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## EDITORIAL COMMENT

I congratulate the authors on this interesting investigation of the Nationwide Inpatient Sample showing increased incidence of NSQIP inpatient postoperative complications at lower volume centers. As the authors describe, most findings extracted from administrative inpatient databases are affected by miscoding and the inability to follow patients beyond inpatient occurrences. The most concerning limitation is that some of the selected complications may represent comorbidities, since the ICD-9 diagnosis (complication) was not temporally distinguishable as postoperative. One could argue that high volume centers have a larger proportion of children with comorbidities and their actual complication rates are lower.

I would like to highlight the tremendous difference between non-high (low) and high volume hospitals. As stated, 75% of hospitals performed fewer than 5 major pediatric urology cases yearly and the mean patient age at the low volume centers was 9.6 years. Most likely these low volume centers are community hospitals where a general urologist may perform an occasional pediatric case. This issue

brings the focus back to the surgeon and not the hospital.

My biggest concern with this investigation was the inability to extract surgeon volume from the NIS database. We and others have observed that surgeon volume trumps hospital volume when complications and outcomes are analyzed.<sup>1,2</sup> Our multivariate analyses of ureter reimplant and pyeloplasty revealed statistically significant associations between surgeon volume (not hospital volume) and postoperative outcomes at academic centers. As we all know, a qualified, experienced surgeon will more likely perform a faster, better surgery, which will most often lead to an uneventful recovery regardless of the hospital setting. Again, I congratulate the authors on demonstrating that children who receive care at higher volume centers will have a shorter length of stay and lower odds of suffering complications after surgery.

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