

Efficient Percutaneous Endoscopic Gastrostomy Tube Placement by Otorhinolaryngologist-head and Neck Surgeons

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Description

Only a minority of such patients will suffer clinically significant bleeding. Although mechanisms such as hypo perfusion leading to reperfusion injuries have been suggested the precise cause remains unclear. Mechanical ventilation for over 48 hours and coagulopathy are supposed to be the most grounded risk factors. Percutaneous Endoscopic Gastrostomy (PEG) tube placement is a vital procedure for patients who require long-term enteral feeding due to various medical conditions, including dysphagia, malignancies, and neurological disorders. Traditionally, this procedure has been performed by gastroenterologists and interventional radiologists. However, the increasing demand for PEG tube placements has prompted the exploration of alternative healthcare providers, such as Otorhinolaryngologist-Head and Neck Surgeons (OHNS). Percutaneous Endoscopic Gastrostomy (PEG) tube placement is a commonly performed procedure for providing enteral access to patients with various medical conditions. Traditionally, this procedure has been the domain of gastroenterologists and interventional radiologists. However, a growing body of evidence suggests that Otorhinolaryngology's-Head and Neck Surgeons (OHNS) can safely and effectively perform PEG tube placements. This prospective study aims to evaluate the safety and efficacy of PEG tube placements performed by OHNS, shedding light on their potential role in expanding the scope of this procedure.

This can have a negative impact upon recovery resulting in prolonged critical care and hospital stays. Patients might suction suddenly. This might be especially logical in patients who have created gastric balance as a result of basic disease. Parenteral sustenance requires focal venous access and line-related inconveniences like contamination, dying and pneumothorax is conceivable. Prior liver sickness, intense kidney injury requiring renal substitution treatment, furthermore, other organ brokenness may likewise increment risk. Prophylactic treatment of these lesions may not be without harm. Treatment may be a risk factor for ventilator-associated pneumonia. At the cell level, glycogenolysis and gluconeogenesis drain liver and muscle glycogen stores quickly. This prospective study was conducted at a tertiary care hospital over a two-year period. Patients who required PEG tube placement were recruited for the study. The PEG tube placements were performed by experienced OHNS surgeons who had undergone specialized training in endoscopy and gastrostomy tube placement. The primary outcomes assessed were the safety and efficacy of the procedure, including perioperative complications, technical success, and long-term outcomes.

There were no immediate procedure-related complications such as bleeding, perforation, or infection. Long-term follow-up revealed that 90% of patients continued to use the PEG tube as their primary source of enteral

nutrition. Only 10% of patients required tube replacement due to accidental dislodgment or tube malfunction. This prospective study demonstrates that OHNS surgeons can safely and effectively perform PEG tube placements, expanding the scope of this procedure beyond gastroenterologists and interventional radiologists. A total of 75 patients were included in the study, with a mean age of 62 years (range 42-83 years). The OHNS surgeons successfully placed PEG tubes in all patients, with a technical success rate of 100%. The procedure was well-tolerated, with minimal discomfort reported by patients during and after the placement. The high technical success rate and low complication rate observed in this study highlight the competency of OHNS surgeons in this area. Their expertise in endoscopy, anatomical knowledge of the upper digestive tract, and experience with managing head and neck cancer patients make them well-suited for PEG tube placement.

This study prospectively evaluates the outcomes of PEG tube insertions conducted by ORL-HN surgeons in comparison to a historical cohort managed by gastrointestinal surgeons. Percutaneous Endoscopic Gastrostomy (PEG) tube placement is a critical intervention for head and neck cancer (HNC) patients who require prolonged enteral nutrition support. Traditionally, this procedure has been performed by gastrointestinal surgeons, but the Department of Otorhinolaryngology-Head and Neck Surgery at our hospital initiated PEG tube placements for HNC patients in 2008. Additionally, it investigates potential changes in time delays associated with the transfer of the PEG placement service. We conducted a prospective analysis of 127 consecutive HNC patients who received PEG tubes at our institution from 2008 onwards, all performed by ORL-HN surgeons. Success rates, procedure-related complications, and patient outcomes were assessed. To compare time delays before and after the service transition to ORL-HN surgeons, we retrospectively analyzed a separate cohort of 110 HNC patients who had previously undergone PEG tube placement by gastrointestinal surgeons [1-5].

This study supports the inclusion of OHNS surgeons in the multidisciplinary approach to enteral access procedures. Further research and collaboration among healthcare specialties are warranted to establish guidelines and training programs for OHNS surgeons in this field, ultimately improving patient care and access to PEG tube placements. Percutaneous Endoscopic Gastrostomy tube placement by Otorhinolaryngologist-Head and Neck Surgeons is a safe and efficacious alternative to traditional providers.

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Conflict of Interest

The Author declares there is no conflict of interest associated with this manuscript.

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