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Risk Factors for 30-Day Readmission after Surgical Treatment of Gastric Cancer: A Single-Center Experience

The aim of the work: to determine the frequency and risk factors for 30-day readmission after gastrectomy for gastric cancer at a single specialized oncologic center.

Materials and Methods. A retrospective single-center cohort study included 145 patients who underwent surgery in 2024. Clinical, demographic, nutritional parameters, comorbidities, type of surgery, and postoperative complications were analyzed. Univariate and multivariate logistic regression was applied to identify independent risk factors.

Results. The 30-day readmission rate was 9.7%. The leading causes included gastrointestinal complications, infections, and exacerbation of chronic conditions. Independent risk factors were: sarcopenia (OR=3.92; 95 % CI: 1.54–9.94), postoperative complications Clavien-Dindo ≥II (OR=2.61; 95 % CI: 1.18–5.78), operation time >4 hours (OR=2.45; 95 % CI: 1.01–5.94). The findings are consistent with literature data highlighting the multifactorial nature of readmissions. Nutritional status and frailty play a significant role.

Conclusions. Timely assessment of nutritional status, sarcopenia, and enhanced postoperative monitoring can reduce the risk of readmission.

Key words: nutritional status; sarcopenia; frailty; complications; readmissio; gastric cancer.

Problem Statement and Analysis of Recent Research and Publications. Thirty-day hospital readmission following surgery has become a key indicator of the quality of surgical care in modern clinical practice. In oncologic surgery, this metric is used not only to evaluate treatment outcomes but also to identify gaps in discharge planning, peri-discharge monitoring, and outpatient follow-up.

In countries with well-developed healthcare systems (e.g., the USA, UK, Canada), the 30-day readmission rate is integrated into hospital performance evaluations and may influence

institutional funding, as it is considered an indirect marker of either insufficient postoperative control or an incomplete treatment process.

According to the literature, even under modern conditions of ERAS protocols and minimally invasive techniques, the readmission rate after oncologic gastrectomy ranges from 4 to 15 %, depending on the type of surgery, comorbidities, and the structure of postoperative care.

Thus, 30-day readmission not only worsens survival outcomes but also complicates medical logistics, increases healthcare expenditures, and reduces patients' quality of life. In a single-specialty surgical oncology center, analyzing the frequency and structure of readmissions helps identify systemic weak points and tailor local postoperative care protocols and nutritional support to patient-specific needs. The most common causes of readmission include infectious complications, nutritional disorders, delayed gastric emptying, cardiovascular events, and wound-related issues [1, 3, 4].

Despite advances in gastric cancer surgery, including widespread adoption of laparoscopic techniques, ERAS protocols, and personalized oncologic approaches, the rate of 30-day readmission remains significant – on average, 9–10 % according to multicenter studies. Systematic reviews have confirmed that readmissions may result from both medical and organizational factors, including postoperative complications, nutritional deficiencies, sarcopenia, cardiovascular comorbidities, and social determinants at discharge.

In real-world practice, especially in dedicated gastric cancer surgical centers, early identification and risk stratification of patients prone to adverse postoperative outcomes are of critical importance.

This study aims to deepen understanding of postoperative trajectories in this patient cohort and provide a basis for targeted postoperative surveillance protocols for high-risk individuals.

Literature Review. Concept and Significance of Postoperative Readmission. Thirty-day readmission after oncological surgical interventions is increasingly viewed as an integrated indicator of the effectiveness of surgical treatment, the quality of postoperative care, and overall patient prognosis. According to Zhang et al. (2019), the 30-day readmission rate after radical gastrectomy for gastric cancer averages 8 % (95 % CI: 4–12 %) [1]. A large cohort study by Xiao et al. (2018; n=2023) reported that the most common causes of readmission were bowel obstruction, intra-abdominal abscesses, and nutritional disorders [2]. Readmissions are closely associated with increased mortality, reduced quality of life, and greater economic burden for both healthcare systems and patients [1, 3].

Common Causes of Readmission. The most frequent clinical causes of readmission include nutritional deficiency, surgical site infections, delayed gastric emptying, cardiovascular complications, and postoperative anastomotic stenosis or leakage [1,4,5]. For example, Cai et al. (2022) identified delayed gastric emptying as the most common cause of readmission, accounting for 18.6% of cases [4]. Thomson et al. (2015) also observed that the majority of complications occurred within the first 10 days after discharge [6].

