Choosing a Surgical Team

I'm Dr Jonathan Salo, I'm a GI Cancer Surgeon in Charlotte, North Carolina. These videos are designed to educate you about cancer and its treatment and help you and you cancer care team make the right decisions for you.

Of course, there is no substitute for the expert opinions of your cancer care team.

An esophagectomy is an operation to remove a cancer in the esophagus. If you are in need of an esophagectomy, you will need to choose an esophagectomy surgery team.

In this video, you will learn about how to:

- Choose a hospital
- Choose a surgeon
- Get a second opinions

Esophagectomy is a complex operation, and because of it's complexity, the outcomes aren't the same for every hospital and every surgery, so there is a lot of variation in outcomes

Outcomes are different between:…

Different hospitals…

and different surgeons…

When we talk about outcomes after esophagectomy, we are going to focus on two areas:

The first is complications.

The most important of these complications is the rate of anastomotic leak.

If this is not a familiar term to you, please take a minute to watch our video about esophagectomy surgery.

(pause)

Another important outcome is the risk of death in the first 90 days after surgery

Because esophagectomy is complex, it's no surprise that *experience counts*

In general, Esophagectomy Outcomes are better at high-volume hospitals…

… and for Experienced surgeons (16)

The question is How many cases is enough? or How many operations does a hospital or surgeon need to do each year in order to have sufficient experience.

The Leapfrog Group has addressed this very question. Leapfrog group is a non-profit medical watchdog group which has promoted transparency in health care outcomes. (17)

They gathered a group of experts and reviewed the medical research to come up with some proposedd volume guidelines for recommended minimum of operations per year for esophagectomy surgery

In 2018 they made their recommendations that hospitals should perform at least 20 esophagectomy operations per year, and surgeons should perform at least 7 operations a year,

in order to have enough familiarity with the surgery.

(pause)

We have a link to their recommendations

https://ratings.leapfroggroup.org/sites/default/files/inline-files/2023%20Adult%20and%20Pediatric%20Complex%20Surgery%20Fact%20Sheet.pdf

Bibliography:

https://ratings.leapfroggroup.org/sites/default/files/2025-03/2025%20Adult%20and%20Pediatric%20Complex%2

In 2019 The Leapfrog Group surveyed hospitals and found that only 3% of hospitals in the U.S. met the guidelines for hospital volume and surgical volume

Which means it some patients may need to travel to find a high-volume hospital with high-volume surgeons.

However 25% of hospitals had a surgeon meeting the volume guidelines by performing 7 or more esophagectomy operations per year. (20)

https://www.leapfroggroup.org/sites/default/files/Files/Leapfrog%20Report%20on%20Safe%20Surgical%20Volumes%202020.pdf

How does this help you? I would recommend that you *interview your surgeon*

This may seem a bit awkward at first, but most of us are comfortable about doing some comparison shopping when it comes to:

- buying a house
- or a car
- or a flat-screen TV

I would recommend that you ask

"How many esophagectomy operations do you personally perform each year?"

This is a very specific question. It's not asking whether there is a high-volume surgeon somewhere in the hospital, or what the volume of the *hospital* is,

But it's designed to find out of *your* surgeon has the experience necessary.

If the surgeon volume is less than 7 cases per year, I would see that you have two choices.

One is to get a second opinion, and we'll talk about that towards the end of the video

The other is to ask whether there is an experienced surgeon who can join your surgeon in the operating room for your surgery.

One of the challenges for surgeons in the beginning stages of their careers is how to safely acquire experience with complex surgery

One way to address that challenge is to have more experienced surgeons working with less experienced surgeons to allow the patient to have the best outcomes possible

…while also allowing the training of the next generation of surgeons.

To my mind, mentoring is a safe way for lower-volume surgeons to gain experience (and become high-volume surgeons) while they are providing patients with the benefits of the experience of a high-volume surgeon.

Now that you have located an surgeon, what else do you need to look for? It turns out that you need more than just a high-volume surgeon.

A research study looked at outcomes among high-volume hospitals in New York state (28)

And they found two-fold variation in mortality outcomes

… and complications

https://pubmed.ncbi.nlm.nih.gov/34292582/

In other words, some high-volume hospitals had twice the complication rate of other hospitals.

You will want to know something about your surgeon's complication rate

So back to your interview with your surgeon…

I would ask "What is the anastomotic leak rate in operations you personally perform?"

Again, you aren't as interested in what the average is for the hospital, or what the average is in the medical literature, but the personal experience of that surgeon.

