Therapeutic oesophagogastroduodenoscopy by a ‘surgeon-endoscopist’: Viable or vulnerable?*

Sir,

Surgical oesophago-gastro-duodenoscopy (OGD) is losing ground with the perception that it is the realm of medical gastroenterology.[1] Anecdotal evidence suggests that a fair number of surgeons in India perform diagnostic OGD but are reluctant to pursue therapeutic OGD. Against this background, 265 consecutive therapeutic OGDs attempted by the author were reviewed over two periods - as a Trainee (T) in UK, Upper gastrointestinal surgical firms (150 procedures in 113 patients) and as a Consultant (C) in a 100-bed Indian hospital, but lacking full-time gastroenterology service (115 procedures in 88 patients). Outcome measures such as technical success, complications within 72 hours and in-hospital mortality were compared on an ‘intention-to-treat’ basis. Completed procedures included balloon dilatation of oesophageal strictures (n=101; T-61, C-40), percutaneous endoscopic gastrostomy (PEG) (n=61; T-37, C-24), insertion of oesophageal self expanding metal stent (SEMS) (n=12; T-3, C-9), endoscopic hemostasis with injection of adrenaline (peptic ulcer) or polidocanol (varices) or multiband variceal ligation (n=25; T-5, C-20), non-contact Nd-YAG laser ablation of proliferative oesophageal tumors (n=23; T-23, C-0) and miscellaneous procedures (n=33; T-17, C-16 - consisting of removal of PEG bumper and foreign body, food bolus disimpaction, nasojejunal tube placement, gastric polypectomy, argon plasma coagulation for tumor-bleeding and injection of botulinum toxin for achalasia). There were five failures in the each period - three balloon dilatations, one PEG and one fibrin injection of gastric fistula (Trainee) and two dilatations, one PEG, one SEMS and one endoscopic foreign body removal (consultant).

Procedural success was 96.6% (145/150) and 95.6% (110/115) of which establishing oral/enteral feeding was attempted in 87.3% (131/150) and 71.3% (82/115) of the procedures in the Trainee and Consultant period, respectively. Major early complication rate was 2.0% as Trainee (3/150; oesophageal perforation - 2, respiratory depression - 1) and 1.7% (2/115; oesophageal perforations) as Consultant. No patient died within 72 hours but there was one in-hospital death in each period, neither of which was directly related to therapy. Therapeutic procedures accounted for 40 and 12% of all OGDs in the trainee and consultant period, respectively, reflecting differing caseload but nevertheless contributing significantly to the surgical workload.

This audit demonstrates that with appropriate training surgeon-performed therapeutic OGD is safe and effective and compared well with large procedure-specific series from non-surgical units.[2,3] The underutilization of therapeutic OGD by surgeons may be due to insufficient training time and endoscopy units, lack of inter-disciplinary co-ordination and concerns regarding sedation.[4] There are several advantages of a surgeon-led therapeutic OGD, particularly for surgical oncologists, gastrointestinal, and head and neck surgeons. It ensures continuity of care, better utilization of time, enables intra-operative use and is useful where multi-disciplinary input is not available. Eleven PEGs were inserted intra-operatively in major head and neck cancer surgery and complex life-threatening neck injuries where enteral feeding beyond four weeks was anticipated. This obviated the need for a nasogastric tube with its attendant problems.
and a medical gastroenterologist-performed PEG either at the time of operation or as a separate pre-operative procedure—a logistical difficulty even in tertiary centers. Therapeutic OGD is an useful tool in our armamentarium and should be at the core of surgical training.[3]

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