Predictive Factors. 1. Nutritional Status and Sarcopenia. Poor nutritional status, defined as a Nutritional Risk Screening (NRS) 2002 score ≥3, is one of the most reliable predictors of readmission. According to Cai et al., this factor is associated with a more than threefold increase in risk (OR=3.43; p=0.034) [4]. In the same study, sarcopenia was found to be an even stronger independent risk factor (OR=4.25; p=0.033). A meta-analysis by Wang et al. (2022) confirmed that frailty and reduced physiological reserve are key contributors to poor survival and increased readmission risk [7]. These findings are corroborated by Zhuang et al. (2015), who also identified nutritional risk as an independent predictor [8].

2. Postoperative Complications. The presence of any postoperative complications – particularly of Clavien-Dindo grade III or higher – is a strong independent predictor of readmission (OR=2.66, p<0.001) [5]. This includes both early complications (e.g., infections) and delayed ones (e.g., abscesses, bleeding). Xiao et al. (2018) also reported postoperative complications as an independent risk factor (OR=5.1, p<0.001) [2]. Similar findings were reported by Ammori et al. (2018), who noted that complications, prolonged hospital stay (>10 days), and comorbidities were significantly associated with higher readmission risk [9].

3. Extent and Type of Surgery. Radical surgical procedures, such as total gastrectomy and combined organ resections, significantly increase the risk of unplanned hospital readmission. According to a meta-analysis by Wu et al., the odds ratio for total gastrectomy was 2.24, and for combined resections it was 1.53 [5]. These findings were reinforced by an updated meta-analysis by Li et al. (2024), which also highlighted pancreatectomy as an independent risk factor [10].

4. Comorbid Conditions. Cardiovascular disease (e.g., hypertension, ischemic heart disease), pulmonary disease, and diabetes mellitus significantly contribute to readmission risk. Wu et al. reported an OR of 1.18 for diabetes, while Li et al. confirmed the

predictive value of cardiovascular and pulmonary comorbidities [5, 10].

5. Frailty. In their 2022 meta-analysis, Wang et al. found that patients with clinical signs of frailty had a 3.6-fold increased risk of readmission within 12 months (HR=3.63; 95 % CI: 1.87–7.06) [7]. Frailty is a geriatric syndrome characterized by diminished physiological reserve and resilience to stress. It is now recognized as an independent predictor of adverse postoperative outcomes [7].

Biological Basis. Frailty reflects cumulative impairments in various physiological systems, including sarcopenia, neuroendocrine dysfunction, immune dysregulation, and metabolic vulnerability. As a result, even minor external stressors can lead to abrupt functional decline – such as postoperative complications, delirium, prolonged disability, or hospital readmission.

Assessment Tools. Common clinical tools used to evaluate frailty include:

- Clinical Frailty Scale (CFS) – a 9-point scale ranging from “very fit” to “terminally ill”;
- Frailty Index (FI) – a quantitative deficit-based measure (≥0.25 is considered critical);
- G8 questionnaire – specific to older oncology patients;
- Charlson Comorbidity Index and ECOG Performance Status, which are often used as surrogate markers.

In oncology, ECOG Performance Status remains the most widely used.

Frailty and Gastrectomy. Patients with gastric cancer often belong to the elderly population, where the prevalence of frailty ranges from 25 to 50 %, depending on assessment tools. In the meta-analysis by Wang et al. (2022), which included 2,792 patients after gastrectomy, frailty was associated with a nearly 4-fold increase in readmission risk within one year (HR=3.63; 95 % CI: 1.87–7.06) [7]. Frailty was also associated with:

- Reduced overall survival (HR ~2.0);
- Higher rates of postoperative complications;
- Prolonged hospitalization;
- Greater need for palliative care.

Clinical Relevance. Frailty should be viewed as a multidisciplinary issue, requiring integration of geriatric assessment, nutritional support, and preoperative optimization. Early detection of frailty allows for more accurate risk stratification and facilitates tailored surgical decision-making. In some cases, delayed surgery with prehabilitation may be appropriate.

6. Surgical Access and ERAS Protocols. The LOGICA trial (2021) comparing laparoscopic versus open gastrectomy reported equal readmission rates (9 %) in both groups, indicating that surgical approach alone may not be a major determinant [11]. Meanwhile, a meta-analysis by Wang et al. (2018) showed that while ERAS protocols can reduce hospital stay, they do not necessarily decrease complication rates and may even be associated with increased early readmissions, possibly due to premature discharge in high-risk patients [12] (fig).

