



Patients' experience of temporary tracheostomy after microvascular reconstruction for cancer of the head and neck[☆]

S.N. Rogers^{a,b,*}, L. Russell^b, D. Lowe^{a,b}

^a Evidence-Based Practice Research Centre (EPRC), Faculty of Health and Social Care, Edge Hill University, St Helens Road, Ormskirk, L39 4QP

^b Regional Maxillofacial Unit, University Hospital Aintree, Liverpool, L9 1AE, UK

Accepted 9 August 2016

Abstract

A temporary tracheostomy is commonly done in patients who have reconstruction after the ablation of advanced oral cancer to provide easy access to a secure airway in case a haematoma forms or the patient needs a return to theatre. Although relatively simple to do, we know little about the patients' experience, and to find out, we designed a three-stage study. First, we conducted semi-structured interviews to identify items related to the functional, emotional, and social impacts of the tracheostomy, on the ward and on removal ($n = 15$ patients). Secondly, we used these items to develop a short, one-page questionnaire in collaboration with the Patient and Carer Support Group and Research Forum, and thirdly, we did a cross-sectional postal survey of 125 patients who had had a temporary tracheostomy as part of free tissue reconstruction between January 2013 and July 2015. Of them, 86 responded (69% response rate). Generally patients reported a negative experience. In the cross-sectional survey most responders ($n = 52$, 60%) stated that they would "very much" avoid a tracheostomy if at all possible. The main problems concerned fear and communication, and between one-third and one-half stated that they had had "very much" or "quite a bit" of a problem in regard to choking, discomfort, attracting attention, sleeping, and general management (other than the suctioning). This feedback should form part of the information that is given to patients; it should also enable us to reflect on optimal perioperative care, and help to inform the debate about the selection criteria.

© 2016 The British Association of Oral and Maxillofacial Surgeons. Published by Elsevier Ltd. All rights reserved.

Keywords: Tracheostomy; Head and neck cancer; Reconstruction; Patient experience

Introduction

In the UK, the early postoperative management of free flaps in the head and neck varies. In a national postal survey sent to maxillofacial surgical units in the UK, 69% of units (39/57) electively did a tracheostomy "usually" or "almost always" after free-flap reconstruction in the head and neck.¹ After operation, the relatively low rate of complications with tracheostomy^{2,3} is balanced against the risk of potentially life-threatening acute compromise of the airway and the difficulties of emergency intubation.⁴ The morbidity associated with a temporary tracheostomy is well recognised and

[☆] This clinical outcomes study was part funded by the Head and Neck Cancer (HaNC) Patient and Carer Research Forum based at Aintree University Hospital. The paper has not been submitted to another journal or presented at any meeting. The study approved by the Clinical Audit Department at Aintree University Hospital. There is no conflict of interest.

* Corresponding author.

E-mail addresses: snrogers.aintree@gmail.com (S.N. Rogers), lukesrussell@googlemail.com (L. Russell), astraglobeltd@btconnect.com (D. Lowe).

<http://dx.doi.org/10.1016/j.bjoms.2016.08.006>

0266-4356/© 2016 The British Association of Oral and Maxillofacial Surgeons. Published by Elsevier Ltd. All rights reserved.

includes chest infection, haemorrhage, displacement of the tube, removal and a longer stay in hospital, and tracheal stenosis. Some units avoid temporary tracheostomy^{5,6} and, depending on the patient, extubate immediately postoperatively or intubate overnight.⁷ There is debate as to whether these patients are best managed on a high dependency ward or intensive care unit.⁸

We routinely do temporary tracheostomies in most patients who have free tissue reconstruction after resection of oral and oropharyngeal cancer, and the Björk flap technique is standard practice, as it can be safely used in adults.⁹

Although considered a comparatively simple procedure, the Patient and Carer Support Group at Aintree University Hospital expressed concerns that some patients find the experience very distressing, and pointed out that members of the clinical team sometimes do not fully appreciate this. Astrachan et al¹⁰ reported the views of 60 nurses in critical care who thought that tracheostomy had considerably more practical and psychological benefits than prolonged endotracheal intubation, but to our knowledge, there is a lack of patient-reported outcomes. As we were unable to find any report concerning what adult patients think about a temporary tracheostomy, we aimed to identify the concerns of our patients to gain a better understanding of how they feel, and to improve the quality of care and their experience.

