

Fig. 3. Intraoperative drawing, which is meant to document extraordinary findings.

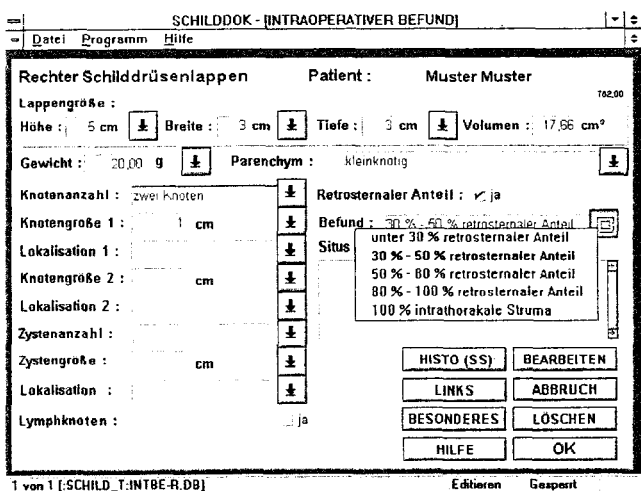


Fig. 4. All important surgical parameters of one side.

goitres, that are goitres recurring on the side operated on, are carrying an increased risk of complications.

Another contradictory term is "intrathoracic goitre" (18). In this matter we follow the definition by Röher stating that an intrathoracic goitre has to be situated 100% in the thorax having an aberrant vascular supply. If 30 to 50% of the goitre are intrathoracically located, it is called retrosternal goitre, and if the intrathoracic part comprises more than 50%, we talk about a goitre extending towards the intrathoracic space.

In literature, the paresis rates of the recurrent nerve are partially defined either by the number of pareses per patient or by the number of pareses on the side of the thyroid gland operated on ("nerves at risk") (2, 12).

We believe it is necessary to go even one step further. To achieve a comparability of these complication rates, the paresis rate of the recurrent nerve has to be defined as the rate of newly occurred pareses related to the operated side and to the various operating techniques.

The quality of the physicians' actions can be assessed and subsequently improved by several methods (15, 16, 20).

When evaluating this quality we have to take into account the structure of the patient-collective (16).

On the one hand there are traditional methods of internal quality assurance like morning discussion, indication – and mortality-conferences, wardrounds with a senior doctor (or consultant), achievement-/performance and complication statistics and internal guidelines (6, 15, 20).

On the other hand there are a number of methods of external

quality assurance like, first of all, the tracer methodology in North Rhine-Westphalia, where experiences were gathered with that method. According to their purpose they defined standard complication rates, for example with cholecystectomies, and compared them with other hospitals (11, 15, 20).

Further methods include audits and studies on quality improvement (15, 16).

A study for reviewing the indications of operation for asymptomatic carotid stenosis has been finished this year. Only surgeons who could prove a combined mortality and permanent stroke rate below 3% in a prospective study of their patient-collective were admitted to this study. The treatment results were compared with the ACAS-study on asymptomatic carotid stenosis which, among other factors, took the structure of the patient-collective into account (1).

A standard, similar to that in carotid surgery was set for the paresis rate of the recurrent nerve and the total complication rate, related to the various operating techniques, e.g. to subtotal goitre resection, or thyroidectomy.

SCHILDDOK could be employed to compare the hospitals, and to assess and analyze the frequency of complications based on an equal risk profile. A superordinate institution would have to draw conclusions from this analysis and, if the standard was extremely exceeded, should intervene regulatively.

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From the Department of Transplantation Surgery I/A, University Graz  
**Invited Commentary to: "Quality Assurance in Benign Thyroid Diseases Surgery"**

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The paper presented (2) may be an important step towards making more use of standardized databases in surgery. SCHILDDOK seems to be a feasible and easy-to-handle tool in standardizing operative records in surgery. The mayor point of its validity, however, seems to be the integration of this system in different other recording systems to be developed (i.e. QUADRA).

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DataEase). On first sight, the features in this documentation may be applied to other operations. Great effort was applied to the simplicity of the system in order not to "over-document" daily procedures. Nevertheless, there are some important points to be mentioned: Quality assessment is not only guaranteed by the installation of a computer documentation system, but also in external monitoring and auditing. Computer assisted documentation per se is not suited to assure high quality surgery, it just makes results more comparable – if there is proper data acquisition –.

In the paper mentioned above some conclusions are drawn that are not related to the initial purpose: How do the authors find evidence that the installation of the program did increase surgical quality? Their rate of recurrent nerve palsies show low levels compared to the literature. How did the SCHILDDOK program affect this rate? How are laryngological data assessed and recorded? Unfortunately, in most papers on thyroid surgery, palsy rates are the only data given on surgical quality. In a sophisticated documentation system, there would be room for more postoperative data, such as pain duration, hypocalcemia, hospital stay etc., which also affect the outcome. This presentation offers no explanation in which way data recording can estimate the recurrence rate immediately post operation, and how it can distinguish between persistent and recurrent adenomas.

The authors are encouraged to proceed in this database system and to extend these systems to other fields in surgery, always with the endpoint in mind to have a standardized documentation covering all surgical fields.