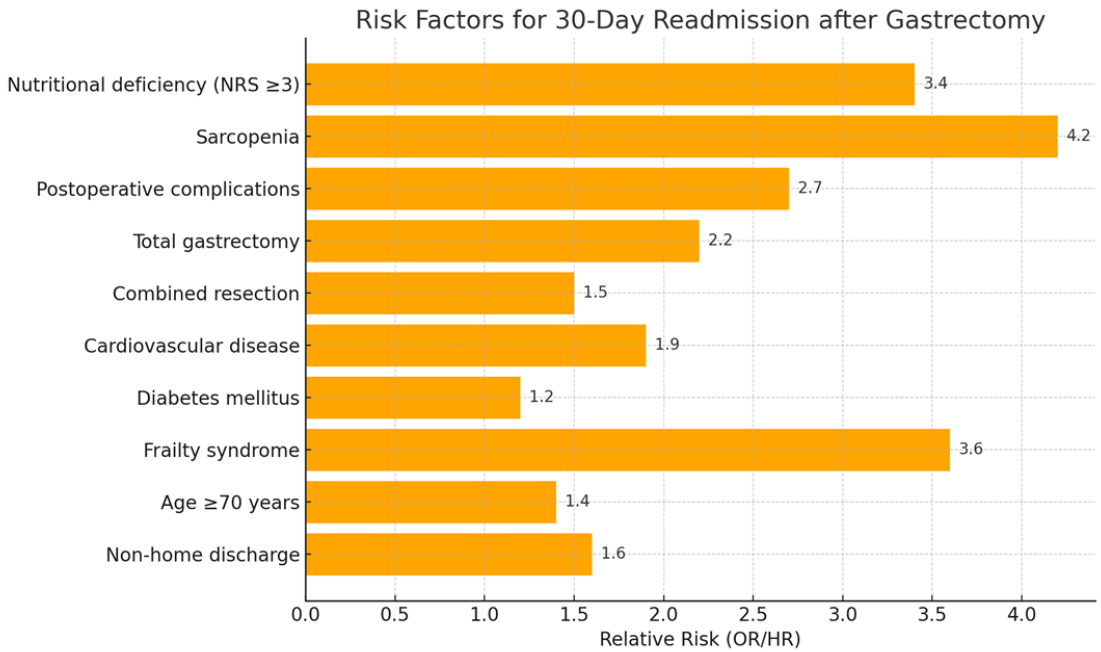

Fig. Relative risk (OR/HR) of identified predictors of 30-day readmission after gastrectomy based on published data and meta-analyses.

Conclusions from the Literature Review:

1. Thirty-day readmission after gastrectomy is a common and clinically significant complication with a multifactorial etiology.

2. The most important risk factors include:

- nutritional deficiency and sarcopenia;
- presence of postoperative complications;
- total gastrectomy and combined resections;
- cardiovascular and pulmonary comorbidities;
- physiological frailty in elderly patients.

3. Timely risk stratification based on these factors allows for individualized postoperative monitoring, optimized discharge planning, structured rehabilitation, and a reduction in the likelihood of readmission.

4. It is recommended to conduct preoperative nutritional counseling, screen for sarcopenia and frailty, and implement close monitoring of patients with comorbidities during the early postoperative period.

The aim of the work: to determine the frequency of 30-day readmission in patients who underwent surgical treatment for gastric cancer at a single-specialty surgical oncology center; to identify clinical, surgical, and nutritional risk factors associated with increased likelihood of readmission; to evaluate the influence of patient characteristics and surgical variables (age, sarcopenia, nutritional status, surgery duration, complications, gastrectomy type, surgical approach) on the risk of readmission.

Materials and Methods. Study Design. This was a retrospective, single-center cohort study conducted to evaluate the rate and predictors of 30-day hospital readmission after radical surgical treatment for gastric cancer.

Clinical Setting and Study Period. The study analyzed data from 145 patients who underwent radical gastrectomy (total or subtotal) for histologically confirmed gastric cancer in a single-specialty surgical oncology hospital during the calendar year 2024.

Inclusion and Exclusion Criteria

Inclusion criteria:

- Age ≥18 years;
- Histologically confirmed gastric cancer (stage I–III);
- Completion of R0 resection with curative intent;
- Patient discharged from the surgical department.

