer inadequate for primary optimum surgery. Therefore, NAC may be a valuable alternative treatment for these patients.


Measuring quality in clinical care is a time-consuming manual task. The vast amounts of clinical data collected through electronic medical records EMRs create an opportunity to develop tools that automatically assess quality indicators; however, the diversity of EMR implementations limits the ability to implement general, reusable methods. We evaluate an ontology-based virtual medical record VMR approach as a standardized, sharable methodology for defining data abstractions needed for quality of care assessment. Using a set of cancer quality indicators, we conducted a requirements analysis for modeling these abstractions with an OWL-based VMR. We found that the VMR approach needs to be extended to support population-based aggregations of clinical events, models of intended versus completed actions, and models of workflow and delivery systems. Incorporating the patient perspective on quality also requires additional extension of the VMR. We are using these results to create a virtual quality record based on EMR data.


BACKGROUND: In recent years, there have been several studies, using a wide variety of methods, aimed at developing quality indicators for palliative care. In this Quality Indicators for Palliative Care study Q-PAC study we have applied a scientifically rigorous method to develop a comprehensive and valid quality indicator set which can contribute to a standardized method for use in other countries.
METHODS AND DESIGN: Firstly, an extensive literature review identified existing international quality indicators and relevant themes for measuring quality in palliative care. Secondly, the most relevant of these were selected by an expert panel. Thirdly, those prioritized by the experts were scored by a second multidisciplinary expert panel for usability and relevance, in keeping with the RAND/UCLA-method, combining evidence with consensus among stakeholders. This panel included carers and policymakers as well as patients and next-of-kin. Fourthly, the draft set was tested and evaluated in practice for usability and feasibility; the indicators were then translated into questionnaires presented to patients, next-of-kin and care providers. To encourage the acceptance and use of the indicators, stakeholders, including national palliative care organizations, were involved throughout the whole project. CONCLUSION: Our indicator development trajectory resulted in a set of quality indicators applicable to all patients in all palliative care settings. The set includes patient and relative perspectives and includes outcome, process and structure indicators. Our method can contribute internationally to a more standardized and rigorous approach to developing quality indicators for palliative care.


This paper explains the reasons and context behind the introduction of the Quality and Outcomes Framework QOF in the UK in April 2004. The QOF is a pay -for-performance scheme covering a range of clinical and organisational areas in primary care. In 2004, 52% of the framework related to clinical care, increasing to 66% in 2006 and 70% in 2009. From April 2009, the National Institute for Health and Clinical Excellence NICE has led a new process for developing the clinical QOF indicators. Clinical areas are now prioritised by an advisory committee appointed by NICE; the QOF indicators then undergo a formal consensus procedure followed by piloting in representative practices across England. However, what are the attributes of a good QOF indicator and how do these differ from those of a good quality indicator, such as validity and sensitivity to change? This paper describes the concept of 'QOFability', which relates to why some areas are, and others are not, prioritised for the QOF. Factors include the prevalence of the clinical issue, the accuracy of data extraction from GP clinical systems, the clarity of diagnosis, the relevance of incentivised actions, the direct attribution to all primary care staff and consideration of any possible unintended consequences of introducing any given indicator. The paper concludes by considering the future direction of the QOF, recommending a focus on creating feasible, valid, reliable and piloted 'QOFable' clinical indicators.


BACKGROUND: Scoping studies are an increasingly popular approach to reviewing health research evidence. In 2005, Arksey and O'Malley published the first methodological framework for conducting scoping studies. While this framework provides an excellent foundation for scoping study methodology, further clarifying and enhancing this framework will help support the consistency with which authors undertake and report scoping studies and may encourage researchers and clinicians to engage in this process. DISCUSSION: We build upon our experiences conducting three scoping studies using the Arksey and O'Malley methodology to propose recommendations that clarify and enhance each stage of the framework. Recommendations include: clarifying and linking the purpose and research question stage one; balancing feasibility with breadth and comprehensiveness of the scoping process stage two; using an iterative team approach to selecting studies stage three and extracting data stage four; incorporating a numerical summary and qualitative thematic analysis, reporting results, and considering the implications of study findings to policy, practice, or research stage five; and incorporating consultation with stakeholders as a required knowledge translation component of scoping study methodology stage six. Lastly, we propose additional considerations for scoping study methodology in order to support the advancement, application and relevance of scoping studies in health research. SUMMARY: Specific recommendations to clarify and enhance this methodology are outlined for each stage of the Arksey and O'Malley framework. Continued debate and development about scoping study
methodology will help to maximize the usefulness and rigor of scoping study findings within healthcare research and practice.


Thirty patients aged 34-69 years median 56 with previously untreated FIGO Stage III and IV ovarian carcinoma were given carboplatin 400 mg/m² and ifosfamide 5 g/m² with mesna every 28 days for a median of 3 cycles, followed, where possible, by laparotomy. Objective responses were observed in 13 43% patients, 11 of whom proceeded to laparotomy. Nine were successfully debulked, and two of these had removal of all macroscopic disease. Three cycles of chemotherapy were found to achieve the optimum response for the least toxicity. After a minimum follow-up of 32 months, two patients who had had debulking surgery remain alive. The median response duration was 13.9 months in the debulked group compared with 3 months in those who remained inoperable, while the corresponding median survivals were 23.4 and 6.4 months. This study suggests that neoadjuvant chemotherapy given over 8 weeks may render debulking surgery feasible in a proportion of patients presenting with unresectable ovarian cancer and can result in an improved median survival.


OBJECTIVE: The aims of this study are to investigate the actual time from primary surgery for epithelial ovarian cancer OC to initiation of chemotherapy TI amongst Danish women in 2005 -2006, and to compare the survival for groups with early initiation \( \leq \)median TI and late initiation of adjuvant chemotherapy \( > \)median TI. METHODS: All Danish women who underwent primary surgery for OC in the period 1 January 2005 to 31 December 2006 and recorded in the Danish Gynaecological Cancer Database DGCD) were included. The five-year survival was estimated overall and by TI exposure. The Cox proportional hazard regression analysis was used to compute the adjusted hazard ratio HR. RESULTS: The median TI was 32days 25 -75% quartile: 24days; 41days. The strongest prognostic factors for death were residual tumour and the International Federation of Obstetrics and Gynecology FIGO stage. The unadjusted HR for death in patients with TI\( \leq \)32days was 0.85 95% CI: 0.70; 1.04, \( p \) -value 0.12. When adjusted for residual tumour and FIGO-stage the HR was 1.13 95% CI: 0.92; 1.39, \( p \) -value 0.26. The overall five-year survival was 42.8%, 95% CI: 38.9%; 46.5%. CONCLUSIONS: This nationwide population-based cohort study revealed a non-significant increased risk of death for patients with TI\( > \)32days compared with the reference TI\( \leq \)32days. The strongest prognostic factors were residual tumour after surgery and FIGO-stage. The overall five-year survival was 42.8% 95% CI: 38.9%; 46.5%.


OBJECTIVE: This paper provides a brief review of definitions, characteristics, and categories of clinical indicators for quality improvement in health care. ANALYSIS: Clinical indicators assess particular health structures, processes, and outcomes. They can be rate- or mean-based, providing a quantitative basis for quality improvement, or sentinel, identifying incidents of care that trigger further investigation. They can assess aspects of the structure, process, or outcome of health care. Furthermore, indicators can be generic measures that are relevant for most patients or disease-specific, expressing the quality of care for patients with specific diagnoses. CONCLUSIONS: Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization in the health care system. To ensure that reliable and valid clinical indicators are used, they must be designed, defined, and implemented with scientific rigour.

OBJECTIVE: To describe steps in developing and testing clinical indicators based on state of the art methods in previous literature and experience in the Danish National Indicator Project. ANALYSIS: The development process includes a planning phase, where the clinical area to be evaluated is chosen and the measurement team selected and organized. The planning phase is followed by a development phase where clinical indicators are prioritized and selected by the measurement team on the basis of documentation and knowledge from the scientific literature. When clinical indicators have been selected, specific measure specifications should be designed, including inclusion and exclusion criteria for the target population, description of a risk adjustment strategy, identification of data sources, description of data collection procedures, and an analytical plan for data analyses. Before clinical indicators are implemented they should be tested for reliability and validity. Preliminary tests may identify areas requiring further modifications and specifications of the indicators. CONCLUSION: Using clinical indicators for quality assessment represents an important approach to documenting the quality of care. Consumers of indicator information clinicians, administrators, purchasers, regulators, and patients need reliable and valid information for benchmarking, making judgments, and determining priorities, accountability and quality improvement. This underlines the fact that clinical indicators must be developed and tested with scientific rigor in a transparent process.


OBJECTIVE: In most countries there is no mandatory national system to track the quality of care delivered to the citizens. This paper describes an example of a national indicator project that aims at documenting and improving the quality of care nationwide. ANALYSIS: The Danish National Indicator Project was established in 2000 as a nationwide multidisciplinary quality improvement project. From 2000 to 2002, disease-specific clinical indicators and standards were developed for six diseases: stroke, hip fracture, schizophrenia, acute gastrointestinal surgery, heart failure, and lung cancer. Indicators and standards have been implemented in all clinical units and departments in Denmark treating patients with the six diseases, and participation is mandatory. All clinical units and departments receive their results every month. National and regional audit processes are organized to explain the results and to prepare implementation of improvements. All results are published in order to inform the public, and to give patients and relatives the opportunity to make informed choices. CONCLUSION: The surveillance of health care quality is greatly aided by the use of relevant quantitative indicators. This paper describes how it is possible to organize nationwide monitoring using clinical indicators.


BACKGROUND: Epithelial ovarian cancer EOC is the most lethal gynecological cancer. Several hospitals throughout the region provide primary treatment for these patients and it is well know that treatment quality is correlated to the hospital that delivers. The aim of this study was to investigate the management and treatment of EOC in a Region of the North Italy Emilia-Romagna, Italy. METHODS: A multidisciplinary group made up of 11 physicians and 3 biostatisticians was formed in 2009 to perform clinical audits in order to identify quality indicators and to develop Region-wide workup in accordance with the principles of evidence-based medicine EBM. The rationale was that, by setting up an oncogynecology network so as to achieve the best clinical practice, critical points would decrease or even be eliminated. Analysis of cases was based on the review of the medical records. RESULTS: 614 EOC patients treated between 2007 and 2008 were identified. We found only 2 high-volume hospitals >/= 21 patients/year, 3 medium-volume hospitals 11-20 operated patients/year, and 7 low-volume hospitals </= 10 operated patients/year. Only 222 patients 76.3% had a histological diagnosis, FIGO surgical staging was reported only in 206 patients 70.9% but not all standard surgical procedures were always performed, residual disease were not reported in all patients. No standard number of neoadjuvant chemotherapy cycles was observed. CONCLUSIONS: The differences in terms of treatments provided led the multidisciplinary group to identify reference centers, to promote centralization, to ensure uniform and adequate treatment to patients treated in
regional centers and to promote a new audit involving all regional hospitals to a complete review of the all the EOC patients.


PURPOSE: To compare the progression-free and overall survival in small-volume residual ovarian cancer after treatment with intravenous IV) cisplatin and paclitaxel or an experimental regimen of IV carboplatin followed by IV paclitaxel and intraperitoneal cisplatin. PATIENTS AND METHODS: Patients were randomized to receive either IV paclitaxel 135 mg/m² over 24 hours followed by IV cisplatin 75 mg/m² every 3 weeks for six courses or IV carboplatin area under curve 9 every 28 days for two courses, then IV paclitaxel 135 mg/m² over 24 hours f lowed by intraperitoneal IP cisplatin 100 mg/m² every 3 weeks for six courses. RESULTS: Of the 523 patients who entered this trial, 462 were determined to be assessable, with prognostic factors well balanced between the treatments. Neutropenia, thrombocytopenia, and gastrointestinal and metabolic toxicities were greater in the experimental arm. As a result, 18% of the patients received < or = two courses of IP therapy. Progression-free survival was superior for patients randomized to the experimental treatment arm median, 28 v 22 months; relative risk, 0.78; log -rank P =.01, one-tail). There was a borderline improvement in overall survival associated with this regimen median, 63 v 52 months; relative risk, 0.81; P =.05, one-tail). CONCLUSION: An experimental regimen including moderately high-dose IV carboplatin followed by IP paclitaxel and IV cisplatin yielded a significant improvement in progression-free survival when compared with a standard regimen of IV cisplatin and paclitaxel. Because the improvement in overall survival was of borderline statistical significance and toxicity was greater, the experimental arm is not recommended for routine use. However, the results provide direction for further clinical investigation in small-volume ovarian cancer.


OBJECTIVE: The Austrian Association for Gynecologic Oncology initiated in 1998 a prospective quality assurance program for patients with ovarian cancer. The aim of this study was to evaluate factors predicting overall survival especially under consideration of department volume. METHODS: All Austrian gynecological departments were invited to participate in the quality assurance program. A questionnaire was sent out that included birth date, histology, date of diagnosis, stage, and basic information on primary treatment. Description of comorbidity was not requested. Patient life status was assessed in a passive way. We did record linkage between each patient's name and birth date and the official mortality data set collected by Statistics Austria. No data were available on progression-free survival. Patients treated between January 1, 1999 and December 31, 2004 were included in the analysis. Mortality dates were available to December 31, 2006. Data were analyzed by means of classical statistical methods. Cut-off point for departments was 24 patients per year. RESULTS: A total of 1948 patients were evaluable. Approximately 75% of them were treated at institutions with fewer than 24 new patients per year. Patient characteristics were grossly similar for both department types. Multivariate analysis confirmed established prognostic factors such as International Federation of Gynecologists and Obstetricians FIGO stage, lymphadenectomy, age, grading, and residual disease. In addition, we found small departments <24 patient s per year to have a negative effect on overall survival hazards ratio, 1.38: 95% confidence interval, 1.2 -1.7; and P < 0.001. CONCLUSIONS: The results indicate that in Austria, rules prescribing minimum department case load can further improve survival for patients with ovarian cancer.

BACKGROUND: Compared with younger people, older people have a higher risk of adverse health outcomes when presenting to emergency departments. As the population ages, older people will make up an increasing proportion of the emergency department population. Therefore it is timely that consideration be given to the quality of care received by older persons in emergency departments, and to consideration of those older people with special needs. Particular attention will be focused on important groups of older people, such as patients with cognitive impairment, residents of long term care and patients with palliative care needs. This project will develop a suite of quality indicators focused on the care of older persons in the emergency department. METHODS/DESIGN: Following input from an expert panel, an initial set of structural, process, and outcome indicators will be developed based on thorough systematic search in the scientific literature. All initial indicators will be tested in eight emergency departments for their validity and feasibility. Results of the data from the field studies will be presented to the expert panel at a second meeting. A suite of Quality Indicators for the older emergency department population will be finalised following a formal voting process. DISCUSSION: The predicted burgeoning in the number of older persons presenting to emergency departments combined with the recognised quality deficiencies in emergency department care delivery to this population, highlight the need for a quality framework for the care of older persons in emergency departments. Additionally, high quality of care is associated with improved survival & health outcomes of elderly patients. The development of well-selected, validated and economical quality indicators will allow appropriate targeting of resources financial, education or quality management to improve quality in areas with maximum potential for improvement.


