

An Opinion on Thoracic Surgery Quality and Cost

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Description

The ultimate goal of every well-run business is to achieve the highest quality at the lowest cost, and medicine is no exception. The value of medicine has been a watchword in hospital administrative suites for several years, and health care practitioners have felt the strain. The value of health care is defined as the health outcomes we achieve per dollar spent, according to the value equation. Furthermore, it is believed that employing such a concept of value brings together all stakeholders in health care—patients, providers, and payers—and that, if done correctly, all can gain.

The goal should be the same in the field of thoracic surgery. Surgeons must strive for high-quality patient outcomes while remaining cost-conscious whenever possible [1,2]. As a result, increased survival and quality of life for our patients are achieved, while lower costs ensure more resources are available to successfully treat those who are in need. The goal of this essay is to look into the current problems that thoracic surgeons confront in terms of providing the most value to our patients. In recent years, as health-care resources have become more limited, healthcare experts have begun to question the efficacy of medical procedures and medicines [3]. In both the developed and developing worlds, lung cancer is a major cause of morbidity, mortality, and health-care expenses. Lung cancer is expected to account for 20% of all cancer-related costs, with a doubtful benefit.

Since 1996, Germany has adopted set reimbursement rates for surgery. Fixed rates for medical procedures and treatments will be determined in the future based on the German diagnosis-related groups (G-DRG), which are based on the Australian DRG system. In a retrospective health economic cross-sectional analysis, we looked at 65 individuals who had surgery for primary lung carcinomas. The costs of treatment were linked to the tumor's stage as determined by the UICC 1997 and the surgical method. Our goal was to see if the stage of the tumour or the surgical approach had an impact on expenses and outcomes [4].

Malignancy and major surgery are two primary risk factors for deep venous thrombosis in thoracic surgery patients. During their hospitalizations for thoracotomy, 26% of patients had thromboembolic events, according to one research. As a result, all patients having pulmonary resection should be treated with graduated compression stockings and low molecular weight heparin as a preventative measure. Low molecular weight heparin should

be started the evening before surgery, allowing at least 12 hours between heparin administration and epidural insertion. Similarly, if an epidural is being withdrawn, the nighttime dose should be skipped and the epidural should be removed the next morning.

VATS

Video-assisted thoracic surgery (VATS) has been a common surgical technique over the last two decades. Improvements in operational and visual instruments accompanied this. Although there is no universal definition of VATS, it often refers to thoracoscopy with a modest number of small incisions and no rib spreading. The treatment of lung cancer with VATS is based on the notion that it has a similar oncological outcome to open thoracotomy but is a less intrusive procedure [5]. However, randomised controlled trials with scientifically validated comparisons of VATS and open thoracotomy have been seldom reported. VATS was found to have a decreased incidence of postoperative complications and a 1-2 day shorter hospital stay in some studies employing big national or regional datasets.

Conflict of Interest

No conflict of interest by author.

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