
ASSOCIATION OF VA SURGEONS

Decreased Wait Times After Institution of Office-Based Hand Surgery in a Veterans Administration Setting

Carpal tunnel syndrome is a common peripheral nerve compression disorder causing symptoms of numbness, tingling, weakness, and muscle atrophy. Open carpal tunnel release (CTR) is a common treatment modality traditionally performed in the operating room with sedation or general anesthesia. It can also be performed in the surgeon's office under local anesthesia only.1 In our study, we examined the number of days from initial consultation and visit to operative intervention in a Veterans Administration (VA) setting. A significant decrease in wait time from initial consultation to operative intervention and from initial visit to operative intervention was hypothesized to occur with the transition to office-based hand surgery procedures, without an increase in complications.

Methods | Institutional review board approval from the Richard L. Roudebush VA Medical Center was obtained to construct a database of recent surgical procedures performed for carpal tunnel syndrome by the plastic surgery service. Operations including CTR in conjunction with other procedures were excluded. The minor procedure room is located within the plastic surgery clinic, with a single nurse serving as a circulating nurse. The hand and forearm are prepped and draped, and both monopolar cautery and bipolar cautery are available. A more specific description to a similar configuration can be found in Leblanc et al.2 The study variables collected were age, sex, tobacco use, procedure, time from initial consultation to surgery (in days), time from initial clinic visit to surgery (in days), location of the procedure (the minor procedure room in the surgeon's office or the operating room), and complications. An independent 2-tailed t test was used to compare mean values using SPSS version 20 (IBM).

Results | Two separate types of CTR were analyzed: office-based CTR (44 patients) and operating room-based CTR (54 patients). The Table contains a comparison of the 2 groups of patients who underwent 1 of the 2 types of CTR. Significant decreases in time from initial consultation to surgery and from initial clinic visit to surgery were observed in the office-based group (P < .05). There was no difference in complications between the 2 groups. Complications in the operating room-based group included 2 infections requiring oral antibiotics and 4 minor wound dehiscences that resolved with local wound care. In the office-based group, there were 2 infections (one requiring intravenous antibiotics and the other resolving with oral antibiotics) and 2 minor wound dehiscences.

Discussion | Office-based hand surgery procedures have been validated in a variety of settings but are not the default method of performing hand surgery procedures in the United States. We have demonstrated a significant decrease in time to procedure with the use of an office-based procedure in a VA setting, without sacrificing quality. Open CTR can be completed safely in the office; the complication rate was not statistically different between the 2 groups in our series. To our knowledge, this is the first description of decreased times to surgery due to the institution of office-based open CTR. Previous studies demonstrated that early intervention is associated with a faster return to daily activities of living and to normal function compared with late intervention.3 The limitations of our study include its retrospective nature and the steps of conservative management, including steroid injections, which are often offered to patients who do not wish to undergo surgery immediately. A wider application of office-based minor hand surgery would likely result in significantly increased patient access to surgery in the VA system.

Stephen Duquette, MD
Naveed Nosrati, MD
Adam Cohen, MD
Imtiaz Munshi, MD, MBA
Sunil Tholpady, MD, PhD

Author Affiliations: Division of Plastic Surgery, Department of Surgery, Indiana University, Indianapolis (Duquette, Nosrati, Cohen, Tholpady); Richard L. Roudebush VA Medical Center, Indianapolis, Indiana (Cohen, Munshi, Tholpady).
Corresponding Author: Sunil Tholpady, MD, PhD, Division of Plastic Surgery, Department of Surgery, Indiana University, RI 2514, 705 Riley Hospital Dr, Indianapolis, IN 46202 (stholpad@iupui.edu).

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Patient-Centered Operating Room Briefings to Improve Surgical Quality

To the Editor—Hicks and colleagues1 highlight several ways in which operating room briefings improve patient safety and surgical quality, citing 4 categories of outcomes in their Table 2 that are aligned with Medicare incentives to reduce 30-day readmission rates. The concept of quality, however, has grown increasingly multifactorial in measurement and application. For instance, of the 3 domains of quality in the Centers for Medicare & Medicaid Services' Hospital Inpatient Value-Based Purchasing Program (clinical process of care, patient experience of care, and mortality outcomes), the patient experience of care counts for 30% of a hospital's overall score.2 Whether patient satisfaction surveys are valid as an independent measure of surgical quality3 remains a subject of ongoing investigation, but the influence of the patient experience on what has been called the “trauma of hospitalization”4 merits attention, both in principle and as it applies to public reporting and hospital reimbursement.

Consistent with a patient-centered surgical culture, operating room briefings should, when possible, include personalizing details about the patient. This can be performed while identifying the patient during the time-out, and it need not be cumbersome or time-consuming. For instance, “This is Mr Jones, who had a right rotator cuff tear 6 months ago and hasn't improved with conservative therapy. He also volunteers as a basketball coach at Central High. Today we're going to do an arthroscopic repair so he can be ready for the upcoming season.” The addition of a few words of explanation in a few seconds of time elevates the briefing from being about Mr Jones, the rotator cuff repair case, to being about Mr Jones, the coach who needs his rotator cuff repaired.

That distinction is significant, and it benefits the patient experience. When a patient-centered briefing model was recently piloted at my institution, there was initially reluctance, akin to the implementation challenges outlined by Hicks and colleagues.1 But personalizing the briefing succinctly accomplishes 3 objectives: it introduces an unfamiliar patient to the operating room staff; it adds a human dimension to a briefing that is usually filled with technical jargon; and, importantly, it reminds all the participants of the culture of surgical safety and quality of which they are a part.

Certainly some of the improved outcomes associated with operating room briefings can be attributed to better staff communication or attention to prophylaxis. But in terms of the “supportive culture” to which Hicks and colleagues refer that sustains a commitment to surgical quality, patient-centered briefings underscore a key tenet of both perioperative teamwork and the patient experience: putting the patient first.

Kevin Koo, MD, MPH, MPhil

Author Affiliation: Department of Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire.

Corresponding Author: Kevin Koo, MD, MPH, MPhil, Department of Surgery, Dartmouth-Hitchcock Medical Center, One Medical Center Dr, Lebanon, NH 03756 (kevin.koo@hitchcock.org).


Conflict of Interest Disclosures: None reported.


Correction

Error in Text: In the Original Investigation entitled “Breast Cancer Following Ovarian Cancer in BRCA Mutation Carriers” published in the December issue of JAMA Surgery (2014;149[12]:1306-1313, doi:10.1001/jamasurg.2014.1081), an error was found in the text. The last sentence of the Results section should read “There was no significant difference in disease-free survival between those patients who developed breast cancer and those who did not” instead of “There was no significant difference in disease-free survival between those patients who developed breast cancer and those who did.” This article was corrected online.

Error in Byline and Author Contributions: In the Original Investigation entitled “Optimal Time for Early Laparoscopic Cholecystectomy for Acute Cholecystitis,” published online December 17, 2014, in JAMA Surgery (doi:10.1001/jamasurg.2014.2339), the second author’s name in the byline should have been given as Augustine Obirieze, and in the Author Contributions as Obirieze. This article was corrected online.

Errors in Figure Labels: In the Original Investigation titled “Risk and Patterns of Secondary Complications in Surgical Inpatients” published online December 3, 2014, in JAMA Surgery (doi:10.1001/jamasurg.2014.1795), the labels for Figure 4 and Figure 5 were inadvertently transposed. This article was corrected online.