INTRODUCTION: Severe obesity is a major risk factor for conversions and complications after laparoscopic Hiatal hernia repair (LHHR). This study aims to report our experience in LHHR without mesh and compare the short-term outcomes between non-obese (BMI< 30) vs obese subjects.

METHODS: We retrospectively reviewed the clinical charts of 657 LHHR patients between 2009-2019. Primary outcomes were complications and conversions. Patients with gastrointestinal malignancy, concomitant bariatric surgery, or redo HHR were excluded. The diaphragmatic defect was closed primarily using a non-absorbable unidirectional barbed suture followed by a Nissen fundoplication.

RESULTS: Total of 533 [non-obese: 319 (59.8%); obese: 214 (40.2%)] patients were included. Mean age was 67.3 ± 13.2 years with a female (n=372, 69.8%) and Caucasians (n=379, 71.1%) predominance. From available 428 patients' data with HH analyzed, type III HH was most prevalent (n=218, 50.9%) type. Primary LHHR with a non-absorbable barbed suture was performed in 505 (94.7%) patients. The anti-reflux procedure was performed in 398 (74.7%) patients with higher Nissen fundoplication 370 (92.2%). Operative time, LOS, and postoperative complications were similar, except for abdominal pain, more frequent in non-obese subjects (P=.003). Overall, clinically significant recurrence rate was 4.3%, without difference between the two groups, at a mean follow-up of 17.0 ± 24.4 months (P=.354). All recurrences were surgically repaired at an average of 39.2 ± 37.3 months from the first surgery. No conversion to open HHR was observed in the whole cohort.

CONCLUSION: LHHR without mesh appears to be safe and effective in the short term regardless of the BMI of the patient. Recurrence and complication rates are comparable between non-obese and obese subjects.

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Show Me the Money, I’ll Show You My Complications: Impact of Incentivized Incident Self-Reporting among Surgeons

INTRODUCTION: Promoting patient safety through incentivized self-reporting of adverse events and medical errors may be an effective approach in providing valuable insight into how and why medical errors occur. The purpose of this study is to evaluate the impact of financially incentivized incident self-reporting on provider engagement, workplace attitudes, and effects on patient-related incident reports.

METHODS: A retrospective review of incidents reported via the internal incident reporting system from September 2018 to September 2019, 4 months preceding and 9 months following the intervention, within the Department of Surgery, was conducted. The primary outcomes were changes in provider-reported incidents over time and changes in workplace attitude based on survey responses.

RESULTS: 218 patients involved in reported incidents were identified. The average age and ASA score of these patients were 58.3 years and 2.6 respectively. There was a significant (p<.001) increase in physician (37.1% vs 67.8%) and physician’s assistant (2.9% vs 18.6%) report rates in the department after incentivization. Our analysis also revealed a significant decrease in reported iatrogenic injuries (14.3% vs 3.8%, p = .013). Survey responses showed that the intervention led to process improvement measures within some divisions.

CONCLUSION: Incentivized self-reporting is an effective way of promoting physician engagement and raising awareness of quality improvement efforts to ensure patient safety. There is a need for more dependable and easy-to-understand data analytics, which can also be used as a motivating force for providers. Future studies will focus on the impact of process improvement interventions implemented to improve patient care and safety.

Socioeconomic Status and English Language Proficiency Alter Outcomes after Appendectomy

INTRODUCTION: We aimed to determine the effect of race, and socioeconomic factors on delivery of care and postoperative outcomes after appendectomy.

METHODS: Demographics and 30-day complications after appendectomy from an inner-city hospital prospectively collected database (2008-2017) were analyzed under IRB. Wilkoxon-rank sum test, Fisher’s exact test, chi-square, and multivariate regression tests were used to evaluate the effect of race, gender, income, insurance, and limited English proficiency (LEP) on outcomes after appendectomy. Propensity-score match (PSM) to compare 1:1 English speaker’s vs LEP patients was performed.

RESULTS: We reviewed 558 consecutive appendectomies. We sought to detect any bias in care by looking at delays in providing surgical consultation and management. This was tested looking at time intervals from initial presentation to surgical consultation or surgery. No bias in care was found according to race, income, insurance, or language skills. Lower income was associated with delay in ER presentation (P=0.01), higher postoperative abscesses (P=0.01), and composite complications (OR=2.44,1.08-4.63).