



Complete Summary

GUIDELINE TITLE

Guidelines for collaborative practice in endoscopic/thoracoscopic spinal surgery for the general surgeon.

BIBLIOGRAPHIC SOURCE(S)

Society for American Gastrointestinal Endoscopic Surgeons (SAGES). Guidelines for collaborative practice in endoscopic/thoracoscopic spinal surgery for the general surgeon. Los Angeles (CA): Society for American Gastrointestinal Endoscopic Surgeons (SAGES); 2003 Oct. 6 p. [3 references]

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

Conditions requiring endoscopic/thoracoscopic spinal surgery

GUIDELINE CATEGORY

Evaluation
Treatment

CLINICAL SPECIALTY

Neurological Surgery
Surgery
Thoracic Surgery

INTENDED USERS

Hospitals
Physicians

GUIDELINE OBJECTIVE(S)

- To provide practical guidelines, which will assist hospital-privileging committees when granting privileges to perform collaborative endoscopic spine surgery
- To provide recommended training requirements, clinical responsibilities, and definition of roles for the general surgeon who participates as a member of a collaborative endoscopic spine surgery team
- To promote high quality patient care

TARGET POPULATION

Patients undergoing endoscopic/thoracoscopic (spinal access) surgery

INTERVENTIONS AND PRACTICES CONSIDERED

Roles and Responsibilities of the General Surgeon in Collaborative Endoscopic/Thoracoscopic (Spinal Access) Surgery

Preoperative

1. Interview and examination of patient
2. Development of an operative plan with the spine surgeon
3. Obtaining informed consent from patient after explaining risks and complications of the procedure as well as the specific roles and responsibilities of the endoscopic general surgeon and spine surgeon

Intraoperative

1. Positioning the patient and locating the trocars
2. Entry into the peritoneum or the retroperitoneum and safe dissection to expose the proper spinal anatomy
3. Safe exit of the peritoneum or the retroperitoneum and closure of the trocar sites
4. Management of laparoscopic complications

Postoperative

1. Follow-up of patient in accordance with usual standards of practice
2. Provision of discharge plans and patient instructions
3. Out patient follow-up, with particular attention to postoperative laparoscopic complications

4. Proper documentation of each surgeon's participation according to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This statement was reviewed and approved by the Board of Governors of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) October, 2003. It was originally prepared by an ad hoc Committee on Collaborative Surgery Practices and the most recent revisions made by the Society of American Gastrointestinal Endoscopic Surgeons Guidelines Committee.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Roles and Responsibilities of the General Surgeon in Collaborative Endoscopic/Thoracoscopic (Spinal Access) Surgery

Preoperative Role and Responsibilities

The endoscopic general surgeon should arrange to interview and examine the patient preoperatively and should participate with the spine surgeon in development of an operative plan. Special attention should be directed towards suitability of the patient for anesthesia and for the proposed endoscopic procedure. The endoscopic surgeon should not feel obligated to participate in any procedure that he/she does not feel is in the best interest of the patient. Risks and complications unique to the endoscopic access portion of the procedure should be identified and communicated to the patient at this time, as well as the specific roles and responsibilities of the endoscopic general surgeon. The endoscopic general surgeon and spine surgeon should each communicate their individual experience in this procedure to the patient. This results in a true informed consent. Both co-surgeons must be named on the patient consent form.

Intraoperative Role and Responsibilities

Intraoperatively, the endoscopic general surgeon should participate in positioning the patient and selecting the proper locations of the trocars. The endoscopic general surgeon is not only responsible for safe entry into either the peritoneum or the retroperitoneum but also must participate in safe dissection to expose the proper spinal anatomy. He/she should be immediately available throughout the entire operative procedure. At the conclusion of the procedure, the endoscopic surgeon is responsible for safely exiting the peritoneum or retroperitoneum and for closure of trocar sites. The endoscopic surgeon must be capable of recognizing and managing intraoperative laparoscopic complications.

Postoperative Role and Responsibilities

The patient should be followed by the endoscopic surgeon postoperatively in accordance with the usual standards of practice for similar laparoscopic procedures. Discharge plans and instructions should be coordinated with those of the co-surgeon and provided to the patient. Outpatient follow-up should be provided to confirm absence of postoperative laparoscopic complications related to the access procedure. Any adverse outcomes must be communicated between the co-surgeons.

Documentation

Each co-surgeon must adequately document his/her respective preoperative, intraoperative, and postoperative participation according to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence was not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Implementation of these methods, in conjunction with the standard Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines for granting hospital privileges, should help hospitals ensure that collaborative endoscopic spine surgery is performed only by individuals with adequate training and proven surgical competence. High quality patient care will result.

POTENTIAL HARMS

Risks and complications of endoscopic/thoracoscopic spinal surgery: The most serious intra-operative complication that may occur, and which is the primary reason a co-surgeon is required for spine access, is a major vascular injury. The aorta, vena cava, and iliac arteries and veins may all be mobilized during the operation. Any of these structures may be injured and require emergent repair.

