

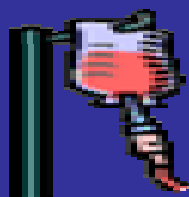


NetCAP E-Newsletter

<< Jan-Mar 2006 >>

Spring Edition

“Network – A group engaged as a supportive system of sharing information and services.”



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CABG Surgery in California

Last month, California's Office of Statewide Health Planning and Development released its report of CABG surgery statistics for 2003, developed by the CCORP (California CABG Outcomes Reporting Program). This project used to be voluntary in California, but as of 2003 became mandatory.

One hundred and twenty-one licensed hospitals provided data. There were 21,272 isolated CABG surgeries reported in 2003. The overall operative mortality rate for isolated CABG surgery in California was 2.91%. Nationally, the Society of Thoracic Surgeons (STS) reported 2.4% for the same measure. The risk-adjusted operative mortality rate for California hospitals ranged from 0% to 8.8%, revealing wide variation in CABG surgery outcomes after adjusting for patients' pre-operative health conditions. However, the majority of hospitals (113 of 121) performed within the expected range compared to the state's overall mortality rate.

CCORP uses multiple tools to analyze the collected information such as risk-adjusted regression analysis and data audits. This type of scrutiny has import for all members of the cardiac surgery team, because everyone, including the cardiac anesthesiologist, falls under the microscope. Does this type of reporting motivate surgeons to operate only on patients with low-risk adjusted morbidity? Apparently not! The report found that there was close agreement between the number of deaths predicted by the risk adjustment model and the actual number of deaths, especially for the most severely ill patients. This means that the risk model gives hospitals appropriate credit for treating the most clinically complex cases. Consequently, the report advocates that hospitals and surgeons should not exclude high-risk patients from appropriate CABG surgeries as a means to improve performance scores.

Do hospitals with lower CABG volume have worse outcome data? The CCORP found that there was no significant association between hospital CABG volume and risk adjusted hospital operative mortality. The analyses showed that patients have a similar risk of dying from a CABG procedure at hospitals with lower annual volumes as compared to hospitals with higher annual volumes of CABG surgeries.

Who was the best? – UC Davis Medical Center with 0.0% mortality. Who was the worse? – Alvarado Hospital Medical Center with 7.23% mortality. Notably from 1997 – 2004, the volume of isolated CABGs in California decreased by 31%, while percutaneous angioplasty interventions increased by 37%.

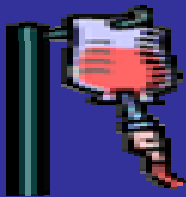
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NetCAP

• Network of Cardiac Anesthesia Professionals

• An e-information network for professionals involved in cardiac anesthesia

• NetCAP is sponsored by NCAC, PA



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Aprotinin – in the News

In January 2006, 2 research studies were published that question the safety of aprotinin. The New England Journal of Medicine published an article by Mangano et al reporting an association of aprotinin injection with serious renal toxicity and ischemic events (myocardial infarction and stroke) in patients undergoing CABG. Another study published in the January 2006 on-line edition of Transfusion by Karkouki et al reporting a higher incidence of renal dysfunction in patients undergoing CABG treated with aprotinin. Both of these reports have generated shockwaves through the cardiac surgery/anesthesia world because of aprotinin's impressive track record of safety and efficacy in reducing perioperative bleeding.



The Society of Cardiovascular Anesthesiologists (<http://scahq.org>) issued a statement on their website that have questioned the Mangano study;

- The study sample (4,374 patients) was non-randomized.
- A variety of statistical techniques, including propensity analysis, were used in an attempt to eliminate confounding factors and biases.
- No data were presented regarding variations in practices and outcomes among different centers and countries, factors that may require additional complex statistical adjustments.

The SCA state that *"For these reasons, we believe the findings of Mangano's report may not be generalized to all patients, and the suggestion to immediately curtail all use of aprotinin is premature. Until further data are made available, or until formal recommendations are issued by the FDA, the SCA suggests its members continue to carefully weigh the potential risks of aprotinin against the risks of bleeding associated with a planned cardiac operation."*

Bayer Healthcare AG (<http://www.bayer.com>) has issued a similar reservation; *"Bayer has been working and will continue to work closely with regulatory authorities in all countries where Trasyolol is marketed to address questions regarding product safety. We share the company's data on Trasyolol with regulatory authorities on an ongoing basis and welcome their evaluation of these published reports. Bayer believes that Trasyolol is a safe and effective treatment when used in accordance with the product."*

And ...



This Newsletter contains information, views and judgments expressed exclusively by Paul G. Loubser, M.D. Since judgments are subjective in nature, they should be interpreted with some caution.

Every effort will be made to be conscientious about reporting accurate and reliable information. Feedback is welcome on any subject matter. The newsletter is also posted on our website.