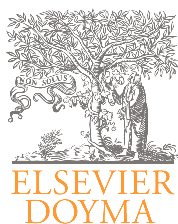

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Letters to the Editor

The Importance of the Discharge Summary Reports☆

Sobre la importancia del informe de alta hospitalaria

Dear Editor:

An interesting article by Gómez-Rosado et al.[1] that was recently published in this journal analyses the importance of correctly writing and completing hospital discharge summaries for the management of surgical services. As the authors indicate, patients have a right to these hospital reports, and it is the responsibility of physicians to provide them.

Although there are regulations about the minimum requirements that should be included in discharge summaries and make up the so-called Minimum Basic Data Set (MBDS), a wide variability has been reported in their makeup.[2] There is probably not enough awareness about the transcendence and value of a good discharge summary, both in its content as well as its presentation. We like to tell our residents that a surgical patient only takes two things home from the hospital: a wound and a discharge report. The wound is shown to family members, while the summary is shown to the primary care physician and other specialists. This means that, on many occasions, all that is left from a surgical process, ranging from the simplest to the most complex, is a scar and a hospital document. Both aspects transmit an image of the surgeon as well as his/her surgical department, so they should both be treated with care and not be done sloppily or hurriedly.

Moreover, the clinical coding systems used in hospitals in order to assign the diagnosis-related group DRG of patients and ultimately determine hospital services are mainly based on data that appear in summaries. Thus, what does not appear in the hospital report will not be translated into the final DRG, which will be either erroneous or uncoded. What would happen if a hospital were funded according to their DRG?

Information quality was a concern of Gómez-Rosado when they studied (out of 713 admittances) 24 outlier cases, for which 4 reports were unclear, 9 insufficient and 5 clearly not valid. This occasionally resulted in a change in DRG. It would have been interesting to know the result from the analysis of the 689 remaining reports, which is a result that, as the authors indicated, should offer better numbers as they are not extreme cases, although this remains to be seen.

Periodical audits or samplings should be used to determine the correlation between the DRG code assigned based on discharge summaries and the complete patient medical file, which is the gold standard. In this regard, we have done research on the degree of comorbidities and postoperative complications that appeared in summaries and in complete medical files.[3] The definition of the comorbidity left room for improvement in 5% of the reports, while the complications were under par in 12%. In such a situation, if we were to compare a hospital with a restaurant, an insufficiently coded summary would be like getting the bill for your meal that did not include either the drinks or dessert. In our current work setting of increased demand to justify the costs, budgeting and funding of public healthcare services, these aspects of medical care are acquiring more and more importance.

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A Decade of Laparoscopic Hepatic Surgery: From Cyst Fenestration to Right Hepatectomy for Living Donor Liver Transplant☆

Una década de cirugía hepática laparoscópica: de la fenestración de quistes a la hepatectomía derecha para trasplante de donante vivo

Dear Editor,

The first laparoscopic hepatic surgery was performed in our country in the year 2000.[1] A short time afterwards, at our hospital we began to apply the laparoscopic approach in liver surgery with the fenestration of simple cysts. In 2004, weperformed our first left lateral segmentectomy due to a single metastasis of CRC. Since then, we have extended the indications to include lesions located in unfavorable segments and, later, to major hepatectomies.

In November 2012, we published in Cirugía Española our experience with 71 resections of solid lesions.[2] Compared with open surgery, our results,[3] similar to those of other authors,[4,5] show how the laparoscopic approach provides benefits in patients that go beyond mere esthetics or shorter hospital stays: less bleeding, less need for transfusion and a lower rate and severity of complications.

One decade later and after more than 100 completely laparoscopic liver resections, we have applied the advantages of this approach to a liver donation for adult transplantation, which is a case we recently reported.[6] The recipient was 69years old and had cryptogenic cirrhosis. This patient presented encephalopathy and refractory ascites with 2episodes of spontaneous bacterial peritonitis, type 1 hepatorenal syndrome and 3 HCC within the Milan criteria. The Child–Pugh score was B-9 and MELD score was 15. The 29-year-old son of the patient, who weighed 74.4 kg, voluntarily offered to be a donor. The right hepatectomy of the donor was performed with a completely laparoscopic approach, extracting the graftthrough a suprapubic incision. The duration was 480 min, with a blood loss of less than 100 ml. The postoperative stay was 4 days. After discharge, the patient showed no need for analgesia and presented a quick and excellent recovery, with no complications within the 90 days after the procedure. It is a unique case, and one should not draw conclusions any further than those related to the feasibility of the procedure. Nonetheless, it does cause us to contemplate how, in just over a decade, we have witnessed the evolution of laparoscopic liver surgery from the fenestration of simple cysts to the most complex procedures. This approach has come of age and has become solidly established in several hospital centers in our country.[7–9]

Conflicts of Interest

The authors have no conflicts of interest to declare.

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