7. The care of patients who did not undergo surgery

Introduction

Some patients admitted as an emergency with a diagnosis of aortic aneurysm do not undergo surgery. The surgical team may judge that the likelihood of survival after operation is so low that the operation would be futile, or the patient may decide that they wish to receive supportive and palliative care only, in the knowledge that without operation death is inevitable for a patient with a ruptured aortic aneurysm. This chapter explores the characteristics of the patients in this study who did not undergo surgery.

7. The care of patients who did not undergo surgery

Demographics

78 emergency patients received palliative care and did not undergo surgery. The one remaining patient who received palliative care was an elective admission. The average age was 83 years. This compares with an average age of 73 for all emergency patients in whom a decision was made to operate (Figure 1).

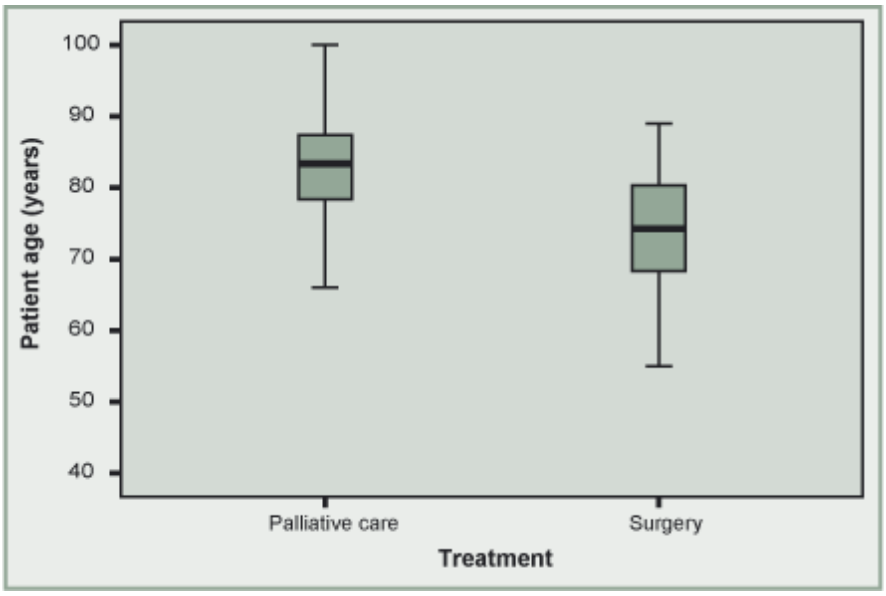

Figure 1. Age by type of treatment

64% (50/78) were males compared with 81% (218/268) of males in operated emergency patients.

43% (33/76) of patients were known to have an aortic aneurysm before presentation as an emergency admission, compared with 26% (54/211) of emergency patients who had an operation.

55% (68/124) of emergency admission patients aged 80 or over underwent surgery compared to 90% (196/218) of patients aged less than 80 years. However of the 68 patients aged 80 or over who did have surgery, 37% (25/68) were discharged from hospital within 30 days of surgery and 9% (6/68) were alive but had not left hospital.

Decisions about major emergency surgery on elderly patients are very difficult. NCEPOD has recommended against futile surgery in the past [1]. Although, elderly patients undergoing emergency aortic aneurysm repair did survive to 30 days, NCEPOD has no information on the length or quality of life of those who survived. Considerable resources such as the use of scarce critical care beds will have been consumed in caring for all those elderly patients undergoing surgery who did not survive.

7. The care of patients who did not undergo surgery

Size of unit

A greater proportion of emergency patients underwent surgery at large units than at intermediate or remote units.

The data were analysed to ascertain whether the type of unit into which emergency patients were admitted was associated with a difference in the likelihood of receiving palliative care rather than surgery (Figure 2).

