

in the United States to examine surgeons' knowledge about CPM. A study of 81 surgeons in Australia asked about CPM but did not question surgeons about CBC risk or survival after CPM.⁶ What is not clear is how surgeons' knowledge translates into treatment patterns. Are patients undergoing CPM more frequently because surgeons are not adequately informing them? Could this be because the surgeons themselves are not well informed? Decision aids or teaching materials that address CPM and its utility for a patient with newly diagnosed breast cancer are needed. Part of this intervention will have to involve not only educating patients on CPM's risks and benefits, but also teaching surgeons how to effectively counsel patients on CPM to ensure informed decision making.

Katharine Yao, MD

Jeff Belkora, PhD

Mark Sisco, MD

Shoshana Rosenberg, ScD, MPH

Isabelle Bedrosian, MD

Erik Liederbach, BS

Chihsung Wang, PhD

Author Affiliations: Department of Surgery, NorthShore University HealthSystem, Evanston Hospital, Evanston, Illinois (Yao, Sisco, Liederbach); University of California, San Francisco, School of Medicine, San Francisco (Belkora); Dana Farber Cancer Institute, Boston, Massachusetts (Rosenberg); Department of Surgery, MD Anderson Cancer Center, Houston, Texas (Bedrosian); Center for Biomedical Research Informatics, NorthShore University HealthSystem, Evanston, Illinois (Wang).

Corresponding Author: Katharine Yao, MD, Department of Surgery, NorthShore University HealthSystem, Evanston Hospital, 2650 Ridge Ave, Walgreen Bldg, Ste 2507, Evanston, IL 60201 (kyao@northshore.org).

Published Online: November 25, 2015. doi:10.1001/jamasurg.2015.3601.

Author Contributions: Dr Yao had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Yao, Belkora, Sisco, Bedrosian.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Yao, Belkora, Liederbach, Wang.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Yao, Liederbach, Wang.

Administrative, technical, or material support: Yao, Liederbach.

Conflict of Interest Disclosures: None reported.

- Rosenberg SM, Tracy MS, Meyer ME, et al. Perceptions, knowledge, and satisfaction with contralateral prophylactic mastectomy among young women with breast cancer: a cross-sectional survey. *Ann Intern Med.* 2013;159(6):373-381.
- Portschy PR, Abbott AM, Burke EE, et al. Perceptions of contralateral breast cancer risk: a prospective, longitudinal study. *Ann Surg Oncol.* 2015;22(12):3846-3852.
- Mavaddat N, Peock S, Frost D, et al; EMBRACE. Cancer risks for *BRCA1* and *BRCA2* mutation carriers: results from prospective analysis of EMBRACE. *J Natl Cancer Inst.* 2013;105(11):812-822.
- Kruper L, Kauffmann RM, Smith DD, Nelson RA. Survival analysis of contralateral prophylactic mastectomy: a question of selection bias. *Ann Surg Oncol.* 2014;21(11):3448-3456.
- Nichols HB, Berrington de González A, Lacey JV Jr, Rosenberg PS, Anderson WF. Declining incidence of contralateral breast cancer in the United States from 1975 to 2006. *J Clin Oncol.* 2011;29(12):1564-1569.
- Musiello T, Bornhammar E, Saunders C. Breast surgeons' perceptions and attitudes towards contralateral prophylactic mastectomy. *ANZ J Surg.* 2013;83(7-8):527-532.

Defining the Need for Transitional Care From Pediatric to Adult Surgery for Young Adult Patients With Surgically Corrected Congenital Anomalies

A child born with a congenital birth defect today has a much higher probability of reaching adulthood than in the past. Significant advances in neonatal resuscitation and surgical management have improved prognoses for diseases such as congenital diaphragmatic hernia, esophageal atresia, and imperforate anus. As these children grow into adolescence, new challenges emerge as results from long-term studies that show ongoing morbidity among adolescent and adult survivors demonstrate a clear need for structured and formal transitional care.^{1,2} Unanswered, however, are the questions of how and when the transition of care should take place. Few quantitative data exist about patients' transition to adult care and their long-term follow-up. A growing body of literature suggests that there are long-term sequelae of many surgically corrected congenital anomalies, such as metaplastic changes in patients with esophageal atresia repair and chest wall deformities in patients undergoing thoracotomy in infancy. Survivors of congenital surgical disease are those who will benefit most from standardized approaches to transitional care. Our study seeks to quantify the need for transitional surgical care for pediatric patients with surgical anomalies in the coming decades.

Methods | The institutional review board at the University at Buffalo, State University of New York, deemed our study to be exempt from approval because the research does not include any patient contact or records. Seven correctable thoracic and gastrointestinal pediatric surgical anomalies (omphalocele, congenital diaphragmatic hernia, Hirschsprung disease, esophageal atresia/tracheoesophageal fistula, myelomeningocele, anorectal malformation, and gastroschisis) were analyzed, and their incidences were extrapolated for the time period from 2030 to 2050. These anomalies were chosen because they are relatively common, survivable congenital anomalies that often require long-term care. The initial year of contribution was arbitrarily set at 2015 to provide a contemporary analysis of the burden of care that exists. The year 2030 would then represent the first year of patients reaching 15 years of age, when transition of care should begin. Incidences were calculated using the following method:

