Letters to the Editor

Outcome in Patients who require a Gastrostomy after Stroke

SIR—We are concerned that the above paper [1] paints a rather gloomy picture for percutaneous gastrostomy (PG) feeding following acute dysphagic stroke. This is an important area which to date, unfortunately, been neglected in the medical literature. The 37 PG-fed patients in the above study had an extremely poor outcome with over 50% dying during the original hospital admission and only 12 patients (33%) surviving for more than 3 months. In addition, the quality of life of the surviving group was markedly affected with all but one being severely disabled (mean modified Barthel Index of four). These results are quite different from our recently published study [2] in which insertion of a percutaneous endoscopic gastrostomy feeding tube resulted in a much better outcome for patients, particularly compared with nasogastric feeding.

The mortality following acute dysphagic stroke is high and has been estimated at 49% [3]. However, we have demonstrated that PG feeding can significantly improve the mortality in this group. In our study, the 6-week mortality was only 12% and subsequent follow-up has shown a mortality at 6 months of only 35%. In addition, 40% of the original PG-fed group were discharged from hospital within 6 weeks of the procedure (all to nursing homes). The majority of our long-term survivors showed a generally poor quality of life, i.e. a Barthel Index of around 5, but there was a smaller group (24%) who had a mean Barthel Index of almost 10. There are likely to be several reasons for the better outcome in our study, but the most crucial issue relates to the timing of PG feeding. In our study, patients were fed at a mean of 14 days compared to 26 days in the above study. In addition, we can assume that in the latter study, patients either received intravenous fluids alone or, more likely, nasogastric feeding, which has been shown to be associated with a poorer prognosis [4-6], prior to initiating the PG feeding? We believe that such delayed nutritional support and/or initial feeding with a nasogastric tube will largely explain the adverse effect on patient outcomes in the authors’ study.

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SIR—We welcome the comments by Norton and colleagues and agree that dysphagia and malnutrition have been neglected areas in the care of stroke patients. Our study was a retrospective review of all percutaneous gastrostomies (PG) inserted after stroke in West Yorkshire between 1992 and 1994. The delay in initiating PG feeding was one of the main findings of our study. It reflected practice among clinicians caring for stroke patients at the time and we agree that this is one of the principal reasons for the poor outcomes reported.

It is encouraging that a recent report by Norton et al. [1] showed more promising results from earlier intervention with PG feeding in those who had persisting dysphagia after 14 days of the stroke. However, concerns have been expressed about the methodology of the trial. We await confirmation of these results in larger trials of well matched stroke patients with longer follow-up.

Finally, we are concerned that Norton et al. [1] twice equate quality of life (QL) with low Barthel Index, which is a measure of physical function. QL assessment should include the four domains of physical, functional, psychological and social health [2]. Physical disabilities after stroke may have a negative impact on quality of life but this is not a simple relationship [2]. Stroke patients with minor physical dysfunction may also suffer reduced quality of life [3-5]. A QL measure which has been validated in stroke patients would be desirable in further studies of the outcome in patients who need a PG after stroke.

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