Exclusion criteria:

- Palliative or incomplete (R1/R2) resections;
- Presence of synchronous malignancies;
- Perioperative mortality before hospital discharge;
- Incomplete or missing clinical documentation;

Non-gastrectomy procedures or purely diagnostic surgeries.

Data Sources and Collection

Patient data were collected from institutional records including inpatient medical charts, operative reports, laboratory results, and outpatient visit notes. The following variables were recorded:

- Demographics: age, sex, body mass index (BMI);
- Functional status: ECOG Performance Status;
- Sarcopenia (assessed by CT at L3 level, using EWGSOP2 criteria);
- Nutritional risk: Nutritional Risk Screening (NRS 2002);
- Comorbidities: cardiovascular, respiratory, endocrine;
- Type of surgery (subtotal or total gastrectomy);
- Duration of surgery, intraoperative blood loss;
- Postoperative complications (Clavien-Dindo classification);
- Length of hospital stay, day of readmission;
- Reason for readmission.

Definition of a 30-Day Readmission. Thirty-day readmission was defined as any unplanned hospital admission to any facility within 30 days after discharge from the initial surgical hospitalization.

Ethical Considerations. This study complied with the principles of the Declaration of Helsinki. The study protocol was approved by the institutional ethics committee. All patient-identifying information was anonymized prior to analysis.

Statistical Analysis. Data were analyzed using IBM SPSS Statistics v.26.

- Descriptive statistics were presented as means ± standard deviation or median with range, as appropriate.
- Associations between individual variables and 30-day readmission were examined using univariate analysis (χ^2 test, Student's t-test, or Mann–Whitney U-test).
- Variables with $p < 0.1$ in univariate analysis were included in a multivariate logistic regression model to identify independent predictors of readmission.
- Results were reported as odds ratios (OR) with 95 % confidence intervals (CI). A p-value < 0.05 was considered statistically significant.

Results. A total of 145 patients who underwent surgery for gastric cancer in 2024 were included in the analysis. The mean age was 61.9 years (median 63; range: 31–86), with an almost equal sex distribution: 73 (50.3%) men and 72 (49.7 %) women. The mean BMI was 25.96 kg/m² (range: 17–44). The majority of

patients had a good functional status, with 98 (67.6 %) scoring ECOG 0. Cardiovascular comorbidities were the most prevalent, affecting 108 (74.5 %) of patients. A history of previous abdominal surgery was noted in 38 patients (26.2 %).

Rate of 30-Day Readmission. Within 30 days post-discharge, 14 patients (9.7 %) were readmitted. The median time to readmission was 10 days (range: 2–28 days). The main causes of readmission were:

- Gastrointestinal complications (including delayed gastric emptying): 4 cases (28.6 %);
- Infectious complications: 3 cases (21.4 %);
- Decompensation of chronic comorbidities: 3 cases (21.4 %);
- Postoperative hemorrhage or hematoma: 2 cases (14.3 %);
- Pain or recurrent nausea/vomiting: 2 cases (14.3 %).

*Univariate Analysis.*The following variables were significantly associated with 30-day readmission:

Sarcopenia (p=0.012);

Presence of postoperative complications (p=0.006);

Operation duration >4 hours (p=0.03);

Nutritional Risk Screening (NRS) score ≥3 (p=0.04).

Multivariate Analysis. Independent predictors of 30-day readmission based on multivariate logistic regression included sarcopenia, postoperative complications, surgery durations (table).

Clinical Observations. In several cases, readmission occurred due to delayed gastric emptying despite adherence to laparoscopic approaches and ERAS protocols. In one patient, hospital readmission was triggered by a postoperative catheter-associated infection, indicating a need for stricter infection control. Patients with sarcopenia experienced prolonged postoperative recovery and more frequent complaints of general fatigue and hypoalbuminemia.

Discussion. Comparison with previous research data. In our study, the 30-day readmission rate after surgical treatment of gastric cancer was 9.7 %, which is consistent with data from multicenter studies reporting a range between 8 and 15 % [1, 4, 5]. The most common causes of readmission were gastrointestinal and infectious complications, which aligns with findings from Zhang et al. (2019) [1] and Cai et al. (2022) [4].

The independent risk factors identified in our study — sarcopenia, postoperative complications of Clavien-Dindo grade II or higher, and operative duration over 4 hours are in agreement with previously published resuts. Wang et al. (2022) demonstrated that both frailty and sarcopenia are significantly associated with increased readmission risk [7]. Wu et al. (2019) and Li et al. (2024) emphasized the impact of surgical complexity and comorbidities on readmission [5, 10].

