

## Sequoia record of QA tabulated rates from AHC meeting minutes Surgical Takeback rate formula:<sup>1,2</sup>

Sequoia QA Department counted 628 procedures. Of these, 79 were Inpatient Open-incision cases, and 549 were Outpatient Laparoscopy (Scope) cases.

Of these, 15 cases required a takeback to the operating room: 4 were Inpatient Open-incision cases, and 11 were Outpatient Laparoscopy (Scope) cases.

Using the takeback rate formula employed by NSQIP and every surgical journal, (divide the number of Takeback cases by the total number of cases performed in each category<sup>1,2</sup>) :

	Total	# OPEN	# SCOPE
# Takebacks	15	4	11
Total	628	79	549
Rate	<b>2.4%</b>	<b>5.0%</b>	<b>2.0%</b>

**My Total Takeback was (15 / 628 = .024), or 2.4% .**

Compare with published NSQIP GynOnc Return to Surgery Rate: 1.5 – 5.6%.<sup>3-5</sup>

**My Inpatient open-incision Takeback Rate is: (4 / 79 = .05), or 5% .**

Compare with published NSQIP GynOnc Open-incision Return to Surgery Rate: 4 – 12%.<sup>6-10</sup>

**My Outpatient laparoscopic Takeback Rate: (11 / 549 = .02), or 2% .**

Compare with published NSQIP GynOnc Scope Return to Surgery Rate: 1.7 – 5.6%.<sup>3,4</sup>

**Sequoia's QA computer tabulated data showed my Takeback rate was 2.9%, which falls well within the published normal NSQIP range compared with GynOnc specific data nationwide. Dr. Chandrasena did not obtain these published rates.**

1. Birkmeyer JD, Hamby LS, Birkmeyer CM, Decker MV, Karon NM, Dow RW. Is unplanned return to the operating room a useful quality indicator in general surgery? *Arch Surg*. Apr 2001;136(4):405-11.
2. Lin Y, Meguid RA, Hosokawa PW, et al. An institutional analysis of unplanned return to the operating room to identify areas for quality improvement. *Am J Surg*. Jul 2017;214(1):1-6. doi:10.1016/j.amjsurg.2016.10.021
3. Lonnerfors C, Reynisson P, Persson J. A randomized trial comparing vaginal and laparoscopic hysterectomy vs robot-assisted hysterectomy. *Journal of minimally invasive gynecology*. Jan 2015;22(1):78-86. doi:10.1016/j.jmig.2014.07.010
4. Hanwright PJ, Mioton LM, Thomasse MS, et al. Risk profiles and outcomes of total laparoscopic hysterectomy compared with laparoscopically assisted vaginal hysterectomy. *Obstetrics and gynecology*. Apr 2013;121(4):781-7. doi:10.1097/AOG.0b013e3182887f4e
5. Szender JB, Frederick PJ, Eng KH, Akers SN, Lele SB, Odunsi K. Evaluation of the National Surgical Quality Improvement Program Universal Surgical Risk Calculator for a gynecologic oncology service. *Int J Gynecol Cancer*. Mar 2015;25(3):512-20. doi:10.1097/IGC.0000000000000378
6. Patankar S, Burke WM, Hou JY, et al. Risk stratification and outcomes of women undergoing surgery for ovarian cancer. *Gynecologic oncology*. Jul 2015;138(1):62-9. doi:10.1016/j.ygyno.2015.04.037
7. Tamussino KF, Lim PC, Webb MJ, Lee RA, Lesnick TG. Gastrointestinal surgery in patients with ovarian cancer. *Gynecologic oncology*. Jan 2001;80(1):79-84. doi:10.1006/gyno.2000.6037
8. Peiretti M, Bristow RE, Zapardiel I, et al. Rectosigmoid resection at the time of primary cytoreduction for advanced ovarian cancer. A multi-center analysis of surgical and oncological outcomes. *Gynecologic oncology*. Aug 2012;126(2):220-3. doi:10.1016/j.ygyno.2012.04.030
9. Mourton SM, Temple LK, Abu-Rustum NR, et al. Morbidity of rectosigmoid resection and primary anastomosis in patients undergoing primary cytoreductive surgery for advanced epithelial ovarian cancer. *Gynecologic oncology*. Dec 2005;99(3):608-14. doi:10.1016/j.ygyno.2005.07.112
10. Desale MG, Tanner EJ, 3rd, Sinno AK, et al. Perioperative fluid status and surgical outcomes in patients undergoing cytoreductive surgery for advanced epithelial ovarian cancer. *Gynecologic oncology*. Oct 28 2016;doi:10.1016/j.ygyno.2016.10.027