Mortality of percutaneous endoscopic gastrostomy in the UK

Sir,

We read with great interest the original article by Janes et al[1] and the accompanying Expert’s Comments by Lang[2] published in the March 2005 issue of J Postgrad Med. Janes et al found that 30-day mortality of percutaneous endoscopic gastrostomy (PEG) was 22% in a hospital in the UK during 2002 as opposed to a mortality of 10% 10 years earlier. This increase in mortality was attributed to a trend for less strict patient selection over the last few years.

We wish to support the findings of the above study by providing the results of a prospective audit we conducted in another hospital in the UK over the same period. All patients that received PEG in our hospital over a period of 38 months (May 1999 to June 2002) were followed up until reversion to oral feeding or until death. Seventy-three patients received PEG (mean age 71.7 years). The indications for PEG insertion were: cerebrovascular accident (CVA) 56.1%; non-CVA dementia 30.1%; other organic neurological diseases 11%; malignancy-associated anorexia 1.4%; neck cancer 1.4%.

Overall mortality over the follow-up period was 64.4%. In specific, early mortality (within 4 weeks) was 23.3%, mid-term mortality (4-8 weeks) 11% and late mortality (>8 weeks) 50.1%. Causes of death were: chest infection 83%; myocardial infarction 4%; congestive cardiac failure 6.4%; pulmonary embolism 2.1%; progression of pre-existing malignancy 2.1%. Mortality was 82% for patients with non-CVA dementia and 54% for patients with CVA, \(P=0.05\). No differences were found in survival and in complication rate between patients discharged home (11 patients) and those referred to nursing homes or long-term hospital care (26 patients).

In conclusion, 30-day mortality following PEG insertion is high in British hospitals. Our findings are remarkably similar to the findings of Janes et al.[1] Local and national guidelines on indications for PEG insertion need to be developed. Based on these guidelines a local multidisciplinary team should assess individually each request for PEG insertion.

Leontiadis GI, Moschos J, Cowper T, Kadis S
Department of Gastroenterology, Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE6 9SX, UK

Correspondence:
Dr. Sawas Kadis, E-mail: skadis@doctors.org.uk

References

PubMed ID : 16006716

Insulin prescription errors

Sir,

The articles on drug prescription practices in India and the accompanying editorial in the Journal of Postgraduate Medicine were timely.[3,4] We would like to highlight the medication errors that occur due to faulty practices encountered while prescribing insulin.

In India, there are at least 7 different companies supplying insulin in various forms. Availability of multiple species (bovine, porcine and human), different formulations (regular, NPH, lente, 30/70 and 50/50 combinations) and a variety of insulin analogs and their combinations add to the complexities in prescribing insulin. Errors involved in timing of insulin doses and illegible handwriting (confusing IU or U for 0 etc.) add to the prevalent confusion. For the sake of convenience, several doctors relate to regular insulin as “clear insulin”. But in the current scenario, “clear” insulin could mean regular insulin, Lispro, Aspart or Glargine. Further, patients on Lispro (or Aspart) with Glargine combinations will be using two types of clear insulins. Mistaken identity resulting in hypoglycaemia has been reported.[5]

In addition, some physicians prescribe “Insulin L” which could mean either Lente (an intermediate acting insulin) or Lantus (Glargine, a long acting analogue).[6] Another source of confusion is the use of combination-premixed insulin. Patients who remember their insulin as 30/70 may be using either a premixed combination of human insulin (e.g. Humulinsulin 30/70) or a premixed analog (e.g. Novomix 30/70). Not mentioning the species of insulin is another error that physicians often make.

Considering the various issues involved, it would be advisable for the physicians to write the prescription in full form mentioning the trade name, generic name as well as the species and also expect the manufacturers to agree upon a common formula to designate insulin and analogs depending upon the species, type of insulin and combinations involved. It is heartening to note that steps are being taken in this direction by adding a suffix like R or N to indicate the type of insulin.

Mathew J, Senthil VK
Department of Endocrinology, Diabetes and Metabolism, Christian Medical College, Vellore, Tamil Nadu - 632004, India

Correspondence:
Dr. John Mathew, E-mail: drmathewjohn@yahoo.com

References
Conversion from laparoscopic to open cholecystectomy

Sir,

I read the article by Tayeb et al[1] with interest. Even though the authors have identified the majority of risk factors for conversion to open cholecystectomy, I don’t know why the sex of the patient was not considered. Male gender has been a significant risk factor for a high conversion rate in majority of the studies.[2,3] Another factor is the time of surgery from the onset of symptoms. Patients undergoing intervention within 48 hours of the onset of symptoms experience a lower conversion rate to an open procedure.[4] A study from Belgium highlighted that preoperative C reactive protein seric level less than 10 mg% represent the best candidates for laparoscopic surgery.[5] In another study, the American Society of Anaesthesiologist (ASA) class of more than 2 also predicted conversions in patients undergoing non-elective cholecystectomies.[6] Finally, no matter how much preoperative risk grading or a diagnostic score is done to predict difficult laparoscopic cholecystectomy, the experience of the surgeon is the foremost factor. There should always be a low threshold of conversion whenever he faces any difficulty irrespective of the preoperative predictability.

Bhattacharya K
Department of Surgery, Subham Hospital and Diagnostic Centre, Cooch Behar - 736101, West Bengal, India

Correspondence:
Kaushik Bhattacharya, E-mail: kaushik_srmc@rediffmail.com

References

Authors' Reply

Sir,

We appreciate the comments by Dr. Bhattacharya on our paper to identify the risk factors for conversion to open cholecystectomy (OC). Male gender though pointed out as a major risk factor for conversion; was not identified in our study[1] as a potential risk factor [Table 2]. Hence, we did not include it in the final multivariate model. The goal of our analysis using logistic regression was to present the best fitting yet the most parsimonious model describing the independent relationship of factors with conversion to OC. The criteria for selection of possible factors was based on a p value of less than 0.25 on univariate analysis,[2] and therefore ‘gender’ was not a good variable to be selected (P value = 0.39) for the final model. Use of p value of 0.25 as a screening criterion for selection of candidate factor is based on work by Mickey and Greenland on logistic regression. These authors have shown that the use of a more traditional P value of 0.05 on univariate analysis often fails to identify the factors that are known to be important.[3,4]

Dr. Bhattacharya has in fact extended and clarified other potential risk factors for OC very well. We believe that well-designed trials are needed that will present these risk factors in a more lucid way.

Tayeb M, Raza SA, Khan MR, Azami R
Department of Surgery, Faculty of Health Sciences, The Aga Khan University, Stadium Road, P.O. Box 3500, Karachi, Pakistan

Correspondence:
Syed Ahsan Raza, E-mail: ahsan.raza@aku.edu

References

Spontaneous macular haemorrhage in a patient on aspirin

Sir,

Aspirin is the most commonly used anti-platelet medication in conditions of myocardial and cerebral ischemia.[1] It is known, however, to have a dose-dependent effect on gastrointestinal haemorrhage[2] and can rarely cause fatal cerebral haemorrhages.[3]

We report a 68-year-old male who presented with a two-day history of loss of central vision in his left eye. His visual acuity was 6/5 and 6/36 in the right and left eye, respectively. Anterior segment examination was unremarkable. Fundus examination showed an area of sub-foveal haemorrhage of approxi-