IMPORTANCE: Sedative premedication is widely administered before surgery, but little clinical evidence supports its use. OBJECTIVE: To assess the efficacy of sedative premedication on perioperative patient experience. DESIGN, SETTING, AND PARTICIPANTS: A randomized clinical trial, the PremedX study, enrolled 1062 adult patients who were younger than 70 years and had been scheduled for various elective surgeries under general anesthesia at 5 French teaching hospitals in Marseille, Montpellier, Nimes, and Nice between January 2013 and June 2014. Neurosurgery, obstetrical, cardiac, and outpatient surgery were excluded. INTERVENTIONS: Patients were randomized to 3 groups of 354 participants each to receive 2.5 mg of lorazepam, no premedication, or placebo. MAIN OUTCOMES AND MEASURES: The primary outcome was perioperative patient experience assessed 24 hours after surgery with a validated questionnaire Evaluation du Vecu de l’Anesthesie Generale; EVAN-G) describing 6 domains of satisfaction and a global index score range, 0-100; high scores represent high satisfaction; secondary outcomes included time to extubation and early cognitive recovery. A subgroup analysis was planned a priori in patients with a high level of preoperative anxiety. RESULTS: Premedication with lorazepam did not improve the EVAN-G mean global index for overall level of patient satisfaction 72 [95% CI, 70 -73]; n = 330 compared with no premedication 73 [95% CI, 71 -74]; n = 319 or placebo 71 [95% CI, 70-73]; n = 322 P = .38. Among patients with heightened preoperative anxiety, there were no significant differences found in the EVAN-G mean global index between the lorazepam group 68 [95% CI, 65 -72]; n = 87 and the no premedication group 73 [ 95% CI, 69-77]; n = 57 or the placebo group 70 [95% CI, 67 -72]; n = 87 P = .18. Time to extubation was 17 minutes 95% CI, 14 -20 minutes in the lorazepam group, 12 minutes 95% CI, 11 -13 minutes for the no premedication group, and 13 minutes 95% CI , 12-14 minutes for the placebo group P < .001 and the rate of early cognitive recovery was 51% 95% CI, 45% -56%, 71% 95% CI, 66% -76%, and 64% 95% CI, 59% -69%, respectively P < .001. CONCLUSIONS AND RELEVANCE: Among patients undergoing elective surgery under general anesthesia, sedative premedication with lorazepam compared with placebo or no premedication did not improve the self-reported patient experience the day after surgery, but was associated with modestly prolonged time to extubation and a lower rate of early cognitive recovery. The findings suggest a lack of benefit with routine use of lorazepam as sedative premedication in patients undergoing general anesthesia. TRIAL REGISTRATION: clinicaltrials.gov Identifier: NCT01901003.
Forty-seven patients with presumed Stages I-II invasive ovarian epithelial carcinoma were treated with intravenous 50 mg/m² cis-platinum, for 2-18 cycles median, 9, 50 mg/m² doxorubicin for 2-14 cycles median, 9, and/or 600 mg/m² cyclophosphamide for 2-14 cycles median, 6 after surgical staging by a gynecologic oncologist or a nononcologic surgeon. Mean follow-up is 6.8 years. Cumulative 5-year actuarial survival is 73 +/- 6%; 75 +/- 12% for Stage I and 71 +/- 8% for Stage II disease. When screened for poor prognosticators, only the specialty of the operating surgeon was identified P < 0.05. Five-year actuarial survival and disease-free survival, respectively, for Stages I-II patients surgically staged by a gynecologic oncologist were 83 +/- 7% and 76 +/- 8%, compared to 59 +/- 11% P < 0.05 and 39 +/- 11% P < 0.03 for the group operated upon by a nononcologist.

OBJECTIVE: The aim of this review is to report our experience and the feasibility of neoadjuvant chemotherapy in patients with advanced-stage ovarian cancer. METHODS: Forty-five patients with primarily unresectable advanced-stage epithelial ovarian cancer were treated in our center between 1995 and 2002 by platinum-based neoadjuvant chemotherapy followed by surgery and adjuvant chemotherapy. Their files were reviewed retrospectively. RESULTS: At the end of neoadjuvant chemotherapy, according to RECIST criteria, 1 patient (2.2%) had achieved a clinical complete response CR, 33 (73.4%) a partial response PR, and 8 (17.8%) had stable disease SD). Only 3 (6.6%) patients showed disease progression PD. Surgery was performed in patients with objective response or SD after a median number of 4 courses range: 2-6 of induction chemotherapy. A complete macroscopic debulking was achieved in 24 (53.3%) out of 39 patients in whom cytoreductive surgery was performed. For the entire group, median overall survival was 29 months. Survival was significantly improved in patients with optimal debulking compared to patients with persistent tumor after surgery: 41 months versus 23 months P = 0.0062. Median survival for patients responding to neoadjuvant chemotherapy CR and PR was 44 months compared to 27 months for patients with SD or PD after initial chemotherapy P = 0.01. Neither treatment-related deaths nor significant toxicities were observed. CONCLUSION: Neoadjuvant chemotherapy followed by optimal debulking may be a safe and valuable treatment alternative in patients with primarily unresectable advanced-stage bulky ovarian cancer. Patients with an objective response to chemotherapy or absence of macroscopic residual tumor after surgery have a better outcome. This approach is currently being tested in large, prospective randomized clinical trials.
Advanced Stage III-IV Ovarian Cancer Surgery - Quality Indicators

71 candidate indicators were rated as valid. They were categorized into 8 domains: comorbidity assessment, elderly issues, medication use, patient-provider discussions, intraoperative care, postoperative management, discharge planning, and ambulatory surgery. Of note, 71.78% of the indicators rated as valid address processes of care not routinely performed in younger surgical populations. CONCLUSIONS: Attention to the quality of care in elderly patients is of great importance due to the increasing numbers of elderly undergoing surgery. This project used a validated methodology to identify and rate process measures to achieve high quality perioperative care for elderly surgical patients.


BACKGROUND: Colorectal cancer is the second most common cancer type among new cancer diagnoses in the United States. Attention to the quality of surgical care for colorectal cancer is of particular importance given the increasing numbers of colorectal cancer resections performed in the aging population. A National Cancer Institute-sponsored consensus panel produced guidelines for colorectal cancer surgery in 2000. We have updated and extended that work by using a formal process to identify and rate quality indicators as valid for care during the preoperative, intraoperative, and postoperative periods. METHODS: Using a modification of the RAND/UCLA Appropriateness Methodology, we carried out structured interviews with leaders in the field of colorectal cancer surgery and systematic reviews of the literature to identify candidate quality indicators addressing perioperative care for patients undergoing surgery for colorectal cancer. A panel of 14 colorectal surgeons, general surgeons, and surgical oncologists then evaluated and formally rated the indicators using the modified Delphi method to identify valid indicators. RESULTS: A total of 142 candidate indicators were identified in six broad domains: privileging which addresses surgical credentials, preoperative evaluation, patient-provider discussions, medication use, intraoperative care, and postoperative management. The expert panel rated 92 indicators as valid. These indicators address all domains of perioperative care for patients undergoing surgery for colorectal cancer. CONCLUSIONS: The RAND/UCLA Appropriateness Methodology can be used to identify and rate indicators of high-quality perioperative care for elderly surgical patients. The indicators can be used as quality performance measures and for quality-improvement programs.


BACKGROUND: Although the expanding and aging population will likely increase demand for surgical services, surgeons and other providers must develop strategies to optimize care. We sought to develop process-based quality indicators for elderly patients undergoing abdominal operations to identify necessary and meaningful ways to improve care in this cohort. STUDY DESIGN: Through structured interviews with thought leaders and systematic reviews of the literature, we identified candidate quality indicators addressing perioperative care in elderly patients undergoing abdominal operations. Using a modification of the RAND/UCLA Appropriateness Methodology, an expert panel of physicians in surgery, geriatrics, anesthesia, internal, and rehabilitation medicine formally rated and discussed the indicators. RESULTS: Eighty-nine candidate indicators were identified and categorized into seven domains: comorbidity assessment eg, cardiopulmonary disease, elderly issues eg, cognition, medication use eg, polypharmacy, patient -to-provider discussions eg, life -sustaining preferences, intraoperative care eg, preventing hypothermia, postoperative management eg, preventing delirium, and discharge planning eg, home health care. Of the 89 candidate indicators, 76 were rated as valid by the expert panel. Importantly, the majority of indicators rated as valid address processes of care not routinely performed in younger surgical populations. CONCLUSIONS: Attention to the quality of surgical care in elderly patients is of great importance because of the increasing numbers of elderly undergoing operations. This project used a validated methodology to identify and rate process measures to achieve high-quality perioperative care for elderly surgical patients. This is the first time quality indicators have been developed in this regard.
PURPOSE: We report a prospective randomized trial in women with advanced ovarian cancer to evaluate the importance of chemotherapy dose-intensity on survival, progression-free survival PFS, and response. PATIENTS AND METHODS: A total of 485 patients with epithelial ovarian cancer and residual masses more than 1 cm following surgery stage III presentation or any stage IV presentation were randomly assigned to receive either standard therapy cyclophosphamide 500 mg/m² and cisplatin 50 mg/m² intravenously every 3 weeks for eight courses or intense therapy cyclophosphamide 1,000 mg/m² and cisplatin 100 mg/m² intravenously every 3 weeks for four courses. Dose modification was rigidly controlled to maintain intensity. Clinical and pathologic responses were assessed, when appropriate, as well as PFS interval and survival. RESULTS: A total of 458 patients met all eligibility criteria and were assessed for survival and PFS. The dose-intensive group received the same total dose of cyclophosphamide and cisplatin, but 1.97 times greater dose-intensity than the standard group. Clinical and pathologic response rates; response duration, and survival were similar in both groups of patients. Hematologic, gastrointestinal, febrile episodes, septic events, and renal toxicities were significantly more common and severe in the dose-intensive group. CONCLUSION: A doubling of the dose-intensity in the treatment of bulky ovarian epithelial cancers led to no discernible improvement in patient outcome and was associated with more severe toxicity. This study provides no evidence to support the hypothesis that modest increases in dose-intensity without increasing total dose are associated with significant improvement in overall survival or PFS.

BACKGROUND: Chemotherapy combinations that include an alkylating agent and a platinum coordination complex have high response rates in women with advanced ovarian cancer. Such combinations provide long-term control of disease in few patients, however. We compared two combinations, cisplatin and cyclophosphamide and cisplatin and paclitaxel, in women with ovarian cancer. METHODS: We randomly assigned 410 women with advanced ovarian cancer and residual masses larger than 1 cm after initial surgery to receive cisplatin 75 mg per square meter of body-surface area with either cyclophosphamide 750 mg per square meter or paclitaxel 135 mg per square meter over 24 hours. RESULTS: Three hundred eighty-six women met all the eligibility criteria. Known prognostic factors were similar in the two treatment groups. Alopecia, neutropenia, fever, and allergic reactions were reported more frequently in the cisplatin-paclitaxel group. Among 216 women with measurable disease, 73 percent in the cisplatin-paclitaxel group responded to therapy, as compared with 60 percent in the cisplatin-cyclophosphamide group P = 0.01. The frequency of surgically verified complete response was similar in the two groups. Progression-free survival was significantly longer P < 0.001 in the cisplatin-paclitaxel group than in the cisplatin-cyclophosphamide group median, 18 vs. 13 months. Survival was also significantly longer P < 0.001 in the cisplatin-paclitaxel group median, 38 vs. 24 months. CONCLUSIONS: Incorporating paclitaxel into first-line therapy improves the duration of progression-free survival and of overall survival in women with incompletely resected stage III and stage IV ovarian cancer.

BACKGROUND: One of the cornerstones of ovarian cancer therapy is cytoreductive surgery, which can be performed by surgeons with different specialty training. We examined whether surgeon specialty impacts quality of life as proxied by presence of ostomy and overall survival for women with advanced ovarian cancer. METHODS: Stage III/IV ovarian cancer patients were identified using 4 state cancer registries: California, Washington, New York, and Florida and linked records to the corresponding inpatient-hospital discharge file, AMA Masterfile, and 2000 U.S. Census SF4 File. Predictors of receipt of care by a general surgeon and creation of fecal ostomy were analyzed.
Multivariate modeling was performed to assess the association of hospital volume (low volume LV) [0-4 cases], middle volume MV) [5-9], high volume HV) [10-19], and very high volume VHV) [20+] and surgeon specialty training: gynecologic oncologists/gynecologists, general surgeons, and other specialty on survival. RESULTS: We identified 31,897 Stage III/IV patients; mean age was 64 years. Treatment of patients by a general surgeon was predicted by LV, rural patient residence, poverty, and high level of comorbidity. Patients had lower hazard of death when treated in higher volume hospitals as compared to LV [VHV hazard ratio HR=0.79, P<.0001; HV HR=0.89, P<.001]. Patients treated by a general surgeon had higher likelihood of an ostomy OR=4.46, P<.0001 and hazard of death HR=1.63, P<.0001 compared to gynecologic oncologist/gynecologist. CONCLUSIONS: Advanced stage ovarian cancer patients have better survival when treated by gynecologic oncology/gynecology trained surgeons. Data suggest that referral to these specialists may optimize surgical debulking and minimize the creation of a fecal ostomy.


PURPOSE: To assess progression-free survival (PFS) and overall survival (OS) in patients with suboptimally debulked epithelial ovarian cancer receiving cisplatin 100 mg/m² or 24-hour infusion paclitaxel 200 mg/m² or the combination of paclitaxel 135 mg/m² followed by cisplatin 75 mg/m². PATIENTS AND METHODS: After stratification for disease measurability, patients were randomized to receive six cycles of one of the treatments every 3 weeks. If measurable, complete response (CR) or partial response (PR) was determined. RESULTS: Six hundred fourteen of 648 patients who entered onto the trial were eligible. Monotherapies were discontinued more frequently with cisplatin because of toxicity or patient refusal (17%), and paclitaxel because of progression (20%) compared with the combination therapy 7% and 6%, respectively. Neutropenia, fever, and alopecia were more severe with paclitaxel-containing regimens; whereas anemia, thrombocytopenia, neurotoxicity, nephrotoxicity, and gastrointestinal toxicity were more severe with cisplatin-containing regimens. The CR/PR rates on paclitaxel monotherapy were significantly lower compared with the cisplatin regimens 42% vs 67%, respectively; P <.001. The relative hazard (RH) of first progression or death was significantly greater among those randomized to paclitaxel RH = 1.41; 95% confidence interval [CI], 1.15 to 1.73; P <.001 when compared with cisplatin; however, RH did not differ significantly between the two cisplatin regimens RH = 1.06; 95% CI, 0.895 to 1.30. Relative to cisplatin, the death rate on paclitaxel was 15% greater RH = 1.15; 95% CI, 0.929 to 1.42, and the death rate on the combination treatment was 1% less RH = 0.99; 95% CI, 0.795 to 1.23. These differences among treatment groups were not statistically significant P =.31. CONCLUSION: Cisplatin alone or in combination yielded superior response rates and PFS relative to paclitaxel. However, OS was similar in all three arms, and the combination therapy had a better toxicity profile. Therefore, the combination of cisplatin and paclitaxel remains the preferred initial treatment option.


In major surgery, the implementation of multidisciplinary, multimodal and individualized strategies, collectively termed Patient Blood Management, aims to identify modifiable risks and optimise patients’ own physiology with the ultimate goal of improving outcomes. Among the various strategies utilized in Patient Blood Management, timely detection and management of preoperative anaemia is most important, as it is in itself a risk factor for worse clinical outcome, but also one of the strongest predisposing factors for perioperative allogeneic blood transfusion, which in turn increases postoperative morbidity, mortality and costs. However, preoperative anaemia is still frequently ignored, with indiscriminate allogeneic blood transfusion used as a ‘quick fix’. Consistent with reported evidence
from other medical specialties, this imprudent practice continues to be endorsed by non-evidence based misconceptions, which constitute serious barriers for a wider implementation of preoperative haemoglobin optimisation. We have reviewed a number of these misconceptions, which we unanimously consider should be promptly abandoned by health care providers and replaced by evidence-based strategies such as detection, diagnosis and proper treatment of preoperative anaemia. We believe that this approach to preoperative anaemia management may be a viable, cost-effective strategy that is beneficial both for patients, with improved clinical outcomes, and for health systems, with more efficient use of finite health care resources.