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## Closing Remarks

We share the opinion of *Tscheliessnigg* and *Wolf* (1) that the installation of our database application alone does not by itself satisfy the criteria for Total Quality Management.

SCHILDDOK is only an instrument of quality assurance and can only be as good as its users.

Computerized documentation cannot guarantee high quality in all surgical processes, but is one way of comparing and evaluating standardized data sets.

To achieve high quality in surgical therapy a surgeon must be honest, and be prepared to admit both his complications as well as his good results in public. This is a matter of integrity, which cannot be subjected to an external audit.

The low rate of recurrent nerve pareses was encouraging for us. In our opinion this is a direct result of our surgical handling.

In 56.7% of cases, our findings were confirmed by an independent otolaryngologist. At the moment, we are trying to increase the number of patients who are assessed by an otolaryngologist post-operation.

SCHILDDOK assesses postoperative data such as hypocalcemia, haematoma, bleeding following surgery, and post-operative hospital stay.

From our point of view, quality control of the recurrence rate of goitre after thyroid surgery is an unsolved problem.

Follow-up by the surgeon is hardly possible because of high costs and poor patient compliance (problem of long-term follow-up).

To achieve high quality in postoperative monitoring, a sonography should be performed in every patient 3 months after operation to distinguish between persistent adenomas and recurrent goitre.

Given the tremendous costs in medical care, it is very unlikely that these aims will be widely achieved.

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## Kongreßzusammenfassung

Aus den Universitätskliniken für Kiefer- und Gesichtschirurgie, Unfallchirurgie, Urologie und Orthopädie, Wien

## Highlights der Chirurgie im Kindesalter

Sabine Pichorner

Mit der Übersiedlung aller Wiener Universitätskliniken in das Gebäude des Neuen Allgemeinen Krankenhauses Wien wurde ab August 1993 die gemeinsame Kinderbelegstation 17 B geschaffen, mit der Absicht, den fünf Kliniken:

- Kiefer- und Gesichtschirurgie,
- Orthopädie,
- Plastische Chirurgie,
- Unfallchirurgie und
- Urologie

die Möglichkeit zu geben, die von ihnen behandelten Kinder bis zum 14. Lebensjahr kindgerecht betreuen zu können.

Speziell geschultes Pflegepersonal und liebevoll gestaltete Räumlichkeiten nehmen Kindern die Angst vor dem Krankenhaus und der notwendigen Therapie, bei Säuglingen werden selbstverständlich Mutter und Kind gemeinsam stationär aufgenommen.

Mit der ärztlichen Leitung der Station ist abwechselnd einer der 5 Klinikvorstände betraut.

Um diese ausgezeichnete Einrichtung vorzustellen und um zu zeigen, welche herausragende medizinische Leistungen vollbracht werden, fand im Dezember 1995 das vielbesuchte Symposium „Highlights der Chirurgie im Kindesalter“ statt, bei dem sich alle 5 Universitätskliniken präsentierten.

Am 14. Dezember 1996 wird neuerlich dieses Symposium im Hörsaalzentrum des Allgemeinen Krankenhauses Wien veranstaltet, diesmal in erweitertem Rahmen (Universitätskliniken für Kinderchirurgie, Kinderheilkunde, Augenheilkunde, Hals-, Nasen- und Ohrenheilkunde, Neurochirurgie), wozu alle Interessierten schon jetzt herzlich eingeladen sind.

*R. Ewers und Sabine Pichorner*, Universitätsklinik für Kiefer- und Gesichtschirurgie, Wien: **Schwerpunkte der kiefer- und gesichtschirurgischen Behandlung im Kindesalter**. Kraniofaziale Fehlbildungen stellen schwere Formen und Funktionsstörungen des Gehirn- und Gesichtsschädels dar. Sie entstehen durch vorzeitige Verknöcherung von Suturen am Schädeldach und an der Schädelbasis, durch Wachstumsstörungen oder durch Gesichtsspalten.

Folgen sind typische Schädeldeformierungen (Plagio-, Brachy-, Skapho-, Turri- oder Trigonocephalus usw.) und Mißbildungen (Hypertelorismus, Morbus Crouzon, Apert-, Franceschetti- oder Pierre-Robin-Syndrom) (Abb. 1, 2 und 3).

Das Ziel der operativen Korrektur ist die ungestörte Funktion und eine zufriedenstellende Ästhetik als Dauerresultat. Wichtig für solche trans- oder subkranialen Eingriffe ist die Wahl des Operationszeitpunktes, da das wachsende Gehirn seine Masse normalerweise innerhalb der ersten 6 Lebensmonate verdoppelt, so daß aufgrund des erhöhten Hirndruckes frühzeitige Korrekturen im 1. Lebensjahr notwendig sind. Wenn jedoch Wachstumszentren im Bereich des Mittelgesichtes von Fehlbildungen betroffen sind (z. B. ein- oder beidseitige Hypoplasien), kann ein weiterer Eingriff erst später gegen Ende des Wachstums durchgeführt werden.

Zur Operationssimulation sind an der Universitätsklinik für Kiefer- und Gesichtschirurgie seit 1991 stereolithographische 3-D-

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