Commentary on "The results of pancreatic operations after the implementation of multidisciplinary team conference (MDT): A quality improvement study"

Panagis M. Lykoudis, Vasileia Ntomi

PII: S1743-9191(20)30338-1

DOI: https://doi.org/10.1016/j.ijsu.2020.04.039

Reference: IJSU 5431

To appear in: *International Journal of Surgery*

Received Date: 11 April 2020

Accepted Date: 15 April 2020

Please cite this article as: Lykoudis PM, Ntomi V, Commentary on "The results of pancreatic operations after the implementation of multidisciplinary team conference (MDT): A quality improvement study", *International Journal of Surgery*, https://doi.org/10.1016/j.ijsu.2020.04.039.

Title page

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Authors

Dr Panagis M Lykoudis, MD MSc DIC MRCS FHEA[1,2]

Dr Vasileia Ntomi, MD MSc[2]

Affiliations

1. Division of Surgery & Interventional Science, University College London (UCL), London, UK

2. 3rd Department of Surgery, School of Medicine, National & Kapodistrian University of Athens, Athens, Greece

Corresponding author

Dr Panagis M Lykoudis, MD MSc DIC MRCS FHEA

40, Eirinis ave.
N. Faliro
18547
Piraeus
Attiki
Greece

e-mail: p.lykoudis@ucl.ac.uk

Main text

Since it was first introduced in literature[1], centralization of patient care regarding hepato-pancreato-biliary (HPB) surgery has been extensively studied, with results that vary from insignificant to strongly supportive of this massive regulatory paradigm shift[2]. This heterogeneity can be attributed to a number of factors. The most important is probably the pathway that existed in each country prior to implementation of a modern centralisation system. If for instance, there already was a concept of sub-specialization, and a number of tertiary centres close to the one that modernization would require, it is likely that the reform would not lead to significant improvements. Another vital parameter is the definition of centralization. This term includes epidemiological assessment of the population, adoption of a certain approach to determine the optimal volume of referral centres, implementation of referral pathways, organization of multidisciplinary teams (MDT) involved in assessment and treatment of patients and benchmarks for continuous re-assessment. Furthermore, the outcomes used to measure the efficacy and efficiency of the new model – clinical, financial or patient-reported -, can impact conclusions. Finally, centralization does not follow the rule of "one size, fits all". Some populations adapt and adhere better to pathway changes than others; some countries consist of islands and remote rural areas; some healthcare systems are seriously understaffed within a context of austerity. All these parameters mean that each country needs to discover their own centralization recipe to minimize additional resources needed, to maximize outcome improvement and mitigate disturbances in the existing healthcare service. For this purpose, large scale reports comparing data before and after implementation of centralization, defining the key-points of the new system and clarifying the outcome measures, are needed.

Cordoba Hansen et al.[3], present a comparative study regarding outcomes before and after the implementation of centralization of HPB surgery. The authors state the number of resections before and after the reform, clarifying that it was already a high-volume centre. They present the key-points of this reform; thus, readers can have a clear picture of the new system in the studied country. Outcomes mainly revolve around MDT meeting-related parameters. The above features of the study comply accurately with the aforementioned suggestions; hence the usefulness of reported findings is maximized. As far as the later are concerned, the authors report that MDT discussion led to change of initial diagnosis or therapeutic plan in 1 out of 8 patients. They rightfully argue that this contributed to an almost 4-fold increase in resections, which is much higher than what centralization alone would explain. It is also notable that a significant increase was also seen in the numbers of rare pancreatic lesions such as intraductal papillary mucinous neoplasms. Again, this is something that cannot be attributed exclusively to centralization; the expertise of an MDT contributes to the recognition and assignment to appropriate pathways of rare conditions. Moreover, it increases the collective expertise of the team, which is of paramount importance, beyond what figures of clinical outcomes can depict.

Overall, this is a well-presented analysis of the directly observed benefits of centralization in HPB surgery, and particularly of the MDT meeting. Similar studies from other countries should be strongly encouraged, to see how different strategies work and how each parameter affects outcomes.

Provenance and peer review

Invited Commentary, internally reviewed

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