OBJECTIVE: To analyze the factors prognostic of survival in patients with advanced epithelial ovarian cancer EOC treated with neoadjuvant chemotherapy NAC followed by interval debulking surgery.

METHODS: Outcomes were retrospectively in patients with advanced EOC or peritoneal cancer who received neoadjuvant paclitaxel and carboplatin chemotherapy every 3 weeks for three to four cycles, followed by interval debulking surgery and three additional cycles of the same regimens from January 2001 to November 2010. Therapeutic response was assessed histopathologically as grade 0 to 3, based on the degree of disappearance of cancer cells, displacement by necrotic and fibrotic tissue, and tumor-induced inflammation. Factors prognostic of progression-free survival PFS and overall survival OS were calculated. RESULTS: The 124 enrolled patients had a median age of 62 years range, 35 -79 years. Viable cancer cells were observed in specimens resected from 72 patients 58% at interval debulking surgery after NAC. Multivariate analysis using the Cox proportional hazard model showed that advanced stage IV disease hazard ratio [HR]=1.94, p=0.003, residual cancer at the end of surgery >/=1cm HR=3.78, p<0.001, and histological grade 0 -1 HR=1.65, p=0.03 were independent predictors of decreased OS. Grade 0-1 was also an independent predictor of increased risk of relapse within 6 months odds ratio=8.42, p=0.003. CONCLUSIONS: Residual disease of >/=1cm, advanced stage, and the presence of more viable disease in resected specimens are prognostic factors for survival in advanced EOC patients receiving NAC followed by interval debulking surgery.


PURPOSE: Randomized multicenter trials form the basis of health care development. Regarding cancer research, pathology data are crucial. To maintain the quality of these trials, the auditing of subsequent processes is necessary. The aim of the present study was to examine the completeness and accuracy of data obtained from a special-purpose standardized pathology form compared with the data available through traditional hospital pathology reports. PATIENTS AND METHODS: A retrospective comparison of pathology data case record forms with hospital pathology reports was performed using the data from 300 patients with primary rectal cancer. All of these patients had been included in a large multicenter trial in the Netherlands. Three independent audits were carried out. Special attention was given to the accuracy of parameters, which are important for prognosis and treatment decisions. Furthermore, various factors that possibly influence the occurrence of errors were investigated. RESULTS: Quality control of the pathology data revealed a high accuracy of 86.5% of all data items. However, only one third of the forms were complete and correct. Missing values were most prominent in the number of lymph nodes examined, whereas most errors were made in relation to the circumferential margin. Trained review pathologists made fewer major errors. Discrepancies were detected in all control rounds. CONCLUSION: Successive rounds of quality control are required for accuracy and completeness of pathology data in multicenter trials. In addition to the special-purpose pathology forms, original pathology reports have to be collected, and the data should also be controlled by a trained pathology quality manager.
BACKGROUND: Data analysis of the recent National Survey of Ovarian Carcinoma revealed significant differences in patterns of care among various physician specialists. The goal of this study was to determine if different care patterns led to differences in patient survival. METHODS: Data were collected from 25 consecutive patients with ovarian cancer diagnosed in 1983 and 1988 from 1230 hospitals with cancer programs across the United States. RESULTS: A total of 12,316 patients from 904 hospitals were registered, of whom 20.8% were cared for by gynecologic oncologists GYO), 45.0% by obstetrician-gynecologists OBG), and 21.1% by general surgeons GS. GYO preferred the upper-lower midline incision in 44.1% of patients, whereas both OBG and GS chose the low midline approach in 44-45%. GYO performed more hysterectomies, oophorectomies, omentectomies, and lymph node and peritoneal biopsies than did other specialists. Although the rates of surgery of the small intestine were comparable between GYO and GS, the latter performed significantly more colostomies and resections of the large intestine. The optimal debulking rates were: GYO, 42-45%; OBG, 40-44%; and GS 25%. There was no significant survival difference between patients cared for by GYO and those cared for by OBG for all stage divisions. However, with the exception of patients with Stage I disease, patients cared for by GS had significantly reduced survival than did those cared for by GYO and OBG P < 0.004. CONCLUSION: Efforts must be made to ensure that more patients with ovarian cancer are cared for by physicians in the appropriate specialties.
BACKGROUND: Indicators of quality of care for children in hospitals in low-income countries have been proposed, but information on their perceived validity and acceptability is lacking. METHODS: Potential indicators representing structural and process aspects of care for six common conditions were selected from existing, largely qualitative WHO assessment tools and guidelines. We employed the Delphi technique, which combines expert opinion and existing scientific information, to assess their perceived validity and acceptability. Panels of experts, one representing an international panel and one a national Kenyan panel, were asked to rate the indicators over 3 rounds and 2 rounds respectively according to a variety of attributes. RESULTS: Based on a pre-specified consensus criteria most of the indicators presented to the experts were accepted: 112/13782% and 94/13371% for the international and local panels respectively. For the other indicators there was no consensus; none were rejected. Most indicators were rated highly on link to outcomes, reliability, relevance, actionability and priority but rated more poorly on feasibility of data collection under routine conditions. There was moderate to substantial agreement between the two panels of experts. CONCLUSIONS: This Delphi study provided evidence for the perceived usefulness of most of a set of measures of quality of hospital care for children proposed for use in low-income countries. However, both international and local experts expressed concerns that data for many process-based indicators may not currently be available. The feasibility of widespread quality assessment and responsiveness of indicators to intervention should be examined as part of continued efforts to improve approaches to informative hospital quality assessment.


BACKGROUND: This review aims to present a consensus for optimal perioperative care in rectal/pelvic surgery, and to provide graded recommendations for items for an evidenced-based enhanced recovery protocol. METHODS: Studies were selected with particular attention paid to meta-analyses, randomized controlled trials and large prospective cohorts. For each item of the perioperative treatment pathway, available English-language literature was examined, reviewed and graded. A consensus recommendation was reached after critical appraisal of the literature by the group. RESULTS: For most of the protocol items, recommendations are based on good-quality trials or meta-analyses of good-quality trials evidence grade: high or moderate. CONCLUSIONS: Based on the evidence available for each item of the multimodal perioperative care pathway, the Enhanced Recovery After Surgery ERAS Society, European Society for Clinical Nutrition and Metabolism ESPEN) and International Association for Surgical Metabolism and Nutrition IASMEN) present a comprehensive evidence-based consensus review of perioperative care for rectal surgery.


OBJECTIVE: The objective of this study was to assess the effect of department volume on survival of patients with gynaecological cancer. METHODS: We conducted an observational population-based study in Tyrol, Austria. The analysis includes all patient data on incident gynaecological cancer collected by the Cancer Registry of Tyrol. Data were collected since 1988 on a population-based perspective; publication of incidence data since 1988 in Cancer Incidence in Five Continents gives evidence for good completeness and validity of the database. Patient survival status is assessed in a passive way by probabilistic record linkage between incidence data and official mortality data. We applied a multivariate Cox regression with variables age, sex, stage, year of diagnosis, histological verification of diagnosis, transfer to other hospital and department volume. Department volume was categorised in < or = 11/12-23/24-35/ > or = 36 patients per year reflecting one/two/three/more than three patients per month; categories were computed separately for every site we analysed. Departments with up to 11 patients per year were called small departments. RESULTS: For 4,191 breast cancer patients, we found a negative effect for small departments; hazard ratio HR 1.39, 95% confidence interval CI 1.22, 1.58. For ovarian cancer patients, we also found a negative effect for small departments HR 1.27, 95% CI 1.05, 1.54. For cervical cancer patients, we found a positive effect for small departments HR 0.67, 95% CI 0.51, 0.88. No effect was shown for corpus cancer HR 0.80,
95% CI 0.63, 1.01. CONCLUSION: The results indicate that, in our country, rules on minimum department case-load can further improve survival for breast and ovarian cancer patients.


The surgical management of epithelial ovarian cancer in the South West of England was studied in the two years 1997-1998 in order to determine the factors that influence the outcome of surgery and to provide a baseline from which to assess the effect of centralisation of cancer services. All hospitals in the South West region of England participating in the Regional Cancer Organisation's longitudinal study of outcomes in gynaecological malignancies are included. Six hundred and eighty-two patients with epithelial ovarian cancer were registered with the RCO in the two-year study period. Five hundred and ninety-five women were offered primary cytoreductive surgery of which 438 were said to be optimally cytoreduced. Applying multivariate models to analyse the outcome of surgery, older patients OR = 0.82 per 5-year increase in age, P = 0.0003, patients treated in hospitals managing fewer than ten cases of ovarian cancer per year OR = 1.92, P = 0.02 and patients with FIGO stage 3 OR = 0.02, P < 0.0001 or 4 OR = 0.002, P < 0.0001 disease were less likely to be optimally cytoreduced. Gynaecological oncologists were 2.06 times more likely to attain optimal cytoreduction when compared to general gynaecologists and this was statistically significant P = 0.01. The results from this study support the argument that limiting surgery for ovarian malignancy to specialised surgeons improves the extent of cytoreductive surgery.


PURPOSE: In randomized trials the combination of cisplatin and paclitaxel was superior to cisplatin and cyclophosphamide in advanced-stage epithelial ovarian cancer. Although in nonrandomized trials, carboplatin and paclitaxel was a less toxic and highly active combination regimen, there remained concern regarding its efficacy in patients with small-volume, resected, stage III disease. Thus, we conducted a noninferiority trial of cisplatin and paclitaxel versus carboplatin and paclitaxel in this population. PATIENTS AND METHODS: Patients with advanced ovarian cancer and no residual mass greater than 1.0 cm after surgery were randomly assigned to receive cisplatin 75 mg/m2 plus a 24-hour infusion of paclitaxel 135 mg/m2 arm I, or carboplatin area under the curve 7.5 intravenously plus paclitaxel 175 mg/m2 over 3 hours arm II. RESULTS: Seven hundred ninety -two eligible patients were enrolled onto the study. Prognostic factors were similar in the two treatment groups. Gastrointestinal, renal, and metabolic toxicity, as well as grade 4 leukopenia, were significantly more frequent in arm I. Grade 2 or greater thrombocytopenia was more common in arm II. Neurologic toxicity was similar in both regimens. Median progression-free survival and overall survival were 19.4 and 48.7 months, respectively, for arm I compared with 20.7 and 57.4 months, respectively, for arm II. The relative risk RR of progression for the carboplatin plus paclitaxel group was 0.88 95% confidence interval [CI], 0.75 to 1.03 and the RR of death was 0.84 95% CI, 0.70 to 1.02. CONCLUSION: In patients with advanced ovarian cancer, a chemotherapy regimen consisting of carboplatin plus paclitaxel results in less toxicity, is easier to administer, and is not inferior, when compared with cisplatin plus paclitaxel.


OBJECTIVE: Cytoreduction for ovarian cancer is associated with substantial morbidity. We examined the outcome of patients undergoing surgery for ovarian cancer to determine if there are sub-groups of
patients who may benefit from alternative treatments. METHODS: The National Surgical Quality Improvement Program database was used to identify women who underwent surgery for ovarian cancer from 2005-2012. Multivariable logistic regression models were used to examine the effect of age, race, functional status, ASA class, preoperative albumin and performance of extended cytoreductive procedures on morbidity, mortality and resource utilization. RESULTS: A total of 2870 women were identified. The perioperative complication rate increased from 9.5% in women <50 years, to 13.4% in those age 60-69 years, and 14.6% in women >/=70 years P<0.0001. Similarly, complications rose from 7.3% in those who did not require any extended procedures to 12.9% after 1 procedure, 28.4% for those who had 2, and 30.0% in women who underwent >/=3 extended procedures P<0.0001. In a series of multivariable models, the number of extended cytoreductive procedures performed and preoperative albumin were the factors most consistently associated with morbidity. Using a series of model fit statistics, compared to chance alone, the ability to predict any complication increased by 27.4% when procedure score was analyzed, 22.0% with preoperative albumin, 11% with age, and 4% with functional status. CONCLUSIONS: While preoperative clinical and demographic factors may help predict the risk of adverse outcomes for women undergoing surgery for ovarian cancer, performance of extended cytoreductive procedures is the strongest risk factor for complications.


The aim of this study was to study the impact of hospital level and surgical skill on short-term survival of advanced ovarian, tubal, and peritoneal cancer patients in a prospective population-based study. All 198 women with a diagnosis of advanced epithelial invasive ovarian, tubal, and peritoneal cancer in Norway who underwent surgery during 2002 were included in this study. The data were derived from notifications to the Norwegian Cancer Registry and from medical, surgical, and histopathologic records. The hospitals were grouped into teaching and nonteaching hospitals (NTH), and the operating physicians were classified according to specialty: specialist gynecologist, gynecologist, and surgeon. The follow-up period was from 455 to 820 days. The short-term survival at 450 days was 79% for women operated at teaching hospitals (TH) and 62% at NTH P=0.02. After simultaneous adjustment for seven prognostic factors and residual disease, the risk of death within 600 days at NTH was unchanged compared to TH, hazard ratio 1.83. The women operated on by specialist compared to general gynecologists had a 20% increased short-term survival P < 0.0001. TH and specialist gynecologists achieved better short-term survival of patients operated for advanced ovarian, tubal, and peritoneal cancer. Centralization and specialization of ovarian cancer surgery might improve the outcome for this patient group.


PURPOSE: To assess whether six courses of paclitaxel are effective as consolidation treatment in patients with advanced epithelial ovarian cancer who are in complete response after first-line paclitaxel/platinum-based chemotherapy. PATIENTS AND METHODS: Patients with stages IIb to IV disease in clinical or pathologic complete response after six courses of paclitaxel/platinum-based chemotherapy were randomly allocated to either observation or control) or six courses of paclitaxel 175 mg/m2 every 3 weeks, maintenance. RESULTS: Two hundred patients were randomly assigned from March 1999 to July 2006. Because of the low accrual rate, an unplanned interim analysis of futility according to the Bayesian approach was performed. Grade 2 or greater motor neurotoxicity and sensory neurotoxicity were reported in 11.3% and 28.0% of the paclitaxel-arm patients, respectively. After a median follow-up of 43.5 months, 107 patients 53% had experienced relapse, and 48 patients 24% had died. Two-year progression-free survival rates were 54% 95% CI, 43% to 64% and 59% 95% CI, 49% to 69%; P = not significant) in the control and maintenance arms, respectively. Corresponding 2-year overall survival rates were 90% 95% CI, 84% to 97% and 87% 95% CI, 80% to 94%; P = not significant), respectively. The Cox model showed that residual disease after initial
surgery macroscopic vs no macroscopic residuum; hazard ratio [HR] = 1.9; 95% CI, 1.21 to 3.03 and stage IIIc to IV vs others; HR, 3.10; 95% CI, 1.13 to 8.48 were independent prognostic factors for progression-free survival, whereas the treatment arm maintenance vs control) had no prognostic relevance. CONCLUSION: A consolidation treatment with six cycles of paclitaxel does not prolong progression-free survival or overall survival in patients in complete response after first-line paclitaxel/platinum-based regimens.