QUALIFYING STATEMENTS

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As with all medical procedures, each hospital and the doctors practicing therein are entirely responsible for instituting privileging and practice guidelines for

endoscopic spine surgery and other methodologies in order to provide optimal patient care.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Training and Determination of Competence

Laparoscopic exposure to the spine requires a high degree of skill. Criteria include:

1. Formal fellowship or residency training in an accredited general surgery residency program (or its foreign equivalent). This residency or fellowship training must have conferred upon the surgeon a wide range of experiences in general abdominal surgery, familiarity with open anterior spinal access, and a broad experience in basic vascular surgery procedures.
2. Privileges and experience in basic laparoscopic skills as defined in Society of American Gastrointestinal Endoscopic Surgeons (SAGES) Guidelines for Granting of Privileges for Laparoscopic and Thoracoscopic General Surgery.
3. Privileges and extensive experience in advanced laparoscopic procedures: For the general surgeon, examples of such procedures would include endoscopic adrenalectomy, Nissen fundoplication, extensive adhesiolysis, laparoscopic splenectomy, and laparoscopic colectomy. Specific skills required include, but are not limited to, suturing, major vessel ligation, extensive dissection of tissue planes, as well as retraction and manipulation of bowel.
4. The most serious intra-operative complication that may occur, and which is the primary reason a co-surgeon is required for spine access, is a major vascular injury. The aorta, vena cava, and iliac arteries and veins may all be mobilized during the operation. Any of these structures may be injured and require emergent repair. For this reason, the co-surgeon performing the exposure must have training in and the ability to perform basic vascular surgery in order to perform these exposures. Residency or fellowship training must, therefore, have conferred upon the surgeon basic vascular surgical skills, including but not limited to, the ability to safely achieve mobilization of major vascular structures and safely repair both minor and major arterial and/or venous injuries
5. Specific training for endoscopic spine access must include at least one of the following:
 - Documentation of formal training in laparoscopic spine access during residency training or fellowship
 - Documentation of extensive experience with open retroperitoneal access surgery
 - Formal course, skills lab, and/or preceptorship in spine access as defined in the SAGES document Framework for Post-Residency Training and Education. A preceptorship is highly desirable

Principles of Privileging

Principles of privileging have been formulated and published in a SAGES document entitled "Principles of Privileging in Endoscopic and Laparoscopic Surgery."

Principles include:

Appropriate Training and Qualifications

An applicant for privileges must document that he has fulfilled the criteria for training and competence as defined above. An applicant must have a license to practice medicine in his/her state.

Uniformity of Standards

Within the parameters and definition of distinct roles for the surgeon participants, uniform standards should be developed which apply to all hospital staff requesting privileges to serve as part of the surgical team performing collaborative laparoscopic surgery. Criteria must be established relative to each role that are medically sound but not unreasonably stringent and that are universally applicable to all those wishing to obtain privileges. The goal must be the delivery of high quality patient care.

Responsibility for Privileging

The privileging structure and process remain the individual responsibility of each hospital. It should be the responsibility of each surgical department, through its Chief, to recommend individual surgeons for privileges in collaborative laparoscopic spine surgery as for other procedures performed by members of the department (e.g., privileges for the general surgeon should be granted through the department of surgery). At its discretion, a hospital may set up a joint privileging committee specifically designated to privilege teams of collaborative surgeons.

Proctoring

Proctoring of applicants for privileges in endoscopic spinal access by a qualified, unbiased surgeon experienced in endoscopic spinal access surgery or advanced laparoscopic surgery is recommended. The proctor should always be appointed by, and serve as an agent of, the medical staff's privileging committee.

Monitoring of Endoscopic Performance

To assist the hospital privileging body in the ongoing renewal of privileges, there should be a mechanism for monitoring each surgical endoscopist's procedural performance. This should be done through existing quality assurance mechanisms and should include monitoring utilization, diagnostic, and therapeutic benefits to patients, complications, and tissue review in accordance with previously developed criteria.

Continuing Education

Continuing medical education related to endoscopic spinal access surgery should be required as part of the periodic renewal of privileges. Attendance at appropriate local or national meetings and courses is encouraged.

Renewal of Privileges

For the renewal of privileges, an appropriate level of continuing clinical activity should be required. In addition to satisfactory performance as assessed by monitoring of procedural activity through existing quality assurance mechanisms, continuing medical education relating to endoscopic spinal access surgery should also be required.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Oct

GUIDELINE DEVELOPER(S)

Society of American Gastrointestinal and Endoscopic Surgeons - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

GUIDELINE COMMITTEE

Committee on Collaborative Surgery Practices

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [Society of American Gastrointestinal Endoscopic Surgeons \(SAGES\) Web site](#).

Print copies: Available from the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), 11300 W. Olympic Blvd., Suite 600, Los Angeles, CA 90064; Web site: www.sages.org.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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