Readmission Factors Specific to Our Center. In several cases, complications contributing to readmission were not clinically apparent at discharge – for instance, subclinical infections or early signs of gastric stasis. This suggests potential limitations in current discharge algorithms and patient monitoring. Another challenge is the lack of structured outpatient follow-up protocols, particularly in the first post-discharge week.

Preventive Strategies. Preventive measures that could reduce readmission rates include:

- Implementation of preoperative screening for nutritional status and sarcopenia;
- Greater attention to prolonged operative time as a surrogate for surgical complexity;
- Multidisciplinary postoperative care involving nutritionists, geriatricians, and clinical pharmacists;
- Standardization of discharge procedures using evidence-based checklists to flag high-risk patients.

Development of prehabilitation programs may also improve resilience and surgical outcomes in selected patients undergoing radical gastrectomy.

Study Limitations. This study has several limitations. Its retrospective design limits the ability to establish causality. The single-center nature may reduce generalizability. Additionally, the one-year inclusion period restricts the sample size and precludes longitudinal modeling. Nevertheless, these data offer insight into modifiable and measurable predictors of early readmission.

Conclusions. The 30-day readmission rate after surgical treatment of gastric cancer in a single-

Table. Influence of independent predictors of 30-day readmission based on multivariate logistic regression

Independent predictor	Odds ratio (OR)	95 % confidence intervals (CI)	p-value
Sarcopenia	3.92	1.54–9.94	0.004
Postoperative complications ≥ Cl II	2.61	1.18–5.78	0.018
Surgery duration >4 hours	2.45	1.01–5.94	0.048

specialty center was 9.7 %.The most common reasons for readmission were gastrointestinal complications, infections, and decompensation of preexisting comorbidities. Independent risk factors included: presence of sarcopenia, postoperative complications classified as Clavien-Dindo grade ≥ II, and operation duration exceeding 4 hours. Timely risk stratification, a multidisciplinary care approach, nutritional support, and frailty screening may reduce the risk of readmission. The study results have practical implications for the development of local discharge protocols and postoperative monitoring pathways.

Future Research Directions. Multicenter studies with larger sample sizes are warranted, as well as the development of an integrated predictive model for readmission risk stratification based on nutritional, functional, and surgical variables.

Conflict of Interest. The authors declare no conflict of interest.

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REFERENCES

1. Zhang D, Deng Y, Yang Z, et al. Thirty-day Readmission After Radical Gastrectomy for Gastric Cancer: A Meta-analysis. *Journal of Surgical Research.* 2019; 243:180-188. DOI: 10.1016/j.jss.2019.04.076.

2. Xiao H, Liu W, Ma J, et al. Incidence and Risk Factors of 30-Day Unplanned Readmission After Radical Gastrectomy for Gastric Cancer: A Retrospective Cohort Study. *Scientific Reports.* 2018; 8(1):10582. DOI: 10.1038/s41598-018-28850-8.

3. Cai Y, Chen S, Chen X, et al. Association of Sarcopenia and Low Nutritional Status with Unplanned Hospital Readmission after Radical Gastrectomy in Patients with Gastric Cancer: A Case-Control Study. *Journal of Healthcare Engineering.* 2022; 2022:7246848. DOI: 10.1155/2022/7246848.

4. Wu W, Zhang W, Zhang Y, et al. Risk Factors of the Postoperative 30-day Readmission of Gastric Cancer Surgery After Discharge: A PRISMA-compliant Systematic Review and Meta-analysis. *Medicine.* 2019; 98(10):e14639. DOI: 10.1097/MD.0000000000014639.

5. Li Z, Liu Y, Wang L, et al. Updated Meta-Analysis for Risk Predictors of Readmission in Gastric Cancer. *Oncology Letters.* 2024; 28(4):14629. DOI: 10.3892/ol.2024.14629.

6. Zhuang C-L, Wang S-L, Huang D-D, et al. Risk Factors for Hospital Readmission after Radical Gastrectomy for Gastric Cancer: A Prospective Study. *PLoS ONE*. 2015; 10(4):e0125572. DOI: 10.1371/journal.pone.0125572.

