CLINICAL INFORMATION

Clinicians were asked to provide information on the investigations and physiological measurements made before the procedure. Unfortunately, documentation of patient's pre-procedural investigations was limited and there are no obvious reasons as to why this section was so poorly completed.

From the limited data, 71 patients were shocked, as defined by a tachycardia (pulse rate greater than or equal to 100 bpm) and hypotension (systolic blood pressure less than or equal to 90 mmHg). In addition, three had both a bradycardia (pulse rate less than or equal to 50 bpm) and hypotension. Were all appropriate efforts made to improve the patients' condition before the procedures were carried out?

Key point

The patient's weight was recorded in only 24% of cases.

Data concerning the patient's weight were returned in only 24% (429/1,818) of cases (Table 10).

Table 10. Number of cases where weight was been recorded

Procedure	Total	Number where weight recorded	*(%)*
PEG	719	143	*(20)*
ERCP	237	65	*(27)*
Upper GI	809	209	*(26)*
Lower GI	53	12	*(23)*

The widespread failure to record patients' weight is surprising. The patient's weight is helpful when judging the doses of sedation for endoscopic procedures especially in those who are frail and sick. The weight is also an important marker of nutritional status but the proportion of patients weighed was lowest for the group of patients undergoing a PEG procedure. In nearly all cases it was possible to move the patient to another location prior to their endoscopic procedure so there can be few excuses for failing to weigh patients.

Advisors found that in many cases the correct investigations had not been carried out before procedures; for example, advisors judged that patients scheduled for ERCP should have their bilirubin level and clotting status checked before the procedure. In 93% (221/237) of patients the bilirubin level was available. However, in 80% (189/237) of ERCP patients there was no record of a clotting study having been performed. When appropriate investigations were performed, abnormal results were disregarded.

Case Study

An ERCP was done for common bile duct stones, despite the patient's haemoglobin of 7.0gm/dl and INR of 2.6.

The advisors thought the procedure was appropriate, but should only have been done after the patient's condition was optimised. Did the endoscopist see the test results before the ERCP? Did they appreciate the significance of the results?

As with any patient assessment it is always important to listen to the patient.

Case Study

A GP referred an elderly patient who was complaining of poor fluid intake and loss of appetite. Investigations showed extensive mediastinal tumour probably from a previous lung cancer. An OGD revealed a length of abnormal oesophageal mucosa but there was no evidence of malignancy on biopsy which might have indicated a need for a therapeutic procedure. In the notes the dietician had written "eating all meals, increasing appetite, BMI =22.7". Despite this evidence a stent was inserted at a subsequent OGD.