Seriously ill elderly patients are subjected to futile endoscopies

Susan Mayor *London*

National guidance and ongoing training of staff are needed to improve the selection and care of patients who undergo therapeutic gastrointestinal endoscopy, says a critical appraisal of UK practice that was published last week.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD), an independent body that audits anonymised data on deaths of patients, examined 1818 deaths of inpatients that occurred within 30 days of therapeutic endoscopy.

The authors of the report of the audit found that in about 3% of the 136 000 endoscopies performed in 2002-3 the patient died within 30 days of the procedure. However, the report considered that the procedure had

been performed inappropriately in 14% of these deaths. Of these 14%, more than half the procedures were considered "futile," where the NCEPOD assessors found it impossible to see any potential benefit of performing endoscopy. The report points out that many of these therapeutic endoscopies are performed in seriously ill elderly patients.

The audit, which looked at data on patients who had undergone gastrointestinal therapeutic endoscopies in the 30 days before their death from 252 NHS hospitals and 11 non-NHS hospitals, indicated deficits in ongoing training. Consultants performed three quarters of procedures in the study. However, some performed only a few procedures—often fewer than 20—each year.

Recommendations from the National Confidential Enquiry into Patient Outcome and Death on therapeutic gastrointestinal endoscopy

- Patients must be assessed by the referring clinician and the endoscopist to ensure that the procedure is in the patient's interest
- The decision to perform percutaneous endoscopic gastrostomy requires an in-depth assessment of the potential benefits to the patient. Patients should be reviewed by a multidisciplinary team
- Patients should be reviewed by the consultant endoscopist before therapeutic endoscopic retrograde cholangiopancreatography to ensure that the procedure is appropriate and the patient's condition has been optimised
- The risks and benefits of therapeutic endoscopy should be explained to the patient, and this should be documented on the consent forms
- The ability of those with dementia or acute confusion to provide consent should be tested and clearly documented
- National guidelines are necessary for assuring continuing competency in endoscopy
- All endoscopy units should perform regular audit and review all deaths during, or within 30 days of, therapeutic endoscopy
- All those responsible for administering sedation should have received formal training and assessment
- National guidelines are needed on the frequency and method of the recording of vital signs during endoscopy
- Hospitals should ensure that appropriate monitoring and resuscitation equipment is available in each of their endoscopy rooms and recovery areas
- Hospitals should consider establishing formal on-call arrangements

The NCEPOD advisers considered that this may be insufficient for operators to remain proficient. In 49 cases they judged that the endoscopist was inexperienced.

Dr Anthony Gray, the lead clinical coordinator for NCEPOD and a consultant anaesthetist at Norfolk and Norwich University Hospital, Norwich, said: "There are detailed guidelines on the numbers of procedures required to establish initial competence but nothing on how many endoscopies doctors need to perform each year to maintain competence."

The report also recommended more careful selection of patients to undergo the procedure. Percutaneous endoscopic gastrostomy (PEG)—a procedure to help feeding—was performed on 719 patients who died and was considered futile in 19% of the cases, mainly because patients were considered to be at high risk of death.

Endoscopic retrograde cholangiopancreatography (ERCP) was considered futile in 68% of cases where it had been performed.

Dr Gray commented: "We

were surprised by the number of patients who died quite a short time after undergoing GI [gastrointestinal] therapeutic endoscopy. In some of the cases—particularly in patients having PEG or ERCP—it was difficult to see the benefit, with many having advanced malignancy."

The report also expressed concerns about sedation. Nearly half (41%) of patients who received sedation or a local anaesthetic developed respiratory complications after their endoscopy, and it was thought that combined sedation may have contributed to aspiration pneumonia in some cases.

The quality of informed consent was considered poor in some cases. The audit found that two thirds of patients who had dementia or acute confusion seemed to have provided written consent and advised that the ability of such patients to provide consent should be tested and clearly documented. □

Scoping our Practice is available at www.ncepod.org.uk or as a CD from NCEPOD, Epworth House, 25 City Road, London EC1Y 1AA.