7. Ammori JB, Cendan JC, Berman RS, et al. Predictors of 30-Day Readmissions After Gastrectomy for Malignancy. *Annals of Surgical Oncology.* 2018; 25(9):2537-44. DOI: 10.1245/s10434-018-6592-5.

8. Wang X, Sun Y, Wang P, et al. Impact of Frailty on Survival and Readmission in Patients with Gastric Cancer Undergoing Gastrectomy: A Meta-analysis. *Frontiers in Oncology.* 2022; 12:972287. DOI: 10.3389/fonc.2022.972287.

9. Wang L-H, Zhu R-F, Gao C, et al. Application of Enhanced Recovery after Gastric Cancer Surgery: An Updated Meta-analysis. *World Journal of Gastroenterology.* 2018; 24(14):1562-78. DOI: 10.3748/wjg.v24.i14.1562.

10. Thomson O, Jung MR, Park YK, et al. Analysis of 30-Day Postdischarge Morbidity and Readmission after Radical Gastrectomy for Gastric Carcinoma: A Single-Center Study of 2107 Patients. *Medicine.* 2015; 94(11):e259. DOI: 10.1097/MD.0000000000000259.

11. Van der Veen A, Brenkman HJF, Seesing MFJ, et al. Laparoscopic Versus Open Gastrectomy for Gastric Cancer (LOGICA): A Multicenter Randomized Clinical Trial. *Journal of Clinical Oncology.* 2021; 39(9):978-89. DOI: 10.1200/JCO.20.01540.

12. Asaoka R, et al. Postoperative C-reactive protein level as a predictive marker for surgical site infections after gastrectomy. *Gastric Cancer.* 2018; 21(4):720-28. DOI: 10.1007/s10120-017-0768-2.

13. Brauer DG, Wu N, Keller MR, et al. Care Fragmentation and Mortality in Readmission after Surgery for Hepatopancreatobiliary and Gastric Cancer. Journal of the American College of Surgeons. 2021; 232(6):921-32.e12. DOI: 10.1016/j.jamcollsurg.2021.03.017.

14. Jeong O, Jung MR, Ryu SY. Effectiveness of Enhanced Recovery after Surgery Program Compared to Conventional Care in Gastrectomy: Impact on Readmission and Nutritional Status. *Clinical Nutrition.* 2020; 39(12):3799-05. DOI: 10.1016/j.clnu.2020.02.009.

15. Zhuang C-L, Ye X-Z, Zhang X-Y, et al. Enhanced Recovery After Surgery Programs Versus Traditional Care in Gastrectomy: A Meta-Analysis of Randomized Controlled Trials. *Clinical Nutrition.* 2014; 33(2):307-14. DOI: 10.1016/j.clnu.2013.05.001.

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ФАКТОРИ РИЗИКУ 30-ДЕННОЇ РЕАДМІСІЇ ПІСЛЯ ХІРУРГІЧНОГО ЛІКУВАННЯ РАКУ ШЛУНКА: ДОСВІД ОДНОПРОФІЛЬНОГО ЦЕНТРУ

Мета роботи: визначити частоту та фактори ризику 30-денної реадмісії після гастректомії з приводу раку шлунка в умовах однопрофільного онкохірургічного центру.
Матеріали і методи. Проведено ретроспективне одноцентрове дослідження 145 пацієнтів, які перенесли хірургічне лікування у 2024 р. Аналізували клінічні, демографічні, нутритивні параметри, супутню патологію, тип операції, ускладнення. Проводили уні- та мультиваріантний аналізи для ідентифікації незалежних факторів ризику.
Результати. Частота 30-денної реадмісії становила 9,7 %. Основними причинами були шлунково-кишкові ускладнення, інфекції, декомпенсація хронічної патології. Незалежними факторами ризику виявлено: наявність саркопенії (OR=3,92; 95 % CI: 1,54–9,94), післяопераційні ускладнення Clavien-Dindo ≥II (ВШ=2,61; 95 % ДІ: 1,18–5,78), тривалість операції >4 год (ВШ=2,45; 95 % ДІ: 1,01–5,94). Отримані результати узгоджуються з літературними даними щодо мультифакторної природи реадмісій. Особливу роль відіграють нутрітивний статус та фізіологічна вразливість.
Висновки. Своєчасна оцінка нутрітивного статусу, саркопенії та оптимізація післяопераційного нагляду здатні знизити ризик реадмісії.

Ключові слова: нутрітивний статус; саркопенія; фізіологічна вразливість; ускладнення; реадмісія; рак шлунка.