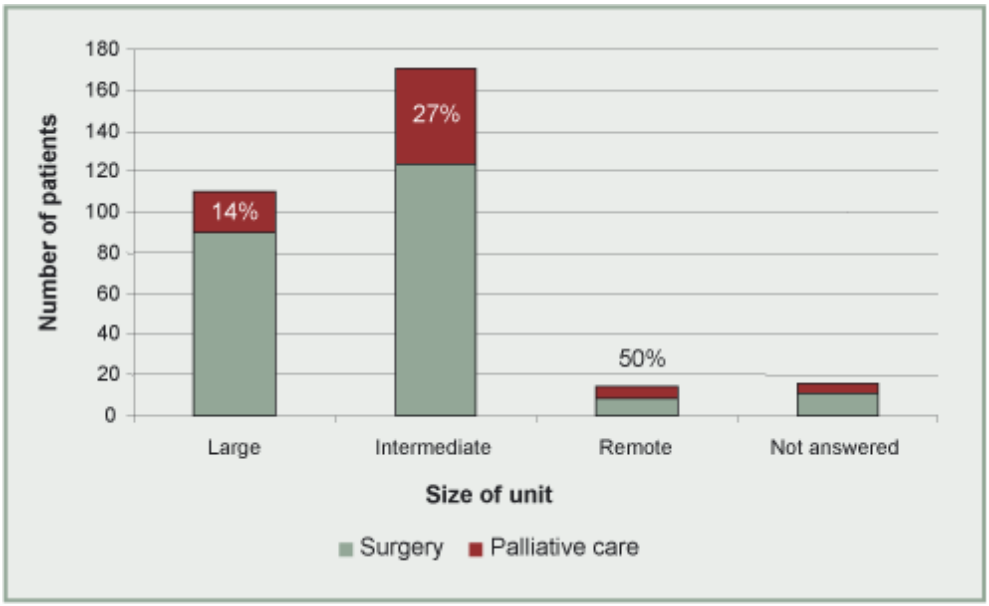

Figure 2. Care of patients by size of vascular unit *n=342*

The smaller the size of the unit, the more likely it was that the patient would receive palliative care. As reported in the chapter on Method, NCEPOD has been unable to carry out case-mix correction so these differences may be due to differences in patient population. Also, if surgery did take place, data was collected from the hospital where the operation took place. If a patient was admitted to one hospital and then transferred to another hospital for surgery, data was collected about the patient from the receiving hospital not the referring hospital. It may have been that smaller units transferred out patients with a good chance of survival, consequently more patients overall at smaller units would have received palliative care.

7. The care of patients who did not undergo surgery

Membership of the Vascular Society of Great Britain and Ireland (VSGBI)

A greater proportion of emergency patients underwent surgery when managed by a member of the Vascular Society of Great Britain and Ireland.

The data were analysed to ascertain whether the likelihood of receiving palliative care was associated with the surgeon caring for the patient being a member of the VSGBI (Figure 3).

