Competing interests None.

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The need for standardised outcome reporting in colorectal surgery

We were interested to read the paper by Morris *et al* demonstrating significant variation in 30-day postoperative mortality following major colorectal cancer surgery in National Health Service hospitals in England.[1] While we agree that understanding the underlying causes of this variation will be invaluable to inform best practice, we think that it is necessary to choose a definition of postoperative mortality that provides information relevant to patients as well as clinicians. In cardiothoracic surgery, this issue has been debated for some years, resulting in a measure of 'operative mortality' which encompasses any death occurring (a) within 30 days after surgery, in or out of hospital, and (b) any death occurring after 30 days during the same hospitalisation subsequent to the operation.[2] Implementing the use of this expanded definition is more complex, but it will provide data about the real risks of surgery where a prolonged stay in an intensive care unit may mean that a postoperative death occurs beyond 30 days. From the patient's perspective, understanding outcomes of surgery including the chances of dying within the same hospital stay or shortly after discharge (but within 30 days) is what matters. This issue of defining surgical outcomes extends beyond mortality reporting. Events such as an anastomotic leak are important to measure, but numerous definitions exist for this term.[3] The lack of uniformity of outcome reporting means that it can be difficult to compare centres and to summarise data in systematic reviews and meta-analyses. One solution to this problem is to create 'core outcomes sets', which include end points to be reported as a minimum in all studies of a particular condition. The use of core outcome sets in clinical audit, prospective studies and randomised controlled trials would reduce some of these problems. The Core Outcome Measurement in Effectiveness Trials initiative facilitates development of such measures in all areas of health care, with the aim of improving data synthesis and reducing outcome reporting bias.[4] We are developing a core outcome set for colorectal cancer surgery—whether 30-day postoperative mortality or operative mortality (including all postoperative deaths) will be part of the core outcome set is yet to be decided.

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CORRECTION

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Benamouzig R, Uzzan B, Deyra J, *et al*. Prevention by daily soluble aspirin of colorectal adenoma recurrence: 4-year results of the APACC randomised trial. *Gut* 2012;**61**:255–61.

There are two numerical errors in the last sentence of the "Results" paragraph of the Abstract of this paper. This sentence should be read as follows: "Also, the proportion of patients with at least one advanced adenoma did not differ (10/**102** (10 %) in the aspirin group vs 7/83 (**8.4** %) in the placebo group; NS)."

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Notes