OBJECTIVE: To determinate the impact of maximal cytoreductive surgery on progression free survival PFS, overall survival OS rates and morbidity, in patients with advanced epithelial ovarian or fallopian tube cancer. METHODS: We reviewed all medical records of patients with stages IIIIC-IV epithelial ovarian and fallopian tube cancer that were managed at our institution between January 2001 and December 2008. The following information was collected: demographics, tumor characteristics, operative information, surgical outcomes and peri-operative complication. RESULTS: A total of 288 patients with advanced epithelial ovarian and fallopian tube cancer were referred to our institution between January 2001 and December 2008, 259 consecutive patients were enrolled in the study. After a median follow-up of 29.8 months, the PFS and OS were 19.9 and 57.6 months, respectively. At univariate analysis, factors significantly associated with decreased PFS included: age greater than median >60 years, stage IV, presence of ascites >1000 cc, presence of diffuse peritoneal carcinomatosis and diameter of residual disease. This was confirmed also at multivariate analysis with age greater than 60 years P=0.025, stage IV vs IIIC P=0.037 and any residual disease P=0.032 having an independent association with worse PFS. CONCLUSIONS: Our study seems to demonstrate that a more extensive surgical approach is associated with prolonged disease-free interval and improved survival in patients with stages IIIIC-IV epithelial ovarian and fallopian tube cancer. Moreover all patients with no residual tumor seem to have the best prognosis and in view of these results we believe that the goal of primary surgery should be considered as leaving no macroscopic disease.


BACKGROUND: The combination of carboplatin and paclitaxel is the standard of care for the treatment of ovarian cancer, yet rates of recurrence and death remain high. We performed a prospective randomized phase III study to examine whether sequential administration of topotecan can improve the efficacy of carboplatin and paclitaxel in first-line treatment of advanced epithelial ovarian cancer. METHODS: A total of 1308 patients with previously untreated ovarian cancer International Federation of Gynecology and Obstetrics stages IIB-IV) were randomly assigned to receive six cycles of paclitaxel and carboplatin followed by either four cycles of topotecan TC -Top; 658 patients or surveillance TC; 650 patients on a 3-week per cycle schedule. The primary endpoint was overall survival, and secondary endpoints were progression-free survival, response rate, toxicity, and quality of life. Time-to-event data were analyzed using the Kaplan-Meier method, and a stratified log-rank test was used to compare distributions between treatment groups. Hazard ratios HRs with 95% confidence intervals CIs were estimated using a Cox proportional hazards model. Categorical data were compared using a stratified Cochran-Mantel-Haenszel test. All statistical tests were two-sided. RESULTS: Median progression-free survival was 18.2 months in the TC-Top arm versus 18.5 months in the TC arm stratum -adjusted HR = 0.97 [95% CI = 0.85 to 1.10]; P = .688. Median overall survival was 43.1 months for the TC -Top arm versus 44.5 months for the TC arm stratum -adjusted HR = 1.01 [95% CI = 0.86 to 1.18]; P = .885. At 3 years, overall survival in both arms was 57% 58.5% in the TC arm and 55.7% in the TC -Top arm. Compared with patients in the TC arm, patients in the TC-Top arm had more grade 3-4 hematologic toxic effects requiring more supportive care and more grade 3-4 infections 5.1% versus 2.7%; P = .034 but did not have a statistically significant increase in febrile neutropenia 3.3% versus 3.1%; P = .
80. Among patients who had measurable disease TC, n = 147; TC -Top, n = 145, overall i.e., complete or partial) response was 69.0% 95% CI = 61.4% to 76.5% in the TC -Top arm and 76.2% 95% CI = 69.3% to 83.1% in the TC arm P = .166. CONCLUSIONS: The sequential addition of topotecan to carboplatin-paclitaxel did not result in superior overall response or progression-free or overall survival. Therefore, this regimen is not recommended as standard of care treatment for ovarian cancer.


INTRODUCTION: Hip fractures are a significant cause of morbidity and mortality and care of hip fracture patients places a heavy burden on healthcare systems due to prolonged recovery time. Measuring quality of care delivered to hip fracture patients is important to help target efforts to improve care for patients and efficiency of the health system. The purpose of this study is to synthesise the evidence surrounding quality of care indicators for patients who have sustained a hip fracture. Using a scoping review methodology, the research question that will be addressed is: "What patient, institutional, and system-level indicators are currently in use or proposed for measuring quality of care across the continuum for individuals following a hip fracture?". METHODS AND ANALYSIS: We will employ the methodological frameworks used by Arksey and O’Malley and Levac et al. The synthesis will be limited to quality of care indicators for individuals who suffered low trauma hip fracture. All English peer-reviewed studies published from the year 2000-most recent will be included. Literature search strategies will be developed using medical subject headings and text words related to hip fracture quality indicators and the search will be peer-reviewed. Numerous electronic databases will be searched. Two reviewers will independently screen titles and abstracts for inclusion, followed by screening of the full text of potentially relevant articles to determine final inclusion. Abstracted data will include study characteristics and indicator definitions. DISSEMINATION: To improve quality of care for patients and create a more efficient healthcare system, mechanisms for the measurement of quality of care are required. The implementation of quality of care indicators enables stakeholders to target areas for improvement in service delivery. Knowledge translation activities will occur throughout the review with dissemination of the project goals and findings to local, national, and international stakeholders.


OBJECTIVE: The objective of the study was to evaluate the prognostic impact of residual tumor size after cytoreductive surgery in patients with epithelial ovarian cancer. METHODS: In this prospective, multicenter study, 226 patients with epithelial ovarian cancer International Federation of Gynecology and Obstetrics stages IIA-IV were included. Patients were treated with cytoreductive surgery and adjuvant platinum-based chemotherapy. Univariate and multivariable survival analyses were performed to investigate the impact of residual tumor size on progression-free and overall survival. RESULTS: In 69.4% of patients, surgery resulted in complete tumor resection; minimal residual disease <\=1 cm was achieved in 87.2% of patients. Advanced tumor stage was associated with a lower rate of complete tumor resection P < 0.001. After cytoreductive surgery, 3-year overall survival rates were 72.4%, 65.8%, and 45.2% for patients without, with minimal, and with gross residual disease >1 cm, respectively P < 0.001. Multivariable survival analysis revealed residual tumor size P = 0.04 and older patient age P = 0.02 as independent prognosticators for impaired overall survival. Complete cytoreduction was predictive for a higher rate of treatment response P = 0.001 and was associated with prolonged progression-free and overall survival P < 0.001 and P = 0.001. CONCLUSIONS: The size of residual disease after cytoreduction is one of the most crucial prognostic factors for patients with ovarian cancer. Patients after complete cytoreduction have a superior outcome compared with patients with residual disease. Leaving no residual tumor has to be the aim of primary surgery for ovarian cancer; therefore, patients should receive treatment at centers able to undertake complex cytoreductive procedures.
The aim of this study was to evaluate the prognostic impact of hemoglobin Hb levels before and throughout the course of platinum-based chemotherapy in patients with primary epithelial ovarian cancer EOC. Medical records of patients who had undergone initial surgery followed by platinum-based chemotherapy for EOC were retrospectively studied. Univariate and Cox-regression models were used to evaluate the prognostic impact of various factors including Hb levels before and throughout chemotherapy in terms of overall survival. Additionally, sensitivity/specificity were calculated using receiver operating curves ROCs and Kaplan-Meier studies were used to determine optimal cut-off levels. The median duration of follow-up was 37.0 months. Degree of anemia before starting chemotherapy was significantly related to overall survival \( p = 0.001 \), but the Hb level throughout chemotherapy demonstrated only a borderline relationship \( p = 0.062 \). Only residual tumor after surgery and degree of anemia before starting chemotherapy proved to be independent prognostic factors \( p = 0.013 \) and \( 0.015 \), respectively. With sensitivity/specificity and Kaplan-Meier analyses, a Hb level before starting chemotherapy of less than 10.5 g/dl was related to shorter overall survival \( p = 0.002 \). In conclusion, pre-chemotherapy Hb level has a prognostic impact on overall survival in patients with EOC candidate to first-line platinum-based chemotherapy. However, the significance of decreased Hb levels during chemotherapy needs to be clarified in further prospective studies to determine optimal Hb levels for achieving a favorable outcome.


Colonoscopy is the diagnostic modality of choice for investigation of symptoms suspected to be related to the colon and for the detection of polyps and colorectal cancer CRC. Colonoscopy with removal of detected polyps has been shown to reduce the incidence and mortality of subsequent CRC. In many countries, population screening programs for CRC have been initiated, either by selection of patients for colonoscopy with fecal occult blood testing or by offering colonoscopy directly to average-risk individuals. Several endoscopy societies have formulated quality indicators for colonoscopy. These quality indicators are almost always incorporated as process indicators, rather than outcome measures. This review focuses on the quality indicators bowel preparation, cecal intubation rate, withdrawal time, adenoma detection rate, patient comfort, sedation and complication rate, and discusses the scientific evidence supporting them, as well as their potential shortcomings and issues that need to be addressed. For instance, there is still no clear and generally accepted definition of adequate bowel preparation, no robust scientific evidence is available supporting a cecal intubation rate \( \geq 90\% \) and the association between withdrawal time and occurrence of interval cancers has not been clarified. Adenoma detection rate is currently the only quality indicator that has been shown to be associated with interval colorectal cancer, but as an indicator it does not differentiate between subjects with one or more adenoma detected.


BACKGROUND: In patients with FIGO International Federation of Gynecology and Obstetrics stage I ovarian carcinoma given care with or without subspecialists, we compared completeness of initial staging and disease-free survival. METHODS: Two groups of patients with stage I ovarian carcinoma were compared. Patients were managed by either gynecologic oncologists or community-based physicians. The two groups were compared for similarities in demographic, tumor, and substage characteristics and survival differences. RESULTS: Fifty-four patients with stage I ovarian cancer were included. The two groups were comparable in age, gravidity, parity, grade, and substage. Substaging was determined to be adequate in 100% of the gynecologic oncologist group and 28% of the community-based group. Postoperative chemotherapy was given to 79% and 36% of the two groups,
respectively. Six-year survival was 90% in the gynecologic oncologist group and 68% in the community-based group. CONCLUSIONS: Of these two groups of patients with stage I ovarian cancer, the group managed without gynecologic oncology involvement had significantly less adequate staging, decreased administration of chemotherapy, and lower survival rates.


BACKGROUND: Sentinel lymph node biopsy SNLB has been adopted as the standard method of axillary staging for women with clinically node-negative early-stage breast cancer. The false negative rate as a quality indicator is impractical given the need for a completion axillary dissection to calculate. The objective of this study was to develop practical quality indicators for SLNB using an expert consensus method and to determine if they were feasible to measure. MATERIALS AND METHODS: We used a modified Delphi consensus process to develop quality indicators for SLNB. A multidisciplinary expert panel reviewed potential indicators extracted from the medical literature to select quality indicators that were relevant and measurable. Feasibility was determined by abstracting the quality indicator variables from a retrospective chart review. RESULTS: The expert panel prioritized 11 quality indicators as benchmarks for assessing the quality of surgical care in SNLB. Nine of the indicators were measurable at the chart or institutional level. CONCLUSIONS: A systematic evidence- and consensus-based approach was used to develop measurable quality indicators that could be used by practicing surgeons and administrators to evaluate performance of SLNB in breast cancer.


The dismal outcome of ovarian, fallopian tube, and primary peritoneal carcinomas calls for an increase in surgical aggressiveness. After a long era during which incomplete cytoreduction was considered acceptable, it has been established that the outcome is directly related to the amount of diseased tissue left in place. Probably as a result of technical limitations of surgeons and anesthesiologists, the majority of teams have fixed a cut-off value of 2 cm to define what was called “optimal” cytoreduction. Although it is now established that reaching the 2 cm cut-off value is the minimal required target, the target has moved towards complete removal of visible implants. However, the methods of assessment of residual disease and the very concept of complete cytoreduction suffer from limitations.


Two concurrent policies can be proposed to improve the quality of care for ovarian cancer surgery: organization of care, audit. The two policies are not to be opposed: the efficacy of any policy must be audited, targets are more rapidly reached and more easily audited when an underlying organization is available. However, the arbitrary definition of criteria is a challenge. The interpretation of results depends on the context of each individual center. There is a definite risk of unwanted effects: competition to reach the cut-off if quantitative caseload criteria are demanded, reduction of the quality of cytoreduction if the complication rate is included, selection of patients if the rate of complete cytoreduction is chosen as a major parameter. Quality control must encompass the standard of preoperative workup, the quality of operative report, the complication rate and the oncological outcome. Although quantitative yearly caseload requirements may contribute to the quality of care, it seems more pertinent to recall the prerequisites that the surgeon must fulfil before undertaking a surgery for ovarian cancer. Knowledge of the specific features of the disease and of all the components of its medical management, skills in general surgical procedures required to complete staging and cytoreduction, and contribution to a multidisciplinary team involved in clinical research are mandatory. Even though no definitive proof is available, the available information tend to show a superiority of the standard of surgical care provided by experienced or specialized surgeons.
BACKGROUND: Based on registries, the European experience has been that <50% of patients are treated according to protocols and/or benefit from the minimum required surgery for ovarian cancer. The French Cancer Plan 2009-2013 considers the definition of qualitative indicators in ovarian cancer surgery in France. This endeavour was undertaken by the French Society of Gynaecologic Oncology SFOG in partnership with the French National College of Obstetricians and Gynecologists and all concerned learned societies in a multidisciplinary mindset. METHODS: The quality indicators for the initial management of patients with ovarian cancer were based on the standards of practice determined from scientific evidence or expert consensus. RESULTS: The indicators were divided into structural indicators, including material equipment), human number and qualification of staff, and organizational resources, process indicators, and outcome indicators. CONCLUSIONS: The enforcement of a quality assurance programme in any country would undoubtedly promote improvement in the quality of care for ovarian cancer patients and would result in a dramatic positive impact on their survival. Such a policy is not only beneficial to the patient, but is also profitable for the healthcare system.


BACKGROUND: The primary management of adult soft tissue sarcomas STS is characterized by heterogeneity across centers. Several studies suggest that it is improved when coordinated by specialized sarcoma centers. PATIENTS AND METHODS: This study, comparing STS patients of the Rhone-Alpes region treated within and outside the cancer network, retrospectively assesses the conformity of medical practice with 'evidence-based medicine' EBM reported under the clinical practice guidelines CPGs of the French Federation of Cancer Centers. Institutional records of 100 new STS patients seen between 1999 and 2001 in the regional comprehensive cancer center and Lyon University hospital were analyzed retrospectively 50/300 new files randomly selected in each institution. Medical decisions were checked for conformity with CPGs. RESULTS: Median age was 58 years range 18 -88 and median tumor size was 9 cm range 1 -26. The most common primary sites were extremities, viscera or trunk. The most frequent histology was leiomyosarcoma 21% or liposarcoma 12%. Only 7% of cases were reviewed by formal multidisciplinary committee before biopsy with 42% pre -surgery biopsies only. The first surgical resection was R0, R1 and R2 in 26, 29 and 45% of cases, respectively. Conformity to CPGs was rated 52, 81, 94 and 95% for initial surgery, radiation therapy, chemotherapy and follow-up, respectively. At multivariate analysis, pre-surgery multidisciplinary discussion, management in reference center and management within cancer network independently predicted conformity to CPGs. CONCLUSIONS: Conformity with EBM was similar to previous reports. Elaboration of treatment strategy within a formal multidisciplinary staff and treatment within a cancer network are both important prognostic factors for optimal clinical care.