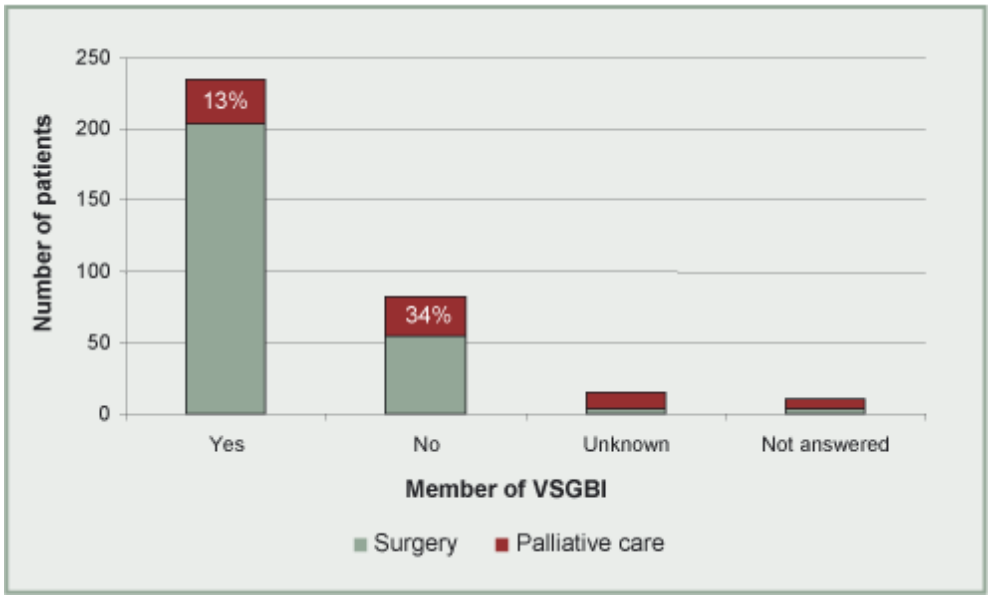

Figure 3. Surgeon's membership of the VSGBI by treatment decision *n=342*

Although it has been made clear in the section on Surgery that membership of the VSGBI cannot be exclusively related to expertise in vascular surgery, the patient was more likely to receive palliative care if the surgeon was not a member of the Vascular Society.

Unfortunately NCEPOD did not ask about the specialty of the surgeon who made the decision as to whether the patient should undergo operation or receive palliative care, so we cannot examine whether a vascular surgeon would have been more likely to operate on the patient than a general surgeon or a consultant in another subspecialty of general surgery who was covering vascular surgical emergencies.

7. The care of patients who did not undergo surgery

On-call rotas

A greater proportion of emergency patients underwent surgery when treated in a hospital with a vascular surgery on-call rota.

The relationship was examined between the number of patients for whom the decision was made to operate and the presence of a surgical vascular on-call rota (Figure 4).

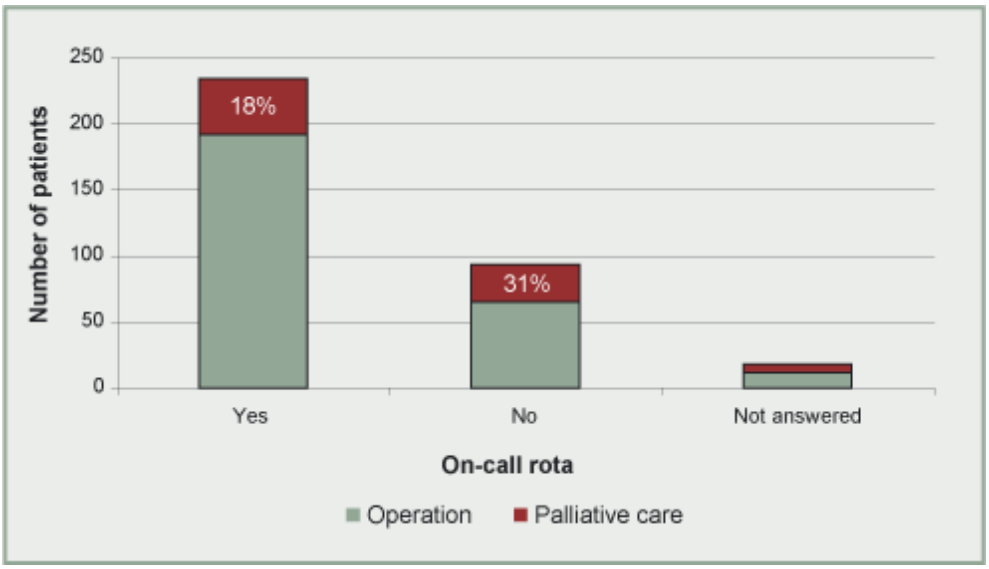

Figure 4. Separate on-call rota for vascular surgery by treatment decision in all emergency admission patients *n=342*

18% (42/231) of patients received palliative care in units where there was an on-call rota for vascular surgery and 31% (29/93) received palliative care in units where there was not an on-call rota (no information about on-call rotas was given for 18 patients). NCEPOD does not know whether these data were affected by hospitals that did not have an on-call rota transferring patients to hospitals that did.

These factors are linked, because membership of the VSGBI and surgical on-call rotas are more likely to be associated with working in a large vascular unit. Data in Table 6 in Organisation of vascular services show that the outcome of surgery after emergency admission was slightly better at large vascular units. Is it possible that there were some patients who received palliative care who might have undergone surgery if they had been admitted to a larger hospital or had come under the care of a surgeon with a greater involvement with vascular surgery?

7. The care of patients who did not undergo surgery

References

1 *Then and Now.* The 2000 Report of the National Confidential Enquiry into Perioperative Deaths. 2000.