

Gastrostomy tube placement: An opportunity for establishing patient-centered goals of care

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Background. Surgeons and other health care providers are frequently consulted for gastrostomy tube placement in seriously ill patients at risk of outcomes poorly aligned with patient goals. Palliative care assessments have been recommended to guide decision-making in this setting. We aimed to characterize patient-centered outcomes and define the extent of unmet palliative care need in patients receiving gastrostomy tubes.

Methods. This is a retrospective study of all adult, nontrauma inpatients who underwent gastrostomy tube placement over 16 months at an urban academic medical center. Outcomes included in-hospital and 1-year mortality, functional status at discharge, and receipt of palliative care assessment preprocedure.

Results. Gastrostomy tubes were placed in 205 patients. In-hospital and 1-year mortality rates were 8% and 19%, respectively. Of patients surviving to discharge, 69% were unable to live independently. Among patients with acute brain injury or respiratory failure, 90% died in the hospital or were severely disabled at discharge. Only 12% of patients received a documented palliative care assessment preprocedure.

Conclusion. Given high risks of mortality and poor functional outcomes, consideration of gastrostomy tube placement is an appropriate but underutilized trigger for palliative care assessment. This study highlights an untapped opportunity to optimize the goal concordance of treatment in operative intervention. (Surgery 2016;■:■-■.)

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SURGEONS AND OTHER HEALTH CARE PROVIDERS are frequently consulted for gastrostomy tube placement, with over 200,000 percutaneous endoscopic gastrostomy tubes placed annually in the United States.¹ Most gastrostomy tubes are placed to provide enteral access for artificial nutrition, with a minority being placed for palliative decompression in the setting of obstruction.² Patients receiving gastrostomy tubes are seriously ill and often have

multiple underlying comorbidities that are typically advanced.³ Additionally, many patients lack decisional capacity with respect to receiving feeding access and rely on surrogate decision-makers to make treatment choices. Ideally, these decisions should help advance patients toward their ultimate care goals in a manner consistent with their preferences and values.

Unfortunately, many patients receive life-sustaining treatment that directly contradicts their wishes or is rated as low value by themselves and their family members.^{4,5} As an important and common component of life-sustaining treatment, gastrostomy tube placement represents a critical decision node in the care of seriously ill patients.

All too often, the decision to place a gastrostomy tube is presented as a routine treatment imperative, required to “move the patient along” toward discharge from the acute hospital setting. In this context, patients and surrogates approached to provide consent for gastrostomy tube placement may be presented with information about the procedural complications reported to occur in 8% to 30% of cases.^{6,7} Decisions about

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gastrostomy tube placement in this setting, however, are often ethically, culturally, and socially complex. Information about technical outcomes overshadows the importance and impact of feeding tube placement and may be insufficient to guide decision-making toward true patient-centered goals.

Knowledge about the expected trajectories of patients receiving gastrostomy tubes can help patients, surrogates, and physicians considering this intervention make informed and goal-concordant decisions. For example, mortality rates in these patients have been documented as high as 11% in-hospital and over 50% at 1 year,^{3,8} and hospital readmission rates are as high as 23%.⁹

Seriously ill patients, however, have been shown to value quality of life as much as, if not more than, quantity of life, and two-thirds of seriously ill adults stated they would refuse life-sustaining treatment leading to severe functional or cognitive limitations.¹⁰ Thus, knowledge of the expected long-term and functional outcomes after gastrostomy tube placement would provide useful and more patient-centered guidance for seriously ill patients, their surrogates, and their physicians considering this intervention as a component of life-sustaining treatment.

Consideration of gastrostomy or feeding tube placement has been identified as an appropriate trigger for discussing the treatment goals and preferences of seriously ill patients and for identifying patients who might benefit from palliative care.^{11,12} Palliative care is an interdisciplinary specialty focused on maximizing the quality of life of seriously ill patients through advanced practices in symptom management, communication, shared decision-making, and psychosocial support of the entire patient-family unit. Palliative care interventions have been shown to improve quality of life and other patient-centered parameters in seriously ill patients.¹³⁻¹⁵

Key components of palliative care assessment include determination of patient/family understanding of illness and treatment options and identification of patient-centered goals to promote goal-concordant trajectories of care, combined with modalities to identify pain, discomfort, and social/spiritual distress.¹¹ Such assessments, which may be performed by generalist providers independently or in consultation with specialists in palliative care, help identify patients in need of higher-level palliative care intervention so that these scarce specialty services for easing patient and family burdens can be delivered with maximal yield.

The aims of this study were to (1) examine the functional outcomes and short-term and 1-year mortality in patients receiving feeding gastrostomy tubes and (2) identify the extent of unmet palliative care need in this vulnerable group. We hypothesized that the prevalence of poor patient-centered outcomes in this population would be high and palliative care use would be low, justifying the gastrostomy consult as an appropriate, but underutilized, trigger for palliative care assessment.

METHODS

This was a retrospective, observational study of all adult, nontrauma patients who underwent a gastrostomy tube placement over a 16-month period, from January 2013 through April 2014, at an urban, tertiary care academic center. Patients were included if they were 18 years old or older and received a gastrostomy tube by any service (surgery, gastroenterology, and radiology) or technique (operative, endoscopic, and fluoroscopic). Subjects were identified using both hospital-based and provider-based procedure billing codes. Charts were queried for demographics, indications for gastrostomy tube, procedure performed, and palliative care interventions and processes.

The primary outcomes of this study were functional status at discharge and in-hospital and 1-year mortality. Functional status was determined using the Glasgow Outcome Scale (GOS) or the Modified Rankin Scale (MRS, for cerebrovascular accident patients only). Scores were obtained from the last physical or occupational therapy note prior to discharge. Using GOS and MRS scores, patients were grouped into 4 categories: dead (GOS = 1, MRS = 6), severe disability (GOS = 2 or 3, MRS = 4 or 5), moderate disability (GOS = 4 and MRS = 3), and mild disability to full recovery (GOS = 1 or 2, MRS = 0, 1 or 2).

To overcome challenges due to sparse data cells, functional status at discharge was also analyzed as a 2-level categorical variable where necessary (in-hospital death/severe disability and moderate/mild disability). For patients who survived to discharge, discharge location was collected. One-year mortality was determined by querying the Social Security Death Index (SSDI) 18 months after the final patient was discharged from the hospital. We assessed the validity of the SSDI by using the patients who were known to have died in the hospital as a reference group. The secondary outcome was the proportion of patients who had a documented goals-of-care discussion prior to

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