BACKGROUND: Several organizations have published evidence-based quality indicators for community-acquired pneumonia CAP. However, there is variability in the types of indicators presented between organizations and the level of supporting evidence for each of the indicators. A systematic review of the literature and relevant Internet Web sites was performed to identify quality indicators for CAP that have been proposed or recommended by organizations, and each of the indicators was then critically appraised, using a well-defined set of criteria. METHODOLOGY: The MEDLINE, EMBASE, Best Evidence, and Cochrane Systematic Review databases and Internet Web sites were searched for articles and guidelines published between January 1980 and May 2001 to identify quality indicators for CAP and relevant evidence. Experts in the area of health services research...
were contacted to identify additional sources. A well-defined set of criteria was applied to evaluate each of the quality indicators. RESULTS: The systematic review of the literature and Internet Web sites yielded 44 CAP-specific quality indicators. The critical appraisal of these indicators yielded 16 indicators that were supported by a study that identified an association between quality of care and the process of care or outcome measure, were applied to enough patients to be able to detect clinically meaningful differences, were clinically and/or economically relevant, were measurable in a clinical practice setting, and were precise in their specifications. CONCLUSIONS: Many organizations recommend indicators for CAP. Indicators may serve as measures of clinical performance for clinicians and hospitals, may help in benchmarking, and may ultimately facilitate improvements in quality of care and cost reductions. However, CAP indicators often vary in their meaningfulness, scientific soundness, and interpretability of results. A set of five critical appraisal questions may assist in the evaluation of which quality indicators are most valid.


OBJECTIVES: To determine the effect of participation in clinical trials on survival of women with ovarian cancer. Disease-specific factors and demographics were also examined. METHODS: A total of 158 women were treated for ovarian cancer at a regional cancer center. All patients were offered treatment with surgery/chemotherapy and were screened at diagnosis for participation in clinical research. Progression-free and overall survival, as well as demographic- and treatment-related data, were recorded. RESULTS: Fifty-three participated in clinical trials and 105 did not. On-study versus off-study subjects were similar in age 64.1 vs 63.5 years, ethnicity 87% vs 85% white, performance status 100% 0 -1 Gynecologic Oncology Group scale, and urban versus rural lifestyle 58% vs 55% urban. Stage of disease, histologic subtype, and type/amount of therapy were also similar. Kaplan-Meier analysis showed superior overall survival for on-study subjects median, 46 vs 25 months, 95% confidence interval, 1.0299 -2.1505 months, P = 0.0343. A trend toward improved progression -free survival approached significance for on-study subjects median, 23 vs 9 months, 95% confidence interval, 0.9545 -2.0022 months, P = 0.0866. CONCLUSIONS: Women with ovarian cancer who participate in clinical trials at this institution have improved survival compared with those who are treated with standard therapies. No other factors examined were associated with treatment completion or survival. Further, participation in clinical research does not vary by age, ethnicity, urban versus rural lifestyle, or cancer stage or histologic subtype. However, disclosure of this information to potential clinical trial participants may represent an ethical conflict and should be carefully considered in light of existing ethical guidelines for human subject research.


We evaluated the relationship between the outcome of newly diagnosed ovarian cancer patients treated in 1123 German gynecology departments in 2001, and their participation in clinical trials through two German cooperative study groups. In addition, we evaluated other potential factors predicting outcome including hospital volume. The analysis was based on 476 patients from 165 hospitals and 3-year follow-up. Patients treated in study hospitals had a higher chance of receiving treatment according to national guidelines. This included a higher chance of receiving optimal staging in early stage disease and of receiving the recommended combination of surgical debulking and combination chemotherapy in advanced disease. On multivariable Cox model analysis, overall survival was significantly worse in patients treated in non-study hospitals.


BACKGROUND: We evaluated the effect of adding secondary cytoreductive surgery to postoperative chemotherapy on progression-free survival and overall survival among patients who had advanced
ovarian cancer and residual tumor exceeding 1 cm in diameter after primary surgery. METHODS: Women were enrolled within six weeks after primary surgery. If, after three cycles of postoperative paclitaxel plus cisplatin, a patient had no evidence of progressive disease, she was randomly assigned to undergo secondary cytoreductive surgery followed by three more cycles of chemotherapy or three more cycles of chemotherapy alone. RESULTS: We enrolled 550 women. After completing three cycles of postoperative chemotherapy, 216 eligible patients were randomly assigned to receive secondary surgical cytoreduction followed by chemotherapy and 208 to receive chemotherapy alone. Surgery was declined by or medically contraindicated in 15 patients who were assigned to secondary surgery (7 percent). As of March 2003, 296 patients had died and 82 had progressive disease. The likelihood of progression-free survival in the group assigned to secondary surgery plus chemotherapy, as compared with the chemotherapy-alone group, was 1.07 95 percent confidence interval, 0.87 to 1.31; P=0.54, and the relative risk of death was 0.99 95 percent confidence interval, 0.79 to 1.24; P=0.92.

CONCLUSIONS: For patients with advanced ovarian carcinoma in whom primary cytoreductive surgery was considered to be maximal, the addition of secondary cytoreductive surgery to postoperative chemotherapy with paclitaxel plus cisplatin does not improve progression-free survival or overall survival.


As consumers, payers, and regulatory agencies require evidence regarding health care qualities the demand for process of care measures will grow. Although outcome measures of quality represent the desired end results of health care, validated process of care measures provide an important additional element to quality improvement efforts, as they illuminate exactly which provider actions could be changed to improve patient outcomes. In this essay, we discuss the advantages and disadvantages of process measures of quality, and outline some practical strategies and issues in implementing them.


This paper outlines the steps in developing and implementing process measures of quality. Developing a process measure includes defining the purpose of and audiences for the measures, choosing the clinical area to evaluate, organizing the assessment team, choosing the component of the process to measure, writing the indicator specifications, performing preliminary tests of feasibility, reliability and validity, and determining scoring and analytical specifications. Given the growing evidence in the literature regarding the impact of care, and an evolving understanding of how to develop and implement process of care measures as outlined here, the future should bring the development and implementation of quality indicators that are rigorously developed and that will provide insights into opportunities to improve the quality of care.


Although complete debulking surgery for epithelial ovarian cancer EOC is more often achieved with interval debulking surgery IDS following neoadjuvant chemotherapy NACT, randomized evidence shows no long-term survival benefit compared to complete primary debulking surgery PDS. We performed an observational cohort study of patients treated with debulking surgery for advanced EOC to evaluate the prognostic value of residual disease after debulking surgery. All patients treated between 1998 and 2010 in three Dutch referral gynaecological oncology centres were included. The prognostic value of residual disease after surgery for disease specific survival was assessed using Cox-regression analyses. In total, 462 patients underwent NACT-IDS and 227 PDS. Macroscopic residual disease after debulking surgery was an independent prognostic factor for survival in both treatment modalities. Yet, residual tumour less than one centimetre at IDS was associated with a survival benefit of five months compared to leaving residual tumour more than one centimetre, whereas this benefit was not seen after
PDS. Leaving residual tumour at IDS is a poor prognostic sign as it is after PDS. The specific prognostic value of residual tumour seems to depend on the clinical setting, as minimal instead of gross residual tumour is associated with improved survival after IDS, but not after PDS.


PURPOSE: To identify quality indicators and establish acceptable quality limits AQLs in pancreatic oncologic surgery using a formal statistical methodology. METHODS: Indicators have been identified through systematic literature reviews and guidelines for pancreatic surgery. AQLs were determined for each indicator with confidence intervals of 99.8 and 95 % above and below the weighted average by sample size from the different series examined. RESULTS: Several indicators have been identified with the following results as AQLs: resectability rate >59 %; morbidity, mortality, and pancreatic fistula rate in pancreaticoduodenectomy <55, <5, and <16 %, respectively; morbidity, mortality, and fistula rate in distal pancreatectomy <53, <4, and <31 %, respectively; number of lymph nodes retrieved >15; R1 resection <46 %; survival at 1, 3, and 5 years >54, >19, and >8 %, respectively. CONCLUSIONS: A series of different indicators for quality surgical care outcome in pancreatic cancer, as well as their limits, have been determined according to a standard methodology.


OBJECTIVE: To evaluate clinicopathological factors and survival outcome of patients with advanced epithelial ovarian carcinoma undergoing multiple bowel resections to achieve optimal < or = 1 cm cytoreduction. METHODS: A case-control study was performed identifying patients undergoing optimal primary cytoreductive surgery with > or = 2 bowel resections between 10/1997 and 2/2006. The two control groups consisted of 1 patients undergoing optimal cytoreduction with < or = 1 bowel resections matched [1:2] for age and stage and 2 patients left with suboptimal disease. Cox proportional hazards model were used to evaluate the effects of demographic and surgico-pathologic factors on survival outcome. RESULTS: A total of 34 patients underwent > or = 2 bowel resections. Sixty-eight patients underwent < or = 1 bowel resections. All patients had optimal cytoreduction and 40/102 patients 39.2% underwent complete cytoreduction. Patients undergoing multiple bowel resections experienced a higher EBL 700 v 500 mL, p=0.01 and longer LOS 10 v 7 days, p=0.01 compared to patients with < or = 1 bowel resections. Multivariate analysis revealed the amount of residual disease to be a statistically significant and radiation therapy to the right pelvic sidewall and cul-de-sac independent predictor of overall survival. The median overall survival time for patients undergoing > or = 2 bowel resections was 28.3 months, which was comparable to patients undergoing < or = 1 bowel resections. 37.8 months, p=0.09 but statistically significantly superior to patients left with suboptimal residual disease 12 months, p=0.02. CONCLUSIONS: Although primary surgery that includes > or = 2 bowel resections is associated with longer LOS and a higher EBL, such extensive procedures are warranted if they will contribute to an overall optimal residual disease state.


OBJECTIVE: To develop and evaluate evidence-informed quality indicators of adult injury care. BACKGROUND: Injury is a leading cause of morbidity and mortality, but there is a lack of consensus regarding how to evaluate injury care. METHODS: Using a modification of the RAND/UCLA Appropriateness Methodology, a panel of 19 injury and quality of care experts serially rated and revised quality indicators identified from a systematic review of the literature and international audit of trauma center quality improvement practices. The quality indicators developed by the panel were sent to 133 verified trauma centers in the United States, Canada, Australia, and New Zealand for evaluation. RESULTS: A total of 84 quality indicators were rated and revised by the expert panel over 4 rounds of
review producing 31 quality indicators of structure n=5, process n=21, and outcome n=5 , designed to assess the safety n=8, effectiveness n=17, efficiency n=6, timeliness n=16, equity n=2, and patient-centeredness n=1 of injury care spanning prehospital n=8, hospital n=19, and posthospital n=2 care and secondary injury prevention n=1. A total of 101 trauma centers 76% response rate rated the indicators 1=strong disagreement, 9=strong agreement) as targeting important health improvements median score 9, interquartile range [IQR] 8 - 9, easy to interpret median score 8, IQR 8 - 9, easy to implement median score 8, IQR 7 - 8, and globally good indicators median score 8, IQR 8 - 9. CONCLUSIONS: Thirty-one evidence-informed quality indicators of adult injury care were developed, shown to have content validity, and can be used as performance measures to guide injury care quality improvement practices.


BACKGROUND: In 2008, the Dutch Health Care Transparency Programme Zichtbare Zorg was set up to develop and apply quality indicators QIs for health care. These QIs serve a range of purposes and can be categorized into those for internal use-for meeting quality standards and to continuously measure improvement formative-and external use-to enable patients and health insurance companies to distinguish between health care providers summative. In order to assess the validity of QIs, a comprehensive Indicator Assessment Framework IAF was developed. This framework specifies the following criteria for validation: content validity, absence of selection bias, absence of measurement bias, and statistical reliability. Because of the intended summative use, the IAF was used for structural assessment of the QIs set for Dutch community pharmacists. OBJECTIVE: To assess the validity of the current set of 52 QIs for community pharmacies using the IAF. METHODS: An expert panel applied the IAF criteria to the set of QIs collected in 1,807 Dutch community pharmacies on their performance in 2011. The QIs were judged as meeting, partly meeting, or not meeting the requirements regarding these criteria. The judgments were evaluated for QI type structure, process, or outcome and for predefined domains. RESULTS: Thirteen QIs 25% were judged as meeting the requirements for all criteria. Among them were 12 structure indicators and 1 process indicator. For process indicators, the criterion for measurement bias poorly met the requirements, and content validity was unsatisfactory for outcome indicators. The 13 overall valid QIs covered 6 out of 10 predefined domains: continuity of care, clinical risk management, compounding, dispensing of medication, management, and quality management. CONCLUSIONS: When subjecting the QI set for community pharmacies to the requirements of the IAF, only a quarter of the QIs met all requirements. To increase the number of valid process and outcome indicators, meaningful aspects for the outcome of pharmaceutical care have to be defined, and uniform measurement of relevant processes has to be implemented.


BACKGROUND: Strong associations between provider i.e., hospital or surgeon procedure volumes and patient outcomes have been demonstrated for many types of cancer operation. We performed a population-based cohort study to examine these associations for ovarian cancer resections. METHODS: We used the Surveillance, Epidemiology, and End Results SEER -Medicare linked database to identify 2952 patients aged 65 years or older who had surgery for a primary ovarian cancer diagnosed from 1992 through 1999. Hospital- and surgeon-specific procedure volumes were ascertained based on the number of claims submitted during the 8-year study period. Primary outcome measures were mortality at 60 days and 2 years after surgery, and overall survival. Length of hospital stay was also examined. Patient age at diagnosis, race, marital status, comorbid illness, cancer stage, and median income and population density in the area of residence were used to adjust for differences in case mix. All P values are two-sided. RESULTS: Neither hospital- nor surgeon-specific procedure volume was statistically significantly associated with 60-day mortality following primary ovarian cancer resection. However, differences by hospital volume were seen with 2-year mortality; patients treated at the low-, intermediate-, and high-volume hospitals had 2-year mortality rates of 45.2% 95% confidence interval
[CI] = 42.1% to 48.4%, 41.1% 95% CI = 38.1% to 44.3%, and 40.4% 95% CI = 37.4% to 43.4%, respectively. The inverse association between hospital procedure volume and 2-year mortality was statistically significant both before P = .011 and after P = .006 case-mix adjustment but not after adjustment for surgeon volume. Two-year mortality for patients treated by low-, intermediate-, and high-volume surgeons was 43.2% 95% CI = 40.7% to 45.8%, 42.9% 95% CI = 39.5% to 46.4%, and 39.5% 95% CI = 36.0% to 43.2%, respectively; there was no association between 2-year mortality and surgeon procedure volume, with or without case-mix adjustment. After case-mix adjustment, neither hospital volume P = .031 nor surgeon volume P = .062 was strongly associated with overall survival.

CONCLUSION: Hospital- and surgeon-specific procedure volumes are not strong predictors of survival outcomes following surgery for ovarian cancer among women aged 65 years or older.


PURPOSE: The aim of this study was to compare the progression-free and overall survivals of women with advanced ovarian cancer treated with neoadjuvant chemotherapy followed by surgery with those treated conventionally with cytoreductive surgery followed by cytotoxic chemotherapy. MATERIALS AND METHODS: Fifty-nine consecutive women with advanced malignancies compatible with ovarian cancer based on 1 physical examinations, 2 computerized tomography scans, and 3 cytologic or histologic specimens and treated with platinum-based combination chemotherapy, i.e., neoadjuvant chemotherapy, were retrospectively reviewed. Forty-one subsequently underwent cytoreductive surgery. Their overall and progression-free survivals were compared to those of 206 consecutive women with Stage IIIC and IV epithelial ovarian cancers treated with conventional cytoreductive surgery followed by platinum-based combination chemotherapy during the same era. RESULTS: No statistical difference was observed in overall survival P = 0.1578 or in progression-free survival between the group treated with neoadjuvant chemotherapy and the conventionally treated group P = 0.5327 despite the neoadjuvant chemotherapy patients being statistically older median age 67 years [range 44 to 85 years] vs a median age of 60 years [range 19 to 79 years] for conventionally treated patients; P < 0. 001 and having a statistically poorer performance status P < 0. 001 than the conventionally treated group. Women undergoing cytoreductive surgery following neoadjuvant chemotherapy had a statistically improved overall survival P < 0.0001 compared to those who did not undergo surgery. CONCLUSIONS: Neoadjuvant chemotherapy does not compromise the survival of women treated for advanced ovarian cancer. Prospective randomized trials comparing neoadjuvant chemotherapy to conventional therapy to determine quality of life experiences and cost/benefit outcomes are now appropriate for women presenting with advanced ovarian cancer.