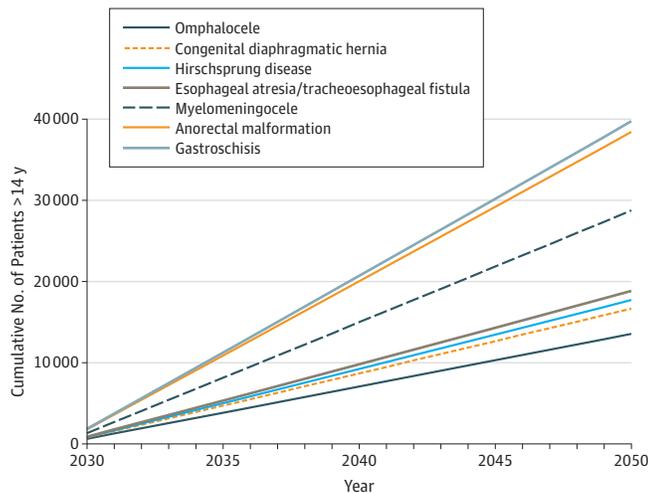
$$[\text{New Patients Starting at 15 Years of Age by Disease}]_{\text{year}} = (\text{Disease Prevalence}) \times (\text{Projected Annual Live Births}_{\text{year}}) \times (\text{Disease-Specific Survival Rates}) \times (\text{Actuarial Survival Rates by Age}).^{3-6}$$

The cumulative burden of disease projected for year is

$$\sum_{n=2030}^{n=\text{year}} (\text{New Patients Starting at 15 Years of Age by Disease})_n.$$

Results | More than 173 000 patients living with some of these surgically corrected thoracic and gastrointestinal anomalies will have entered the pool of patients who will benefit from a coordinated surgical transition plan by 2050 (Figure). Gastroschisis and anorectal malformations comprise the largest subgroups of patients.

Figure. Estimated Patient Populations by Decade From 2030 to 2050 Living With Select Surgically Corrected Thoracic and Gastrointestinal Congenital Anomalies



Discussion | The incidence of young adults living with surgically correctable thoracic and gastrointestinal anomalies will trend upward over the next few decades. This group of patients is at risk for late complications related to their congenital anomalies and surgical procedures. The care burden among patients in this group will undoubtedly be variable, from minimal to complex and significant. More research is necessary to elucidate the spectrum of required care, focusing on morbidity, quality of life, and health care costs. The creation of formal transitional care plans and follow-up may mitigate unfavorable long-term consequences and decrease overall health care costs. Adult care professionals should partner with the pediatric team in this process to inform and plan for the care of newly transitioned complex patients. There has never been a more opportune time than now to address the need for transitional care from pediatric to adult surgery.

Jane Y. Zhao, MD
 Priscilla P. L. Chiu, MD, PhD
 Roshni Dasgupta, MD, MPH
 Howard C. Jen, MD, MSHS
 David H. Rothstein, MD, MS

Author Affiliations: University at Buffalo, State University of New York, Buffalo, New York (Zhao, Rothstein); Hospital for Sick Children and Department of Surgery, University of Toronto, Toronto, Ontario, Canada (Chiu); Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio (Dasgupta); Floating Hospital for Children at Tufts Medical Center, Boston, Massachusetts (Jen); Women and Children's Hospital of Buffalo, Buffalo, New York (Rothstein).

Corresponding Author: David H. Rothstein, MD, MS, University at Buffalo, State University of New York and Women and Children's Hospital of Buffalo, 219 Bryant St, Buffalo, NY 14222 (drothstein@kaleidahealth.org).

Published Online: December 16, 2015. doi:10.1001/jamasurg.2015.4417.

Author Contributions: Drs Zhao and Rothstein had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: All authors.

Acquisition, analysis, or interpretation of data: Zhao, Chiu, Rothstein.

Drafting of the manuscript: Zhao, Rothstein.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Zhao, Rothstein.

Administrative, technical, or material support: Chiu.

Study supervision: Dasgupta, Rothstein.

Conflict of Interest Disclosures: None reported.

1. Naiditch JA, Rothstein DH. Transitional care from pediatric to adult surgery. *JAMA Surg.* 2014;149(11):1099-1100.
2. Giuliani S, Anselmo DM. Transitioning Pediatric Surgical Patients to Adult Surgical Care: A Call to Action. *JAMA Surg.* 2014;149(6):499-500.
3. Mathews TJ, MacDorman MF. Infant mortality statistics from the 2008 period linked birth/infant death data set. *Natl Vital Stat Rep.* 2012;60(5):1-27.
4. United States Census Bureau. <http://www.census.gov>. Accessed April 27, 2015.
5. National Birth Defects Prevention Network. Birth Defects Surveillance, Research & Prevention. State profiles: state-specific birth defects profiles. http://www.nbdpn.org/state_profiles.php. Accessed April 27, 2015.
6. Data.gov. The home of the U.S. Government's open data. <https://www.data.gov>. Accessed April 27, 2015.

COMMENT & RESPONSE

Well-being Programs for Physicians and the Role of the "Doctors' Mess"

To the Editor We commend Salles and colleagues¹ on their comprehensive well-being program, which is laudable in its scope. The issue of physicians' well-being is one shared across the Atlantic.² Increasing strain on health care organizations increases the risk of physician burnout. We provide evidence for another physician wellness program and discuss the concept of the "doctors' mess."

There is a paucity of studies that demonstrate the clinical effectiveness of physician well-being courses. The Mayo Clinic hosts a series of physician wellness courses and used a single-center randomized clinical trial³ to demonstrate efficacy. West and colleagues³ compared alternate weekly 1-hour small-group sessions over a 9-month period for physicians (n = 35) with no intervention for physicians (n = 37) who had an hour of free time as a control. There was no difference (P > .05) in a number of self-rated measures, includ-