LH/ testosterone correlated with age, tumour weight, & almost all SSC. Oestrogen correlated with age, & all SSC (except facial hair/ Adam’s apple/ deepening of voice). Accordingly 2 sets of SSC (surrogate markers) defined estrogenic or androgenic predominance of JNA.

CONCLUSION: In absence of a prior knowledge of receptor-status, the clinical surrogate markers may indirectly reflect corresponding receptor activity (rather than isolated hormone level). This is likely to provide a better rationale for selecting a particular HT. A wide variety of novel agents (GnRH/ triptoreline, LHRH/ degarelix, tamoxifen, enzalutamide) are worth investigating in JNA and a more comprehensive study with (serum/ tissue) levels of hormone/ metabolites, with corresponding receptors (trucut biopsy) might help in standardizing HT.

Does Hospital and Physician Volume Affect Outcomes and Cost for Otoplasty?
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INTRODUCTION: The purpose of this study is to determine whether higher case volume affects postoperative outcomes and hospital costs for pediatric otoplasty.

METHODS: Retrospective cohort study was conducted of otoplasty in the United States from 2010 to 2020 using the PHIS database. High-volume was defined by the 80th percentile, and highest-volume was defined by the 90th percentile of cases performed during the ten-year study period.

RESULTS: During the study interval, 2439 pediatric patients underwent otoplasty. High-volume surgeons performed 74 cases (95%CI 74-78) and highest-volume surgeons performed 101 cases (95% 101-101). High-volume hospitals performed 192 cases (95%CI 192-192) and highest-volume hospitals performed 196 cases (95%CI 196-228). White patients (p=.001, aOR=1.6) and those with commercial insurance (p<.001, aOR=3.4) were more likely to be treated at high-volume hospitals. Patients with above-median income (p<.001, aOR=2.0), living in an urban community (p=.026, aOR=2.1), and with commercial insurance (p<.001, aOR=2.9) were more likely to be treated at highest-volume hospitals. Highest-volume hospitals had fewer infections (p=.026, 0.2% vs 1.9%) and overall complications (p=.031, 0.9% vs 3.3%) than lowest-volume hospitals in the bottom tenth percentile. Billed charges were inversely proportional to hospital volume (p<.001, B=-553/ case), such that high-volume hospitals (p<.001, $12069 vs $21631) and highest-volume hospitals (p<.001, $12059 vs $20603) charged less for otoplasty procedures. Perhaps related to efficiency, high-volume hospitals (p<.001, $4294 vs $5594) and highest-volume hospitals (p<.001, $4312 vs $5361) incurred lower costs.

CONCLUSION: Higher hospital case volume for otoplasty was associated with lower complications, lower admission charges, and lower hospital costs.

Pediatric Parotidectomy: Do Parents Travel Farther for Higher-volume Care?
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INTRODUCTION: The purpose of this study is to investigate whether families travel farther to seek higher-volume hospitals for pediatric parotidectomy.

METHODS: Retrospective cohort study was conducted of pediatric parotidectomy in the United States from 2010 to 2020 using the PHIS database. Trigonometric formulas were used to calculate patient travel distances based on geographic coordinates.

RESULTS: During the study interval, 435 pediatric patients underwent parotidectomy with detailed geographic information available. Only 48.3% (n=210) families chose the closest hospital, whereas 51.7% (n=225) chose a more distant center. The majority of patients traveling to a farther hospital chose a higher-volume institution (72.4%, n=163 of 225). Up to 85.7% (n=373) patients had an available center within their state. Patients with below-median income (p=.012, OR=12.6), not living in an underserved area (p=.037, OR=1.7), and with government insurance (p=.015, OR=1.6) were significantly more likely to choose a farther hospital than the one locally available. Distance to the nearest center was 75 miles (95% CI 70-81), and families choosing a more distant center traveled 144 miles (95% CI 134-159). Patients without a high-volume local center were 4.1 times (95% CI 2.2-7.7) more likely to travel to a farther hospital. Alternative hospitals chosen by patients had a significantly higher case volume than their local center in paired-sample analysis (p<.001), such that hospitals chosen by patients performed 25 more cases (95% CI 22-36).

CONCLUSION: The majority of patient families chose a more distant center than the institution locally available for parotid resection, and almost all of these families chose a higher-volume center.

Socioeconomic Disparities in Pediatric Parotidectomy
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INTRODUCTION: The purpose of this study was to analyze the influence of socioeconomic factors upon access to surgical care for parotid resection, postoperative outcomes, hospital admission charges, and geographic trends across regions of the country.
METHODS: Retrospective cohort study was conducted of pediatric parotid resections performed in the United States from 2010 through 2020 using the PHIS database. Multivariate regression was used to analyze associations of socioeconomic variables.

RESULTS: During the study interval, 985 pediatric patients underwent parotid resections. White patients (p = .016, B = -1.4 years) and with government insurance (p < .001, B = -2.4 years) underwent parotid resection significantly earlier. Patients with above-median income (p = .049, B = -38.2 miles) and living in an urban community (p = .002, B = -77.4 miles) traveled shorter distances, whereas those in underserved areas (p = .028, B = +50.5 miles) traveled longer distances. Patients with above-median income were significantly more likely to be treated at high-volume hospitals (p < .001, aOR = 1.9). Patients with above-median income were significantly less likely to experience surgical complications (p = .028, aOR = 0.2). Patients with white race (p = .019, B = -2.3 days) had significantly shorter lengths of stay. Patients with white race (p < .001, B = -$7240) were billed significantly less for their hospital admission. Billed charges were significantly different across regions of the country (p < .001), such that patients in the West North Central region were billed the least (median $20620), while patients in the Pacific region were billed over twice the amount for their admission (median $49656).

CONCLUSION: Various socioeconomic and demographic factors are associated with access, outcomes, and costs for pediatric parotidectomy.

Robotic Surgery Through a Transhairline Approach for Cervical Lymphatic Malformation in the Pediatric Population

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INTRODUCTION: Lymphatic malformation (LM) is a rare benign disease with a predilection for the head and neck region. The advent of surgical robot in head and neck surgery may provide beneficial outcomes in pediatric population.

METHODS: We illustrate our experiences in the application of a transhairline incision to robot-assisted surgical resection of cervical LM in the pediatric population, two mixed type LM and two macrocystic type LM respectively. Operation time, docking time, console time, surgical results, complications as well as postoperative follow-up were documented.

RESULTS: Cervical LMs could be exposed, visualized properly and safely resected in all four patients who underwent a transhairline approach robotic surgery. Intraoperative events and postoperative results were generally satisfactory and uneventful.

CONCLUSION: Cervical masses in pediatric population could be successfully resected using transhairline approach robotic surgery, thus making it an innovative method in addressing definitive surgical treatment and aesthetic concerns.