OBJECTIVE: To investigate the reproducibility of quality indicators in the care of patients undergoing operations for head and neck cancer. DESIGN: A review of specialty-specific surgical quality indicators in a cohort undergoing procedures for definitive treatment of head and neck cancer, stratified by high and low acuity of the surgical procedures and compared with established benchmarks. SETTING: A large tertiary care institution and an associated multidisciplinary cancer center. PATIENTS: Fifty randomly selected patients with evaluable data who were diagnosed as having head and neck cancer that was definitively treated using any of the 3 modalities surgical procedures, chemotherapy, and/or radiotherapy during a 15-month period at our center. Twenty-one patients who underwent operations form the basis of this report. MAIN OUTCOME MEASURES: Procedures were stratified by acuity on the basis of the extent of the operation. Data were centered on quality indicators designed to reflect length of stay, readmission within 30 days postoperatively, return to the operating room within 7 days of surgery, use of blood products, 30-day mortality, adequacy of reports on surgical pathologic findings, and surgical site infection. RESULTS: Diagnoses in the cohort included carcinoma of the oral cavity in 19 patients 39%, oropharynx in 14 29%, larynx in 13 27%, and hypopharynx in 3 6%. High - and low-acuity surgical procedures were performed in 12 and 7 patients, respectively.
No statistically significant differences in the measures for quality indicators were found between the cohort and the calculated benchmarks. CONCLUSION: Our findings demonstrate the applicability of quality indicators to the care of patients with head and neck cancer treated by surgical intervention stratified by acuity and compared with established benchmarks.


OBJECTIVES: To identify a generic set of face valid quality indicators for primary care mental health services which reflect a multi-stakeholder perspective and can be used for facilitating quality improvement. DESIGN: Modified two-round postal Delphi questionnaire. SETTING: Geographical spread across Great Britain. PARTICIPANTS: One hundred and fifteen panellists representing 11 different stakeholder groups within primary care mental health services clinical psychologist, health and social care commissioner, community psychiatric nurse, counsellor, general practitioner, practice nurse/district nurse/health visitor, psychiatrist, social worker, carer, patient and voluntary organisations. MAIN OUTCOME MEASURES: Face validity median rating of 8 or 9 on a nine point scale with agreement by all panels for assessing quality of care. RESULTS: A maximum of 334 indicators were rated by panels in the second round; 26% were rated valid by all panels. These indicators were categorised into 21 aspects of care, 11 relating to general practices and 10 relating to health authorities or primary care groups/trusts. There was variation in the total number of indicators rated valid across the different panels. Overall, GPs rated the lowest number of indicators as valid 41%, n=138 and carers rated the highest number valid 91%, n=304. CONCLUSIONS: The quality indicators represent consensus among key stakeholder groups in defining quality of care within primary mental health services. These indicators could provide a guide for primary care organisations embarking on quality improvement initiatives in mental health care when addressing national targets and standards relating to primary care set out in the National Service Framework for Mental Health for England. Although many of the indicators relate to parochial issues in UK service delivery, the methodology used in the development of the indicators could be applied in other settings to produce locally relevant indicators.


The objective of the study was to review referral practice, overall management, and survival in women with suspected ovarian cancer in Wales. This study was done prior to introduction of cancer management guidelines in the region. A confidential study questionnaire was sent to 20 participating hospitals. Data on 287 consecutive women with suspected ovarian cancer were collected, of which 250 women underwent primary laparotomy. Information was obtained on referral pattern, preoperative investigations, place of primary surgery, specialty of the primary surgeon, surgical parameters recorded at the time of operation, a final overall stage, adjuvant treatment, and survival outcome. There was a wide variation in referral practice and management of ovarian cancer in Wales. Stage of the disease, attempt at optimal debulking, residual disease, management by a cancer centre multidisciplinary team, and platinum-based chemotherapy were associated with improved overall survival and progression-free survival. More women were alive if managed in the cancer centre at 1 and 3 year after diagnosis P = 0.022. This study has highlighted the acute issue of the standards of clinical care in the area of ovarian cancer management and will emphasize the implementation of better care pathways for ovarian cancers.


The objectives of this population-based, retrospective study, was to find predictive factors for surgical outcome and long-term survival in 447 patients with epithelial ovarian cancer in FIGO-stages III-IV
treated during 1975-1993. The median overall survival rate of this series was 18 months, the 5-year cancer-specific survival rate was 18%, and the 5-year overall survival rate, 16%. In a logistic regression analysis, type of surgeon was the strongest $P=0.006$ predictive factor for surgical outcome after the age of the patient. The optimal debulking rate was 36% for gynecologic oncologists, 29% for general gynecologists, 24% for combined gynecologist and obstetrician with the third level of specialization, and 4% for general surgeons. Optimal debulking no visible tumor or residual tumor <2 cm was achieved in 26% of the cases. Predictive factors of the outcome of cytoreduction were FIGO-stage $P=0.007$, histological subtype $P=0.016$, and tumor grade $P=0.046$ in univariate analyses. In a Cox multivariate analysis the most important prognostic factor for overall survival was the amount of residual cancer $P=0.000001$ before age, grade and stage. Therefore, to achieve optimal surgical outcome and optimal overall survival rate the primary surgery of advanced ovarian cancer should be performed by gynecologic oncologists or by gynecologists specially trained in gynecologic cancer surgery.


OBJECTIVE: To develop and validate a comprehensive complication index CCI that integrates all events with their respective severity. BACKGROUND: Reporting of surgical complications is inconsistent and often incomplete. Most studies fail to provide information about the severity of complications, or inform only on the most severe event, ignoring events of lesser severity. METHODS: We used an established classification of complications, adopting methods from operation risk index analysis in marketing research to develop a formula that considers all complications that may occur in a patient. The weights of each grade of complication, defined as median reference values, were obtained from 472 participants, who rated 30 different complications. Validation to assess sensitivity to treatment effects and validity of the CCI was performed by 4 different approaches, based on 1299 patients. RESULTS: The CCI is calculated as the sum of all complications that are weighted for their severity multiplication of the median reference values from patients and physicians. The final formula yields a continuous scale to rank the severity of any combination of complications from 0 to 100 in a single patient. The CCI was highly sensitive in detecting treatment effect differences in the context of a randomized trial effect size detected by CCI vs conventional standardized morbidity outcomes. It also showed a negative correlation with postoperative health status $r = -0.24$, $P = 0.002$, and high correlation with the results of patient-rated single and multiple complications on conjoint analysis $r = 0.94$, $P < 0.001$. CONCLUSIONS: The CCI summarizes all postoperative complications and is more sensitive than existing morbidity endpoints. It may serve as a standardized and widely applicable primary endpoint in surgical trials and other interventional fields of medicine. The CCI can be readily computed on the basis of tabulated complications according to the Clavien-Dindo classification available at www.assessurgery.com.


BACKGROUND: At present, there are no guidelines on prevention and management of postpartum haemorrhage in primary midwifery care in the Netherlands. The first step towards implementing guidelines is the development of a set of quality indicators for prevention and management of postpartum haemorrhage for primary midwifery supervised home birth in the Netherlands. METHODS: A RAND modified Delphi procedure was applied. This method consists of five steps: 1 composing an expert panel 2 literature research and collection of possible quality indicators, 3 digital questionnaire, 4 consensus meeting and 5 critical evaluation. A multidisciplinary expert panel consisting of five midwives, seven obstetricians and an ambulance paramedic was assembled after applying pre-specified criteria concerning expertise in various domains relating to primary midwifery care, secondary obstetric care, emergency transportation, maternal morbidity or mortality audit, quality indicator development or clinical guidelines development and representatives of professional organisations. RESULTS: After literature review, 79 recommendations were selected for assessment by
the expert panel. After a digital questionnaire to the expert panel seven indicators were added, resulting in 86 possible indicators. After excluding 41 indicators that panel members unanimously found invalid, 45 possible indicators were assessed at the consensus meeting. During critical evaluation 18 potential indicators were found to be overlapping and two were discarded due to lack of measurability.

CONCLUSIONS: A set of 25 quality indicators was considered valid for testing in practice.


BACKGROUND: The increasing presence of managed health care in the United States has been accompanied by the widespread use of performance indicators to assess health plans along various dimensions of quality. Current performance indicator sets virtually ignore psychosocial and behavioral factors in the prevention and management of illness, especially chronic illness, in spite of documented evidence in the medical literature of the importance of these factors. Instead, current indicator sets focus primarily on biomedical interventions to prevent, treat, and manage illness.

METHODOLOGY: In a novel method for developing performance indicators—the use of a storytelling methodology—eight interdisciplinary panels, composed of health care experts at the community, state, and national levels, each completed two stories about patients with chronic illnesses. The first story described experiences a patient might have in the health care system as it is today; the second story retold the events that might transpire if attention to psychosocial and behavioral factors were integrated into the health care system.

FINDINGS: Differences between the two sets of stories developed by the panels revealed common themes and specific areas where indicator development might prove fruitful. Performance indicators were identified from these themes, and work is underway to operationalize them; to identify barriers and opportunities for their inclusion in indicator sets; and to further document their potential health and cost-effectiveness.

DISCUSSION: Although not scientifically rigorous, the storytelling method was found to provide consistent results and may be applied to many aspects of the health care planning process, health education, and quality improvement efforts.


BACKGROUND: Quality of surgical care can be an important contributor to differences in survival among patients, and this suggests considerable potential for quality improvement in surgery of melanoma. Although clinical practice guidelines (CPG) for melanoma have been produced by various organizations, none address in detail some aspects of care related to surgery, and this brings about a quite heterogeneous surgical approach. Thus, Quality Assurance (QA) programs in melanoma surgery are essential.

METHODS: Using the RAND/UCLA Appropriateness Method, an Italian panel of expert surgeons and pathologists belonging to the Italian Melanoma Intergroup (IMI) were invited to vote on statements regarding surgical treatment of melanoma and potential quality indicators for QA. All statements/indicators were scored for appropriateness and judged as valid in cases of 90% agreement.

RESULTS: Consensus was obtained on 15 statements regarding indications for and extent of surgery, wide excision, sentinel node biopsy and lymphadenectomy and on 7 QA indicators suitable to measure surgical performance for internal audit.

CONCLUSIONS: The obtained consensus represents the basis to start a standardized QA program in Italy. The benchmark values of each indicator will be completed and updated according to the forthcoming results of the Clinical National Melanoma Registry (CNMR). Promoting a QA program at each IMI institution should increase the standard of care for melanoma patients in Italy.


Image-guided core biopsy of the omentum and peritoneum was described a decade ago and has since been validated in a number of large studies as a safe and effective means of providing a tissue diagnosis in patients with undiagnosed peritoneal disease. Some studies have addressed its ability for determining whether peritoneal infiltration and/or omental masses in patients with prior malignancy represent recurrent disease or a new disease process. Others have focused on the specific issue of women suspected to have advanced peritoneal carcinomatosis from ovarian or primary peritoneal cancer where the primary management of the patient is directed by the tissue diagnosis. The initial management of many of these women, especially those with advanced disease or substantial comorbidity, is with primary chemotherapy. With current clinical trials for ovarian cancer directed to specific morphological subtypes of the disease, image-guided core biopsy offers a rapid and well tolerated nonsurgical means of providing this information. In this Review, we discuss the technique and its clinical applications, and critically examine the currently available alternative options.


PURPOSE: This study was undertaken to assess if prolonged paclitaxel administration in combination with cisplatin improves overall survival OS in epithelial ovarian cancer EOC. PATIENTS AND METHODS: Eligible patients with suboptimal stage III or IV EOC, fallopian tube, or primary peritoneal cancer were randomly allocated to receive six cycles of cisplatin 75 mg/m² and either paclitaxel 135 mg/m² during 24 hours arm 1 or paclitaxel 120 mg/m² during 96 hours arm 2. RESULTS: Planned accrual was 324 patients; 293 were enrolled before the study was closed as a result of a scheduled interim futility analysis. There were 13 ineligible patients; thus, 140 patients in each arm were assessable. In arm 1, 80% of patients completed all six cycles compared with 83% of patients in arm 2. Grade 4 granulocytopenia was more common in arm 1 79% v 54%; P < .001 whereas grade 3 or worse anemia was more severe in arm 2 6% v 18%; P < .003. The median progression-free survival was 1.03 years for arm 1 versus 1.05 years for arm 2. The median OS was 2.49 and 2.54 years for arms 1 and 2, respectively. There have been 237 reported deaths. The relative death rate was approximately 12% greater in arm 2 hazard ratio, 1.12; 95% CI, 0.860 to 1.45. CONCLUSION: Patients with advanced EOC have a relatively poor prognosis. The results of treatment with cisplatin and paclitaxel are not significantly improved by prolonging the paclitaxel infusion from 24 to 96 hours.


BACKGROUND: Evidence indicates that pain is undertreated in the emergency department ED). The first step in improving the pain experience for ED patients is to accurately and systematically assess the actual care being provided. Identifying gaps in the assessment and treatment of pain and improving patient outcomes requires relevant, evidence-based performance measures. OBJECTIVE: To systematically review the literature and identify quality indicators specific to the assessment and management of pain in the ED. METHODS: Four major bibliographical databases were searched from January 1980 to December 2010, and relevant journals and conference proceedings were manually searched. Original research that described the development or collection of data on one or more quality indicators relevant to the assessment or management of pain in the ED was included. RESULTS: The search identified 18,078 citations. Twenty-three articles were included: 15 observational cohort) studies; three before-after studies; three audits; one quality indicator development study; and one survey. Methodological quality was moderate, with weaknesses in the reporting of study design and methodology. Twenty unique indicators were identified, with the majority 16 of 20 measuring care processes. Overall, 91% 21 of 23 of the studies reported indicators for the assessment or management of presenting pain, as opposed to procedural pain. Three of the studies included children; however, none of the indicators were developed specifically for a pediatric population. CONCLUSION: Gaps in the existing literature include a lack of measures reflecting procedural pain, patient outcomes and the pediatric population. Future efforts should focus on developing indicators specific to these key areas.
The objective of this study is to compare progression-free survival (PFS) and overall survival (OS) of ovarian cancer patients treated with neoadjuvant chemotherapy and surgery to primary surgery and postoperative chemotherapy. Retrospective analysis from 1998 to 2003 of 116 patients with ovarian cancer was performed. Fifty women diagnosed by positive cytology received three cycles of carboplatin and paclitaxel. Thirty-six patients subsequently underwent cytoreductive surgery and completed three further cycles postoperatively. The OS and PFS were compared in 66 women treated with primary surgery and postoperative chemotherapy. A statistically significant difference was observed for OS $P=0.03$, $HR = 1.85$, $CI = 1.06$-$3.23$ and $PFS P=0.04$, $HR = 1.61$, $CI = 1.03$-$2.53$ favoring the primary surgery group. Due to the small numbers, age, grade, stage, pleural effusions, and histologic cell type were controlled for separately in the bivariate analyses. Controlling for stage made the results weaker. A matched subgroup survival analysis was performed on patients who had surgery following neoadjuvant chemotherapy. After matching for stage and grade and controlling age and pleural effusions $N=28$ matched pairs, there was no statistical difference for OS $P=0.95$, $HR = 1.04$, $CI = 0.33$-$3.30$ or $PFS P=0.79$, $HR = 1.11$, $CI = 0.98$-$1.04$. It is concluded that primary surgery should be considered in all patients. Neoadjuvant chemotherapy may be an alternative in a subset of women with the intent to also perform interval debulking.


