LETTER TO EDITOR

Is There a Lack of Awareness of Percutaneous Endoscopic Gastrostomy (PEG) Amongst Local Non-Gastrointestinal Specialists? - Experience with PEG in a Malaysian Hospital

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Sir,

Indications for all types of gastrostomy are similar: temporary or permanent loss of ability to eat, for example because of a debilitating neurological illness or injury, and oropharyngo-oesophageal malignancy or trauma[1]. It is also sometimes used for gastric decompression[2]. Patients who require a gastrostomy may be under the care of neurologists and neurosurgeons, head and neck surgeons, faciomaxillary and dental surgeons, otorhinolaryngologists, plastic surgeons and traumatologists, not to mention general surgeons and gastroenterologists. Hence the clinical end users of gastrostomy are often non-gastrointestinal (GI) specialists. A nasogastric (NG) tube serves as viable alternative.

A gastrostomy is traditionally fashioned surgically[3]. Since Ponsky first described percutaneous endoscopic gastrostomy (PEG) in 1979,[4,5] it has been generally well received by the medical fraternity as it is less invasive and does not need general anaesthesia. This wide acceptance has been facilitated by the proliferation of specialized units, such as stroke units, burns units, head and neck units, neurology institutes and trauma centres, especially in developed countries. Data on the use of PEG in Malaysia is lacking.

We analysed our series of 14 gastrostomy patients over the last 56 months and explain the reason for the absence of referrals for PEG between 1 January 1999 and 31 July 2000. Institution of remedial measures to increase awareness within the hospital was followed by 2 cases of PEG in 2 months. All 14 patients referred for PEG were analysed for their age, sex, diagnoses, indications, types of gastrostomy eventually fashioned, the date it was done, and conversion to button.

Fourteen patients (mean age=54.3 years, range =17 to 86) were referred for PEG over the whole study period from 1 September 1996 to 1 May 2001: 12 in the first 28 months (1 September 1996 to 1 Jan 1999) and none in the second 19 months (1 January 1999 to 31 July 2000). A poster presentation entitled "indications and lessons learnt from a 4-year series of 2 operative and 10 percutaneous endoscopic gastrostomy in a private hospital" was prepared for the International Conference GUT 2000. The posters were displayed on the hospital notice board for the whole month of July 2000 prior to the conference from 24 to 26 August 2000. As a result of increased awareness within the hospital, 2 patients had PEG fashioned in 2 months, both neurological patients. But for the last 7 months, from 1 October 2000 to 1 May 2001, there have been no more cases.

Overall, reasons for referral were dysphagia due to nasopharyngeal carcinoma (NPC) (4), oesophageal carcinoma (1), neurological disorders (3 strokes) or injury (3), gastric atony following surgery for chronic benign pyloric stenosis (2 percutaneous endoscopic gastro-jejunostomy - PEGJ) and short bowel syndrome (1). In 2 NPC patients, the pharynx was deemed impassable with the endoscope and both patients eventually had operative gastrostomy. Ten of the 14 referrals were males. Five of the 12 PEG patients subsequently converted to button. One is on his third button now. Except for 3 who had PEG for benign GI indications, gastrostomy was permanent in the remaining 11.

The absence of referral for PEG during the later periods of the study may be due to lack of awareness within the hospital and the prohibitive cost of PEG. Although an NG tube serves as a viable alternative, it has to be replaced every 2 weeks. As such the cost for NG tube insertion is a recurring cost. Furthermore a prolonged period with an NG tube in situ may result in ulceration of the patient's nostrils and lead to pressure ulcers in the oesophagus and stomach.

In the latest edition of the schedule of fees recommended by the Malaysian Medical Association, subject to interpretation, the surgeon may charge RM795 for insertion of an upper GI prosthesis, or RM1400 specifically for PEG. As PEG is usually a 2-operator procedure,[4,5] the above fee ought to be shared by the 2 operators. Using the former recommendation and adding the cost of the prosthesis (RM500), the cost of PEG is about the same as 18 months of NG tubes, assuming the cost per NG tube insertion is RM33 inclusive of the tube.

In order to promote greater awareness of PEG locally, not only do we need to know the medical, logistic and cosmetic advantages of PEG, but we must also be mindful of the cost of PEG and its alternative. Remedial actions to increase awareness can be taken and is effective but its effect tends to wane with time.

References

1. Rogers DA, Bowden Jr TA. Gastrostomy: Operative or Nonoperative? Surg Clin North Am 1992; 72: 515-24.
2. Herman LJ, Hoskins WJ, Shike M. Percutaneous endoscopic gastrostomy for decompression of the stomach and small bowel. Gastrointest Endosc 1992; 38: 314-8.
3. Achna F. Gastrostomy: Its inception and evolution. Am J Surg 1946; 72: 610-33.
4. Gauderer MW, Ponsky JL. A simplified technique for constructing a tube feeding gastrostomy. Surg Gynecol Obstet 1981; 152: 83-5.
5. Gauderer MW, Ponsky JL, Izant RJ. Gastrostomy without laparotomy: A percutaneous endoscopic technique. J Pediatr Surg 1980; 15: 872-5.