If you surgeon isn't familiar with their personal outcomes, I would recommend getting a second opinion.

Whoever your surgeon is, you want someone who is constantly seeking to improve outcomes for their patients, and the only way to do that is to know what your outcomes are.

Something else you will want to ask about is what your surgeons estimates **your** risk of mortality, meaning death in the first 90 days after surgery.

Now this is a very complex issue, and comparisons between hospitals and between surgeons are *very* difficult

The simple reason is that the risk of mortality after surgery depends upon three different factors.

The first is the experience and skill of the surgeon

The second is the hospital's ability to care for patients after surgery

Caring for a patient after esophagectomy requires a large team of people in addition to the surgeon.

Everyone from the nurses

- to the physicians in the intensive care unit t
- to the dietitians
- and the other specialists in the hospital
- such as radiologists
- and gastroenterologists.

(pause)

Risk of mortality also depends heavily upon the patient.

We know that younger patients encounter fewer problems with surgery than do older patients.

We know patients with major medical problems are more likely to have more problems tolerating surgery

And we know that patients who are fit and active have encounter fewer problems.

Because the risk of mortality depends upon a number of factors beside the surgeon and the hospital, by itself it is not an ideal way of choosing a surgical team.

I would recommend that you ask your surgeon what their personal experience is with mortality after esophagectomy in the first 90 days in patients on whom they personally perform an operation.

The most important thing is that you want a surgeon who is focused on optimizing their outcomes, and they can't do that if they don't have the data

An important follow up question is to ask your surgeon to make an estimate of surgical mortality in *your* particular case.

In other words, starting with the surgeon's overall experience, can they make an estimate of surgical mortality for your case.

I think this is an important question as it helps you know whether our surgeon has the experience with a variety of patients to understand how risky an operation is in a particular patient.

So how can your surgeon give you a personalized risk estimate?

There are several tools your surgeon can use: (39)

A cardiology evaluation can help identify issues which would make surgery higher risk.

You may be referred to a cardiologist for testing such as an echocardiogram or stress test

Pulmonary function testing can also be helpful, particularly for patients who are heavy smokers or have emphysema

There are a variety of ways to test overall fitness.

A simple method that we use in our clinic is to test muscle strength as shown here.

There are other tests such as a 6-minute walk test or a treadmill test that can also be used

Is summary, you need an honest discussion with your surgeon about the risks of surgery.

I would recommend that this not be a discussion that gets delegated to a physician's assistant or nurse practitioner.

What you are looking for is whether your surgeon has a good understanding of who is a good candidate for surgery vs who is a poor candidate for surgery.

(pause)

If you are interested in a second opinion, the primary questions are where? and how?

The easiest place to start is asking your primary care provider for a recommendation,

or other members of your cancer care team such as your medical Oncologist or your gastroenterologist

The important thing is not to hesitate out of concerns for offending the first surgeon you may have seen:

All of us in healthcare want for our patients to have good outcomes from their cancer treatment.

Your second opinion team will need a variety of materials in order to make a recommendation. Your cancer care team can help you assemble these records.

THe first is medical records, which will include:

- Notes from all consultations with any specialists

- Endoscopy reports

You will also need:

- Pathology reports
- Radiology reports
- Cardiology Reports and Records

You may need to sign an authorization request to release your records to the second opinion team

In addition to the radiology reports, the second opinion team will need to see the images themselves.

This can be done by sending a disk from the radiology department to the second opinion team

In many cases, the two radiology departments can work together to send the images electronically

In some cases, in addition to the pathology report, the second opinion team will want to review the pathology slides.

This means that the glass microscope slides will need to be sent from the first pathology lab to the second one.

The slides will usually be send via express shipping such as Fed Ex or UPS.

After the second lab reads the slides, they are returned to the first pathology lab.

There may be a charge by the second pathologist for reading the slides.

This is done routinely but can be the most time-consuming part of the process.

This may sound like a lot of work, but your nurse navigator or cancer center clinic staff can help you here.

The important bottom line message is this: Please don't hesitate to ask for a second opinion. You will likely learn a lot from the process, and it can be very valuable even if you return to your original surgical team.

(pause)

We hope you have found this video helpful. We have some links to other videos.

Feel free to leave a comment or a question, or if you have suggestions for future videos.

If you or a family member have had an encounter with esophagectomy surgery, or experience choosing a surgical team, I would love to hear about your experience, so please take a minute to leave a comment below.

We're working to create new videos, so please subscribe to be notified of new videos when we post them. (29)