OBJECTIVE: In this article, we describe one approach for evaluating the value of developing quality indicators (QIs). STUDY DESIGN AND SETTING: We focus on describing how to develop a conceptual measurement framework and how to evaluate the need to develop QIs. A recent process to develop QIs for injury care is used for illustration. RESULTS: Key steps to perform before developing QIs include creating a conceptual measurement framework, determining stakeholder perspectives, and performing a QI needs assessment. QI development is likely to be most beneficial for medical problems for which quality measures have not been previously developed or are inadequate and that have a large burden of illness to justify quality measurement and improvement efforts, are characterized by variable or substandard care such that opportunities for improvement exist, and have evidence that improving quality of care will improve patient health. CONCLUSION: By developing a conceptual measurement framework and performing a QI needs assessment, developers and users of QIs can target their efforts.


2010 Gynecologic Cancer InterGroup GCIG) consensus statement on clinical trials in ovarian cancer. This report provides the outcomes from the Fourth Ovarian Cancer Consensus Conference.


BACKGROUND: Although quality indicators for the care of acute myocardial infarction (AMI) patients have been described for other countries, there are none specifically designed for the Canadian health care system. The authors' goal was to develop a set of Canadian quality indicators for AMI care. METHODS: A literature review identified existing quality indicators for AMI care. A list of potential indicators was assessed by a nine-member panel of clinicians from a variety of disciplines using a modified-Delphi panel process. After an initial round of rating the potential indicators, a series of indicators was identified for a second round of discussion at a national meeting. Further refinement of indicators occurred following a teleconference and review by external reviewers. RESULTS: To identify an AMI cohort, case definition criteria were developed, using a hospital discharge diagnosis for
AMI of International Classification of Diseases-Ninth revision ICD-9 code 410.x. Thirty-seven indicators for AMI care were established. Pharmacological process of care indicators included administration of acetylsalicylic acid, beta-blockers, angiotensin-converting enzyme inhibitors, thrombolytics and statins. Mortality and readmissions for AMI, unstable angina and congestive heart failure were recommended as outcome indicators. Nonpharmacological indicators included median length of stay in the emergency department, and median waiting times for cardiac catheterization, percutaneous coronary intervention and/or coronary artery bypass graft surgery. INTERPRETATION: A set of Canadian quality indicators for the care of AMI patients has been established. It is anticipated that these indicators will be useful to clinicians and researchers who want to measure and improve the quality of AMI patient care in Canada.


The Canadian Heart Health Strategy and Action Plan recommended that the Canadian Cardiovascular Society CCS lead the development of pan-Canadian data definitions and quality indicators QIs for evaluating cardiovascular care in Canada. In response to this recommendation, the CCS developed and adopted a standardized QI development methodology. This report provides a brief overview of the CCS "Best Practices" for developing pan-Canadian cardiovascular QIs. A more detailed description is available in Supplemental Material. The CCS Best Practices QI development methodology consists of 3 phases: phase I, plan and organize the QI development initiative; phase II, develop and select QIs; and phase III, operationalize the QIs. Phase I includes identifying the cardiovascular focus or content area, determining the objective and/or purpose of the initiative, the target users of, and the target population for, the QIs, and selection of a QI working group. Phase II involves formulating the QIs including generating a preliminary set of QIs and draft definitions, followed by an indicator rating and ranking process based on the CCS QI rating criteria. Phase III involves finalizing technical specifications and pilot testing the QIs. It also describes the CCS QI approval process and addresses knowledge translation. Adoption of a standardized methodology for QI development will improve the quality, completeness, acceptability, and usability of pan-Canadian cardiovascular QIs developed by the CCS. Public release of the QI definitions and related performance data might help improve patient care quality and outcomes.


Sixty-five patients with unresectable advanced epithelial ovarian cancer who underwent exploratory laparotomy or unilateral oophorectomy were reviewed. Forty-five of 65 patients received 3.8 cycles of neoadjuvant chemotherapy NAC and were successfully debulked at interval cytoreductive surgery IRS; 31 of 45 showed no evidence of disease. Patients with residuals <1 cm at IRS had a high possibility of achieving clinical remission. Patients who failed to receive IRS showed poor prognosis. Also, 63 patients who underwent conventional primary debulking surgery with residuals >1 cm were investigated as a contrast. No significant difference was observed in patient survival between the NAC group and the conventional treatment group. NAC and IRS offered patients with unresectable tumors survival similar to that of those with suboptimally resectable tumors at primary debulking. We conclude that this strategy has potential benefits for the patients with clinically aggressive ovarian cancer who are unable to receive standard treatment.


Cancer-associated malnutrition can result from local effects of a tumour, the host response to the tumour and anticancer therapies. Although cancer patients often have reduced food intake due to systemic effects of the disease, local tumour effects, psychological effects or adverse effects of treatment), alterations in nutrient metabolism and resting energy expenditure REE may also contribute...
to nutritional status. Several agents produced by the tumour directly, or systemically in response to the
tumour, such as pro-inflammatory cytokines and hormones, have been implicated in the pathogenesis of
malnutrition and cachexia. The consequences of malnutrition include impairment of immune functions,
performance status, muscle function, and quality of life. In addition, responses to chemotherapy are
decreased, chemotherapy-induced toxicity and complications are more frequent and severe, and survival
times are shortened. Depression, fatigue and malaise also significantly impact on patient well-being. In
addition, cancer-related malnutrition is associated with significant healthcare-related costs. Nutritional
support, addressing the specific needs of this patient group, is required to help improve prognosis, and
reduce the consequences of cancer-associated nutritional decline.


van Riet Paap, J., M. Vernooij-Dassen, et al. 2014. "Consensus on quality indicators to assess the organisation
of palliative cancer and dementia care applicable across national healthcare systems and selected by international
experts." BMC Health Serv Res 14: 396.

BACKGROUND: Large numbers of vulnerable patients are in need of palliative cancer and dementia
care. However, a wide gap exists between the knowledge of best practices in palliative care and their
use in everyday clinical practice. As part of a European policy improvement program, quality indicators
QIs have been developed to monitor and improve the organisation of palliative care for patients with
cancer and those with dementia in various settings in different European countries. METHOD: A
multidisciplinary, international panel of professionals participated in a modified RAND Delphi
procedure to compose a set of palliative care QIs based on existing sets of QIs on the organisation of
palliative care. Panellists participated in three written rounds, one feedback round and one meeting. The
panel's median votes were used to identify the final set of QIs. RESULTS: The Delphi procedure
resulted in 23 useful QIs. These QIs represent key elements of the organisation of good clinical
practice, such as the availability of palliative care teams, the availability of special facilities to provide
palliative care for patients and their relatives, and the presence of educational interventions for
professionals. The final set also includes QIs that are related to the process of palliative care, such as
documentation of pain and other symptoms, communication with patients in need of palliative care and
their relatives, and end-of-life decisions. CONCLUSION: International experts selected a set of 23 QIs
for the organisation of palliative care. Although we particularly focused on the organisation of cancer
and dementia palliative care, most QIs are generic and are applicable for other types of diseases as well.

undergoing major elective open colorectal surgery: a meta-analysis of randomized controlled trials." Clin Nutr
294: 434 -440.

BACKGROUND & AIMS: The aim of the Enhanced Recovery After Surgery ERAS pathway is to
attenuate the stress response to surgery and enable rapid recovery. The objective of this meta-analysis
was to study the differences in outcomes in patients undergoing major elective open colorectal surgery
within an ERAS pathway and those treated with conventional perioperative care. METHODS: Medline,
Embase and Cochrane database searches were performed for relevant studies published between
January 1966 and November 2009. All randomized controlled trials comparing ERAS with
conventional perioperative care were selected. The outcome measures studied were length of hospital
stay, complication rates, readmission rates and mortality. RESULTS: Six randomized controlled trials
with 452 patients were included. The number of individual ERAS elements used ranged from 4 to 12,
with a mean of 9. The length of hospital stay [weighted mean difference 95% confidence interval]: -2.55
-3.24, -1.85] and complication rates [relative risk 95% confidence interval]: 0.53 0.44, 0.64]
were significantly reduced in the enhanced recovery group. There was no statistically significant
difference in readmission and mortality rates. CONCLUSION: ERAS pathways appear to reduce the
length of stay and complication rates after major elective open colorectal surgery without compromising
patient safety.
BACKGROUND: Primary debulking surgery before initiation of chemotherapy has been the standard of care for patients with advanced ovarian cancer. METHODS: We randomly assigned patients with stage IIIC or IV epithelial ovarian carcinoma, fallopian-tube carcinoma, or primary peritoneal carcinoma to primary debulking surgery followed by platinum-based chemotherapy or to neoadjuvant platinum-based chemotherapy followed by debulking surgery—so-called interval debulking surgery.

RESULTS: Of the 670 patients randomly assigned to a study treatment, 632 (94.3%) were eligible and started the treatment. The majority of these patients had extensive stage IIIC or IV disease at primary debulking surgery: metastatic lesions that were larger than 5 cm in diameter in 74.5% of patients and larger than 10 cm in 61.6%. The largest residual tumor was 1 cm or less in diameter in 41.6% of patients after primary debulking and in 80.6% of patients after interval debulking. Postoperative rates of adverse effects and mortality tended to be higher after primary debulking than after interval debulking. The hazard ratio for death intention-to-treat analysis in the group assigned to neoadjuvant chemotherapy followed by interval debulking, as compared with the group assigned to primary debulking surgery followed by chemotherapy, was 0.98 (90% confidence interval [CI], 0.84 to 1.13; P=0.01 for noninferiority, and the hazard ratio for progressive disease was 1.01 (90% CI, 0.89 to 1.15). Complete resection of all macroscopic disease at primary or interval surgery was the strongest independent variable in predicting overall survival.

CONCLUSIONS: Neoadjuvant chemotherapy followed by interval debulking surgery was not inferior to primary debulking surgery followed by chemotherapy as a treatment option for patients with bulky stage IIIC or IV ovarian carcinoma in this study. Complete resection of all macroscopic disease, whether performed as primary treatment or after neoadjuvant chemotherapy, remains the objective whenever cytoreductive surgery is performed. Funded by the National Cancer Institute; ClinicalTrials.gov number, NCT00003636.

OBJECTIVE: To assess the quality of surgical pathology reports of advanced stage ovarian, fallopian tube and primary peritoneal cancer. This quality assurance project was performed within the EORTC-GCG 55971/NCIC-CTG OV13 study comparing primary debulking surgery followed by chemotherapy with neoadjuvant chemotherapy and interval debulking surgery. METHODS: Four hundred and seventy nine pathology reports from 40 institutions in 11 different countries were checked for the following quality indicators: macroscopic description of all specimens, measuring and weighing of major specimens, description of tumour origin and differentiation. RESULTS: All specimens were macroscopically described in 92.3% of the reports. All major samples were measured and weighed in 59.9% of the reports. A description of the origin of the tumour was missing in 20.5% of reports after primary debulking and in 23.4% of the interval debulking group. Assessment of tumour differentiation was missing in 10% of the reports after primary debulking and in 20.8% of the reports after interval debulking. Completeness of reports is positively correlated with accrual volume and adversely with hospital volume or type of hospital academic versus non-academic. Quality of reports differs significantly by country. CONCLUSION: This audit of ovarian cancer pathology reports reveals that in a substantial number of reports basic pathologic data are missing, with possible adverse consequences for the quality of cancer care. Specialisation by pathologists and the use of standardised synoptic reports can lead to improved quality of reporting. Further research is needed to better define pre- and post-operative diagnostic criteria for ovarian cancer treated with neoadjuvant chemotherapy.
minimal harm to the patient in order to ensure best patient outcome. However, variation in the quality of ovarian cancer surgery is apparent. In order to assess and improve the quality of care, quality indicators can be used. METHODS: To identify candidate quality indicators, a literature search was performed using relevant MESH terms. These were assessed for validity, feasibility and measurability. RESULTS: Five quality indicators for staging of presumed early-stage ovarian cancer and six for primary debulking surgery for advanced disease are proposed. CONCLUSION: The defined quality indicators can be used to monitor and improve the quality of surgery for ovarian cancer.


OBJECTIVE: We investigated the influence of hospital and gynecologist level of specialization and volume on surgical results and on survival of ovarian cancer patients. METHODS: Data were collected from 1077 ovarian cancer patients treated from 1996 to 2003 in a random sample of 18 Dutch hospitals. Hospitals and gynecologists were classified according to specialization general, semi-specialized or specialized and by volume <or=6, 7 -12, or >12 cases/year. Outcomes were percentage of adequately staged and optimally debulked patients and length of overall survival. Data were analyzed using multivariable logistic regression surgical results and Cox regression (survival). RESULTS: The level of specialization and the volume of hospitals and of gynecologists were strongly related to the proportion of adequately staged patients adjusted odds ratio OR specialized hospitals 3.9 95% confidence interval CI 2.0 -7.6; specialized gynecologists 9.5 95% CI 4.7 -19. Patients with stage III disease had a higher chance of optimal debulking when treated in specialized hospitals adjusted OR 1.7 95% CI 1.1 -2.7 or by high volume gynecologists adjusted OR 2.8 95% CI 1.4-5.7. Overall survival was best in patients treated in specialized hospitals and by high-volume gynecologists. CONCLUSION: The specialization level of hospitals and the surgical volume of gynecologists positively influence outcomes of surgery and survival. Concentration of ovarian cancer care thus seems warranted.


OBJECTIVE: There is much debate on the effect of specialized care for ovarian cancer patients. In this review we present an overview and summary of the recent literature on this subject. METHODS: The Pubmed database was searched for studies on the relationship between care setting type of gynecologist or hospital) and care outcomes which were published between January 1991 and November 2006. Studies were included if they were of sufficient quality and included patients treated from 1990 onwards. RESULTS: Nineteen articles were retrieved. There were no randomized controlled trials on this subject. Staging and debulking were consistently found to be performed more adequately by gynecologic oncologists pooled relative risk of optimal debulking by a gynecologic oncologist to <2 cm residual disease 1.4 95%CI 1.2 -1.5 and to no macroscopic disease 2.3 95%CI 1.5 -3.5 and in specialized hospitals odds ratios for optimal debulking varied between 1.9 and 6.0. There were no differences in postoperative complication rates between different providers. Chemotherapy was given 1-15% more often in specialized settings. Differences in chemotherapy did not lead to differences in survival of patients treated by gynecologic oncologists, but did influence the effect of hospital on survival. Long-term survival was better after treatment in a specialized hospital. Surgery by a gynecologic oncologist resulted in longer survival in subgroups of patients, leading to a 5- to 8-month median survival benefit for patients with advanced stage disease. CONCLUSIONS: The outcome of ovarian cancer is better when treatment is provided by a gynecologic oncologist or in a specialized hospital.

