

# Percutaneous endoscopic gastrostomies: attitudes of general practitioners and how management may be improved

April Heaney and T C K Tham

## SUMMARY

*Percutaneous endoscopic gastrostomy (PEG) has replaced surgical gastrostomy in patients requiring long-term enteral nutrition. Increasing numbers of patients are being referred for PEG placement. Concern has been raised about patient selection and subsequent follow-up of these patients in the community. We report the views of Northern Ireland GPs to PEGs and how management may be improved.*

**Keywords:** *Percutaneous endoscopic gastrostomy; patient selection; community health care.*

## Introduction

INCREASING numbers of patients are being referred for percutaneous endoscopic gastrostomy (PEG) placement. Concern has been raised about patient selection<sup>1</sup> and subsequent follow-up of these patients in the community.

We wished to examine the attitudes of general practitioners (GPs) to the current situation in Northern Ireland and how the management of these patients may be improved.

## Method

In May 1999 a postal questionnaire was sent to a random selection of GPs from each practice within Northern Ireland ( $n = 365$ ). A single reminder was sent to non-responders after four weeks and returned questionnaires were analysed after three months.

## Results

A total of 275 questionnaires were returned (75% response rate). Two questionnaires were incomplete and were not included in the analysis.

A summary of the GPs' responses is shown in Table 1. The indications for PEG insertion include stroke (48%), motor neurone disease (13%), multiple sclerosis (8%), dementia and anorexia (8%), cerebral palsy (6%), Parkinson's disease (3%) and other (14%). The problems GPs encountered with PEGs include blockage (30%), dislodgement (25%), leakage (18%), local sepsis (16%), pain (8%) and other (3%). Fifty-five per cent of GPs felt that one person should be responsible for follow-up in the community, i.e. a hospital practitioner, GP or nurse specialist and 42% felt that a combination of these people should be responsible; 3% did not know.

When asked who should perform replacement of PEGs in the community, 37% felt that this was a day-case in hospital, 10% felt that it required accident and emergency (A&E) attendance, 25% thought that a consultant domiciliary should perform the task, 10% a nurse specialist, 6% a GP, and 12% did not know. Nineteen per cent of GPs felt that there were too many PEGs performed, 50% did not, and 31% did not know.

GPs were asked what changes they would like to see in the current situation and 38% responded to this question. The changes requested were more education (31%), easier access to problem-solving in the community (24%), structured follow-up (24%), and review of guidelines regarding the indications and ethics of PEG insertion (21%).

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Table 1. General practitioners' responses.

	Percentage
GPs who have received formal education on PEGs	9
GPs with patients on their lists with PEGs	53
GPs who have referred patients for PEG placement	25
GPs who have encountered problems with PEGs	53
PEG problems managed	
In the community	40
In A&E	33
As a hospital admission	27
GPs who thought a telephone advice line would be helpful	78
GPs who saw a role for a nurse specialist	80

**HOW THIS FITS IN***What do we know?*

Increasing numbers of patients are being referred for percutaneous endoscopic gastrostomy (PEG) replacement. Concerns have been raised about patient selection and subsequent follow-up of these patients in the community.

*What does this paper add?*

This brief report gives some insight into GPs' views in Northern Ireland regarding PEG management and how this can be improved.

**Discussion**

Following a report by James *et al*<sup>2</sup> examining the attitudes of a group of Welsh GPs towards PEG tubes, we wished to assess GPs' views in Northern Ireland and evaluate how management may be improved. The limitations of our study were that our questionnaire may have been too prescriptive and a more qualitative approach with open questioning may have been appropriate. Also, the GP profile of non-responders was not examined to see if they differed from those who did respond.

Most (91%) GPs had received no formal education regarding PEGs. This is disappointing as more than half (53%) had patients on their list with PEGs and a quarter had referred patients for PEG insertion.

The British Society of Gastroenterology advises that each hospital should have guidelines for artificial nutritional support in hospital and at home.<sup>3</sup> Our study suggests that the role of the nutrition team should extend into the community.

Fifty-three per cent of the Northern Ireland GPs surveyed encountered problems with PEGs and 60% of these had either required A&E attendance or hospital admission. A particular area of difficulty was dealing with problems out of hours. Sanders<sup>4</sup> has examined this area and suggested employing a specialist nurse in particular to educate staff in nursing homes, which may minimise unnecessary admis-

sions. The Northern Ireland GPs surveyed were supportive of both a telephone advice line and a nurse specialist.

GPs were divided on who should be responsible for follow-up in the community. There are a number of people who could in effect take on this role, provided they received appropriate education and funding.

The issue of PEG replacement may be divided into elective and emergency replacement. Elective replacement of PEGs should take place in the community and it was disappointing that 47% of GPs thought or have found that this was a day-case in hospital or required A&E attendance. PEG replacement may be performed by a trained nurse, GP or hospital practitioner. Emergency replacement of PEGs should also occur in the community, with immediate insertion of the largest catheter possible or replacement PEG tube if possible. For this to occur, both GPs and nurses in nursing homes will need to be educated in particular to cope with these problems out of hours.

In conclusion, management of patients with PEGs in the community could be improved by setting up a specialist service; this has resource implications. A working group from the Clinical Resource Efficiency Support Team has been convened to address these issues.

**References**

1. Tham TCK, Taitelbaum G, Carr-Locke DL. Percutaneous endoscopic gastrostomies: are they being done for the right reasons? *Q J Med* 1997; **90**: 495-496.
2. James A, Parish P, Wilkins WE, Hasan M. Percutaneous endoscopic gastrostomy: attitudes of general practitioners. *Age Ageing* 1998; **27**(suppl 2): A47. [Abstract.]
3. British Society of Gastroenterology. *Guidelines on artificial nutrition support*. London: BSG, 1996.
4. Sanders DS, Carter MJ, Silva JD, *et al*. The community burden of percutaneous endoscopic gastrostomy (PEG). *Gut* 1999; **44** (suppl 1): TH512. [Abstract.]