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Supplementary material

Centralisation of Oesophagectomy in Australia: Is only caseload critical?

Richard Hummel,[1] Ngoc Hoang Ha,[1] Andrew Lord,[1] Markus I Trochsler,[1] Guy Maddern,[1] and Harsh Kanhere[1,2]

[1]Department of Surgery, The Queen Elizabeth Hospital, 8 Woodville Rd, Woodville South SA 5011, University of Adelaide, Australia. Email: richard.hummel@uksh.de; ngoc.h.ha1@gmail.com; andrew.lord@sa.gov.au; Markus.Trochsler@sa.gov.au; guy.maddern@adelaide.edu.au

[2]Corresponding author. Email: Kanhere.harsh@health.sa.gov.au

Text S1 Post-operative protocol

All patients were initially cared for in an Intensive Care Unit.

Pain relief was managed by the Acute pain service in conjunction with the surgical team and ICU.

Gastrograffin swallow was performed on day 5.

The nasogastric tube was removed and oral feeding initiated once the clinical and radiological investigations confirmed no leakage.

Enteral feeding via jejunostomy was utilised until sufficient oral intake was achieved. Drains were utilised and removed as per clinical situation. Underwater seal drains were used in the earlier period, more recently an transhiatal suction drain to the mediastinum has been the norm.

In case of a suspected anastomotic leak, appropriate urgent investigations (endoscopy/contrast swallow/CT scan with oral contrast) were performed as required. Adequate skilled personnel and facilities were available for endoscopic treatments as well as surgical intervention and ICU care if required round the clock. A 24 hour interventional radiology service was available on site.

Figure S1 Long-term survival in the entire patient population (n=47), as well as the two subgroups of patients undergoing surgery from 2000-2005 (n=23) and from 2006-2012 (n=24). p=0.482.