Neoadjuvant chemotherapy has been proposed as an alternative approach to primary cytoreductive surgery as initial management of bulky ovarian cancer with the aim of improving surgical efficiency and quality of life. The data of a retrospective case-control study including 75 patients with advanced epithelial ovarian carcinoma Stages III and IV are presented. In 20 patients, neoadjuvant chemotherapy 3-5 cycles of cytostatics was applied before cytoreductive surgery which was followed by chemotherapy, six cycles in total. In 55 patients cytoreductive surgery was applied as the primary treatment followed by six cycles of chemotherapy. A comparison of both groups of patients showed no significant difference regarding patient age, tumor stage, grade and treatment modality chemotherapy and surgery, without irradiation applied cytostatics and total number of chemotherapeutic cycles. The data from our study confirmed a statistically significant difference in radicality of cytoreduction that was more extensive when applied in combination with neoadjuvant chemotherapy than when applied as primary cytoreductive surgery p = 0.009. No statistically significant difference was found in the survival of the two groups p = 0.79, the response to primary treatment p = 0.52, relapse p = 0.88 or disease-free survival p = 0.61. From the findings of the study and literature review, we may conclude that neoadjuvant chemotherapy followed by interval debulking surgery in patients with advanced epithelial ovarian carcinoma does not have an unfavorable effect on the prognosis.


INTRODUCTION: We evaluated the validity of 8 quality of care indicators for prostate cancer patients treated curatively with radical prostatectomy RP by examining their association with indicator-relevant outcomes. METHODS: We conducted a population-based retrospective cohort study of 646 prostate cancer patients diagnosed between 1990 and 1998 who received RP within 6 months of diagnosis. Data were collected from treating charts and linked to registry and administrative data. Quality indicators included: hospital volume, pre-treatment risk assessment, consultation with a radiation oncologist, appropriate follow-up care, nerve-sparing surgery, units of blood transfused, surgical margin status, and pelvic lymph node dissection during RP. Indicator-relevant outcomes were selected a priori by clinical members of the research team. The associations between indicators and their relevant outcomes were analyzed using regression techniques, to control for potential confounders. RESULTS: Of the quality indicators evaluated, only hospital volume was statistically significantly associated with the gradient in the expected direction. Patients treated in the lowest-volume hospitals <1 RP/month had lower cause-specific survival rates compared to patients treated in the highest-volume hospitals >/=7 RP/month HR=4.71 95%; CI 1.06-20.82. Completeness of follow-up care was associated with cause-specific survival but in the opposite direction to our hypothesis. CONCLUSION: The structural indicator of hospital volume was associated with cause-specific survival in accordance with our a priori hypothesis. Our negative findings for completeness of follow-up care call its validity into question. Issues of statistical power and measurement accuracy may have affected our validation of the remaining indicators underscoring the challenges in assessing the impact of accepted quality indicators.


OBJECTIVE: Describe the methodology and selection of quality indicators QI to be implemented in the EFFECT EFFECTiveness of Endometrial Cancer Treatment) project. EFFECT aims to monitor the variability in Quality of Care QoC of uterine cancer in Belgium, to compare the effectiveness of different treatment strategies to improve the QoC and to check the internal validity of the QI to validate the impact of process indicators on outcome. METHODS: A QI list was retrieved from literature, recent guidelines and QI databases. The Belgian Healthcare Knowledge Center methodology was used for the
selection process and involved an expert's panel rating the QI on 4 criteria. The resulting scores and further discussion resulted in a final QI list. An online EFFECT module was developed by the Belgian Cancer Registry including the list of variables required for measuring the QI. Three test phases were performed to evaluate the relevance, feasibility and understanding of the variables and to test the compatibility of the dataset. RESULTS: 138 QI were considered for further discussion and 82 QI were eligible for rating. Based on the rating scores and consensus among the expert's panel, 41 QI were considered measurable and relevant. Testing of the data collection enabled optimization of the content and the user-friendliness of the dataset and online module. CONCLUSIONS: This first Belgian initiative for monitoring the QoC of uterine cancer indicates that the previously used QI selection methodology is reproducible for uterine cancer. The QI list could be applied by other research groups for comparison.


PURPOSE: To review the literature on goal directed fluid therapy and evaluate the quality of evidence for each combination of goal and monitoring method. MATERIALS AND METHODS: A search of major digital databases and hand search of references was conducted. All studies assessing the clinical utility of a specific fluid therapy goal or set of goals using any monitoring method were included. Data was extracted using a pre-determined pro forma and papers were evaluated using GRADE principles to assess evidence quality. RESULTS: Eighty-one papers met the inclusion criteria, investigating 31 goals and 22 methods for monitoring fluid therapy in 13052 patients. In total there were 118 different goal/method combinations. Goals with high evidence quality were central venous lactate and stroke volume index. Goals with moderate quality evidence were sublingual microcirculation flow, the oxygen extraction ratio, cardiac index, cardiac output, and SVC collapsibility index. CONCLUSIONS: This review has highlighted the plethora of goals and methods for monitoring fluid therapy. Strikingly, there is scant high quality evidence, in particular for non-invasive G/M combinations in non-operative and non-intensive care settings. There is an urgent need to address this research gap, which will be helped by methodologies to compare utility of G/M combinations.


BACKGROUND: One of the most important prognostic factors in advanced ovarian cancer is the macroscopic absence of residual tumor after primary surgery. The impact of surgical outcome on the survival of patients with International Federation of Gynecology and Obstetrics FIGO stage IV disease is less clear and is the subject of this study. METHODS: Surgical and survival data were documented throughout the multicenter prospective randomized phase III trials of the AGO-OVAR OVAR -3/-5/-7 and were used for this exploratory analysis. In these studies, 573 patients with FIGO stage IV disease were first operated, then randomized and homogeneously treated with a combination therapy comprising the intravenous application of platinum and paclitaxel. RESULTS: The median progression-free survival and overall survival of patients with stage IV ovarian cancer were 12.6 and 26.1 months, respectively. Multivariable Cox regression analysis for overall survival revealed that residual tumor, mucinous histological type, multiple sites of metastases, and Eastern Cooperative Oncology Group performance status were statistically significant prognostic variables. Whereas patients with macroscopically complete resection had a statistically significant improved outcome, patients with residual disease of 0.1-1 cm and patients with residual tumor of >1 cm showed similar outcome. CONCLUSIONS: Macroscopically complete resection in FIGO stage IV disease, irrespective of the site of distant tumor spread, is an important prognostic factor and the only prognosticator amenable to improvement by therapy. Our results suggest possible advantages of a reasonable attempt at complete cytoreduction even in FIGO stage IV disease. In addition, tumor biology could be an important factor for achieving complete resection.

PURPOSE: Conflicting results on prognostic factors for advanced epithelial ovarian cancer EOC have been reported because of small sample size and heterogeneity of study population. The purpose of this study was to identify factors predictive of poor prognosis in a similarly treated population of women with advanced EOC. PATIENTS AND METHODS: A retrospective review of demographic, pathologic, treatment, and outcome data from 1,895 patients with International Federation of Gynecology and Obstetrics stage III EOC who had undergone primary surgery followed by six cycles of intravenous platinum/paclitaxel was conducted. A proportional hazards model was used to assess the association of prognostic factors with progression-free survival PFS and overall survival OS. RESULTS: Increasing age was associated with increased risks for disease progression HR = 1.06; 95% CI, 1.02 to 1.11 for an increase every 10 years and death HR = 1.12; 95% CI, 1.06 to 1.18. Mucinous or clear-cell histology was associated with a worse PFS and OS compared with serous carcinomas. Patients with performance status PS 1 or 2 were at an increased risk for recurrence compared with PS 0 HR = 1.12; 95% CI, 1.01 to 1.24. Compared with patients with microscopic residual disease, patients with 0.1 to 1.0 cm and > 1.0 cm residual disease had an increased risk of recurrence HR = 1.96; 95% CI, 1.70 to 2.26; and HR = 2.36; 95% CI, 2.04 to 2.73, respectively and death HR = 2.11; 95% CI, 2.09 to 2.92, respectively. CONCLUSION: Age, PS, tumor histology, and residual tumor volume were independent predictors of prognosis in patients with stage III EOC. These data can be used to identify patients with poor prognosis and to design future tailored randomized clinical trials.


PURPOSE: To identify factors predictive of poor prognosis in a similarly treated population of women with stage IV epithelial ovarian cancer EOC. PATIENTS AND METHODS: A retrospective review of 360 patients with International Federation of Gynecology and Obstetrics stage IV EOC who underwent primary surgery followed by six cycles of intravenous platinum/paclitaxel was performed. A proportional hazards model was used to assess the association of potential prognostic factors with progression-free survival PFS and overall survival OS. RESULTS: The median PFS and OS for this group of stage IV ovarian cancer patients was 12 and 29 months, respectively. Multivariate regression analysis revealed that histology, malignant pleural effusion, intraparenchymal liver metastasis, and residual tumor size were significant prognostic variables. Whereas patients with microscopic residual disease had the best outcome, patients with 0.1 to 1.0 cm residual disease and patients with 1.1 to 5.0 cm residual disease had similar PFS and OS. Patients with a residual size more than 5 cm had a diminished PFS and OS when compared with all other groups. Median OS for microscopic, 0.1 to 5.0 cm, and more than 5.0 cm residual disease was 64, 30, and 19 months, respectively. CONCLUSION: Patients with more than 5 cm residual disease have the shortest PFS and OS, whereas patients with 0.1 to 1.0 and 1.1 to 5.0 cm have similar outcome. These findings suggest that ultraradical cytoreductive procedures might be targeted for selected patients in whom microscopic residual disease is achievable. Patients with less than 5.0 cm of disease initially and significant disease and/or comorbidities precluding microscopic cytoreduction may be considered for alternative therapeutic options other than primary cytoreduction.


BACKGROUND: Validated quality indicators can help health-care professionals to evaluate their medical practices in a comparative manner to deliver optimal clinical care. No international set of quality indicators to measure the organizational aspects of palliative care settings exists. AIM: To develop and validate a set of structure and process indicators for palliative care settings in Europe.
DESIGN: A two-round modified RAND Delphi process was conducted to rate clarity and usefulness of a previously developed set of 110 quality indicators. SETTING/PARTICIPANTS: In total, 20 multi-professional palliative care teams of centers of excellence from seven European countries. RESULTS: In total, 56 quality indicators were rated as useful. These valid quality indicators concerned the following domains: the definition of a palliative care service 2 quality indicators, accessibility to palliative care 16 quality indicators, specific infrastructure to deliver palliative care 8 quality indicators, symptom assessment tools 1 quality indicator, specific personnel in palliative care services 9 quality indicators, documentation methodology of clinical data 14 quality indicators, evaluation of quality and safety procedures 1 quality indicator, reporting of clinical activities 1 quality indicator, and education in palliative care 4 quality indicator. CONCLUSION: The modified RAND Delphi process resulted in 56 international face-validated quality indicators to measure and compare organizational aspects of palliative care. These quality indicators, aimed to assess and improve the organization of palliative care, will be pilot tested in palliative care settings all over Europe and be used in the EU FP7 funded IMPACT project.


PURPOSE: Optimal quality of care is needed for ideal outcomes. In renal cell carcinoma RCC, there is a lack of information defining optimal care. This is particularly important in RCC, with increased complexity of care and a need for coordination among providers. The goal of this study was to identify quality indicators QIs and measures of quality care across the RCC disease spectrum. MATERIALS AND METHODS: A modified Delphi technique was used to select QIs that are relevant and practical to RCC care. This technique involved an expert panel of 13 urologic and medical oncologists who participated in two e-mail questionnaires and an in-person meeting to review and prioritize potential QIs. These potential QIs were identified from a systematic literature review or were suggested by panel members. RESULTS: From 233 literature citations, 34 possible QIs were identified; 24 additional potential QIs were suggested. A final set of 23 QIs was established. These are distributed across the RCC disease spectrum as follows number of QIs in parentheses: screening n=1, diagnosis/prognosis n=3, surgical for localized disease n=6, surgery for advanced disease n=3, systemic therapy n=6, and follow-up n=2. In addition, two QIs related to survival outcomes overall and progression-free survival were selected. CONCLUSION: A systematic, consensus-based approach was used to determine relevant QIs in RCC care. These 23 QIs will provide a means of evaluating the quality of RCC care in an effort to improve outcomes in patients. The next step will be to establish a means of measuring each QI based on defined or yet-to-be-defined benchmarks.


OBJECTIVE: To examine the influence of operator specialty, volume of work and referral to an oncologist on the survival of women with ovarian cancer. DESIGN: Population-based retrospective cohort study, using hospital records and Cancer Registry data. SETTING: The North Western Region, UK. POPULATION: Six hundred and ninety-one women undergoing laparotomy for histologically confirmed ovarian malignancy during 1991 to 1992. METHODS: Univariate and multivariate survival analyses. MAIN OUTCOME MEASURES: Univariate survival estimates. Relative risks, derived from Cox's proportional hazards model, describing the effect on survival of surgeons vs gynaecologists as baseline, high volume vs low volume operators and referral vs nonreferral to an oncologist. RESULTS: After adjusting for woman and disease-related prognostic factors, operation by a surgeon was shown to have an adverse impact on survival RR = 1.58, 95% CI 1.19 to 2.10. Regardless of how a high volume operator was defined in terms of the number of laparotomies performed, no survival advantage over low volume operators could be demonstrated. Women referred to an oncologist had significantly better survival than women not referred RR = 0.54, 95% CI 0.43 to 0.68. CONCLUSIONS: All women
undergoing surgery for ovarian cancer should have access to a gynaecological opinion and postoperatively should be referred for a nonsurgical oncological opinion.


PURPOSE: Although the association between high surgical volume and improved outcomes from procedures is well described, the mechanisms that underlie this association are uncertain. There is growing recognition that high-volume hospitals may not necessarily have lower complication rates but rather may be better at rescuing patients with complications. We examined the role of complications, failure to rescue from complications, and mortality based on hospital volume for ovarian cancer.

PATIENTS AND METHODS: The Nationwide Inpatient Sample was used to identify women who underwent surgery for ovarian cancer from 1988 to 2009. Hospitals were ranked on the basis of their procedure volume. We determined the risk-adjusted mortality, major complication rate, and "failure to rescue" rate mortality in patients with a major complication for each tertile. Univariate and multivariate associations were then compared. RESULTS: We identified 36,624 patients. The mortality rate for the cohort was 1.6%. The major complication rate was 20.4% at low-volume, 23.4% at intermediate-volume, and 24.6% at high-volume hospitals P < .001. However, the rate of failure to rescue death after a complication was markedly higher at low-volume 8.0% compared with high-volume hospitals 4.9%; P < .001. After accounting for patient and hospital characteristics, women treated at low-volume hospitals who experienced a complication were 48% more likely odds ratio [OR], 1.48; 95% CI, 1.11 to 1.99 to die than patients with a complication at a high-volume hospital.

CONCLUSION: Mortality is lower for patients with ovarian cancer treated at high-volume hospitals. The reduction in mortality does not appear to be the result of lower complications rates but rather a result of the ability of high-volume hospitals to rescue patients with complications.


The range and demand for clinical genetic services will continue to grow, and now is an ideal time to assess current service quality. Based on the previous work of quality professional organizations such as the Institute of Medicine IOM and The Joint Commission on the Accreditation of Healthcare Organizations JCAHO) which is now known as The Joint Commission TJC, an independent group of genetic and healthcare quality professionals InheritQual) drafted and defined a list of potential quality indicators for clinical genetics. Perspectives on the appropriateness and the practicality of each indicator were surveyed and analyzed. The Quality Special Interest Group of the American College of Medical Genetics ACMG) chartered the survey results. After measuring the degree of consensus, an expert panel was selected to review the quality indicators based on practicality and applicability. This expert panel comprised of members of the ACMG Quality Sig workgroup met for final consensus and developed a methodology to pilot these indicators.