

Is North America the best place for PCNL in obese patients?

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The article by Alyami and colleagues titled “Impact of body mass index on clinical outcomes associated with percutaneous nephrolithotomy”¹ found no statistically significant difference in percutaneous nephrolithotomy (PCNL) outcomes across various body mass indices (BMI) in 114 patients. These findings from their retrospective chart review are not new; Averch’s group and Lotan’s group have previously shown no impact of BMI on PCNL outcomes in 234 and 150 patients, respectively.^{2,3} It is difficult to draw strong conclusions from these 3 studies, especially given that very small numbers of patients were studied in some of the BMI categories. On the other hand, the Clinical Research Office of the Endourological Society (CROES) Percutaneous Nephrolithotomy Global Study that was published last year showed—in an impressive 3,709 patients—that obesity did indeed have a negative impact on operative times, stone-free rates and re-intervention rates.⁴ Given the contradictory results between the 3 former smaller North American studies and the latter large global trial, and allowing for the acknowledged flaws in the study design of all 4 studies, can one reasonably conclude that North America is the best place for PCNL in obese patients? We think not.

We generally agree with the authors’ findings, but in our experience here at Queen’s University, one particular PCNL outcome is different in obese patients – length of hospital stay. The reason is simple: we are one of two Canadian centres with published series on truly outpatient PCNL,^{5,6} and most obese patients are not candidates for hospital discharge mere hours post-PCNL. Although a number of studies have shown there is no increase in unplanned admissions after outpatient surgery in obese patients, the incidence of obstructive sleep apnea (OSA) among these patients is over 70%.⁷ Recent guidelines from the Society for Ambulatory Anesthesia (SAMBA) recommend that patients with treated

OSA who have stable concomitant disease are suitable for outpatient surgery.⁸ However, patients with untreated or suspected OSA that require opioid analgesics postoperatively are not good candidates for ambulatory surgical procedures. The requirement for overnight admission for oximetry monitoring in these patients results in an increased length of stay unrelated to the surgical procedure.

Given the fact that obesity is more prevalent in North America than other parts of the world,⁹ perhaps it is indeed the best place for obese patients to undergo PCNL. After all, North America is where urologists obtain a greater experience performing PCNL in obese patients. Could this partly explain Alyami’s encouraging PCNL results in obese patients?

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Continuing medical education: The perspective of quality improvement

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Ahmed and colleagues are to be congratulated for their scholarly review of the effectiveness of continuing medical education (CME) for the purposes of specialist recertification.¹ They are correct to point out the dangers of healthcare professionals viewing CME as a method of accumulating credits for its own sake – rather than as a means of improving their practice. This is likely to be particularly at issue in the case of specialist CME where an individual tertiary care specialist may gather the requisite number of credits, but still not do much CME that relates directly to their clinical practice and thus that will *improve* their clinical practice. In any case, education is not like a drug – it is difficult to definitively prove its “effectiveness”

by means of traditional quantitative research trials. It is likely that another perspective is called for.

That perspective may best come from the paradigm of improvement science rather than that of education. It may be better for specialists to measure key outcomes of their practice at baseline, institute clinical quality improvement measures and continually re-measure and measure at the end of a fixed period. At the end they might evaluate the improvement project and see what they have learned. Improvement may thus result in learning, rather than learning resulting in improvement. The key advantage of this approach is that it would result in a project tailored to the individual clinician's need – regardless of their degree of specialization.

Finally the authors are right to draw their review to a close with research questions for the future. To their list of questions, I would add 2 more: (1) should CME be a team-based activity rather than an individual activity?; and (2) what forms of CME offer best value for the sums spent on them? CME has become a multimillion dollar industry. If we are to continue to invest, surely we should have better data on cost-effectiveness, cost benefits or cost utility?²

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