Patients, material, and methods

The study comprised three stages: the generation of content, design of a questionnaire, and a survey of patients.

Stage one involved a structured interview of patients who had had a temporary tracheostomy at the maxillofacial unit at Aintree Hospital. They were asked to describe their early experiences (first 24 hours) of the tracheostomy on the ward and on removal in terms of its functional, emotional, and social impacts. A total of 22 patients were approached and 15 were interviewed by a trials nurse between mid-August and mid-December 2014.

For the second stage we designed a short, one-page questionnaire based on the feedback from stage one, which used a Likert-type four-response option scale (not at all, a little, quite a bit, very much) for each question. We refined our initial draft (which we had done in conjunction with the trials nurse and head and neck clinical nurse specialists) through discussion with the Patient and Carer Support Group, mainly to structure the wording to make it suitable for a postal survey. We then did a small pilot on six inpatients. No changes were required.

The third stage, a postal survey, was sent out in July 2015. We identified patients who had had free flap reconstruction in the maxillofacial unit between January 2013 and July 2015 from the hospital's theatre database, and used the patient records system to collect clinical details. We then sent a questionnaire to those who were alive, and sent a reminder after

four weeks. Inpatients at the time the survey was conducted were also included.

Most of the data are descriptive. Fisher's exact test was used to compare differences between clinical factors (sex, age at tracheostomy, type of flap, time from tracheostomy to survey, and number of days tracheostomy in place).

The study was approved by the Clinical Audit Department at Aintree University Hospital.

Results

The 15 stage-one interviews generated a wealth of qualitative data, and the summary extracts in Table 1 show the breadth of content and depth of feeling conveyed. The key general observation was fear; specifically, a fear of choking. Nursing care was generally regarded as good but the explanation about the tracheostomy before the procedure was not good enough. The tracheostomy made patients feel disempowered and isolated, and they had problems with communication. We used this information to develop the one-page questionnaire.

A total of 181 patients had had reconstruction with a free flap in the maxillofacial unit between January 2013 and July 2015. Of them, 37 were thought to have died by July 2015, five were receiving palliative care, or had recurrence of their primary tumour, or were having other active treatment; six had taken part in the pilot study, and eight were lost to follow-up. The survey population therefore comprised 125 patients and the survey response was 69% (86/125). This did not vary noticeably by sex (men: 51/73, 70%; women: 35/52, 67%), type of flap (soft: 54/80, 68%; composite: 32/45, 71%) or time between tracheostomy and survey (less than 12 months: 38/57, 67%; 12–23 months: 34/45, 76%; 24 months and over: 14/23, 61%), but was lower for younger patients (under 55 years: 22/40, 55%; 55–64 years: 25/37, 68%; 65 years and over: 39/48, 81%, $p=0.03$). Of the 86 responders, 51 (59%) were men and 35 (41%) women, median (IQR) age 62 (55–71) years. A total of 54 (63%) had had a soft free flap (40 radial, 11 anterolateral thigh, 2 latissimus dorsi, 1 rectus abdominus) and 32 (37%) a composite free flap (12 fibular, 11 deep circumflex iliac artery (DCIA), 6 scapular, 3 composite radial). The median (IQR) time from tracheostomy to survey response was 14 (7–22) months.

Table 2 summarises the overall response to the questionnaire. Most (60%) responders stated that they would “very much” avoid a tracheostomy if at all possible; 59% stated that speech was “very much” a problem, and 44% that communication was very difficult with their tracheostomy in place. Between one-third and one-half chose “very much” or “quite a bit” in regard to choking, discomfort, attracting attention, sleeping, and general management (other than the suctioning). Likewise, between one-third and one-half chose “not at all” or “a little” for feeling safe, having sufficient information about the tracheostomy before the operation, and being given enough help to manage it afterwards. One in seven (14%) were “quite” or “very” reluctant to have it removed.

Download English Version:

<https://daneshyari.com/en/article/5638352>

Download Persian Version:

<https://daneshyari.com/article/5638352>

[Daneshyari.com](https://daneshyari.com)