Table 1. Percutaneous endoscopic gastrostomy referral strategy[2]

1. Standardise PEG referral form including concomitant disease
2. Endoscopy nurse triage and dissemination of published evidence
3. Gastroenterological review where necessary
4. Holistic and multidisciplinary approach
5. Advise against PEG feeding in patients with dementia
6. One-week waiting list policy

In response

Editor – I would like to thank Professor Glazier for highlighting areas in which there is a paucity of randomised controlled trial evidence.

He mentions the observational study from the International Cooperative Pulmonary Embolism (PE) Registry reported by Kucher *et al.* In the subgroup of patients with acute PE and a systemic arterial pressure less than 90 mmHg (high-risk PE), thrombolysis did not appear to reduce mortality. Of note patients were not randomised and the patients who received thrombolysis had a higher rate of right ventricular hypokinesis raising the possibility that the thrombolysed group had more severe disease. Hence it is difficult to comment on the role of thrombolysis from this observational study.

In the absence of adequately powered randomised controlled trials, Wan *et al* performed a meta-analysis of randomised trials comparing thrombolytic therapy with heparin in patients with acute PE. In a subgroup analysis, thrombolysis was associated with a significant reduction in death in the trials that included patients with haemodynamically unstable PE.

In terms of my centre's experience of primary surgical embolectomy, Papworth Hospital is a tertiary specialist cardiothoracic centre without an accident and emergency department. Patients are referred with complex thromboembolic disease (for example right ventricular thrombus) or chronic thromboembolic pulmonary hypertension who proceed to pulmonary endarterectomy. As far as I am aware, there are no randomised controlled trials of primary embolectomy versus thrombolysis in patients with high-risk PE. From the surgical series reported in experienced cardiothoracic centres, surgical embolectomy may be a useful treatment in high-risk PE if immediately available.

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Improving outcomes following percutaneous endoscopic gastrostomy (PEG) – a seven-day waiting policy is essential

Editor– We would like to congratulate Skitt *et al* for being the first group to demonstrate a reduction in mortality following gastrostomy tube insertion after a multi-faceted quality intervention approach was applied (*Clin Med* April 2011 pp 132–7). There have been three previous studies in this field which have shown improvements in patient selection for PEG insertion and/or a reduction in referral or insertion rate.[1–3]

Our group have previously used a similar strategy, but with one additional intervention. As gastrostomy insertion is not an emergency procedure, a minimum one-week waiting list policy was initiated (Table 1). In 55% of the cases that we deferred or declined gastrostomy insertion, the patient succumbed within seven days (and for the rest within 30 days).[1] We wonder if the authors had seven day mortality data before and after their strategy for both the patients in whom a PEG was inserted or declined – and if there was any difference in seven day mortality between these two groups?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report highlighted that of those individuals that died within 30 days of PEG insertion, 43% died within the first week.[4] A seven-day waiting list policy has two functions. It serves to provide an opportunity to reflect on the implications of PEG tube insertion prior to undertaking the procedure (for all those involved in the decision making process). Secondly, in some cases patients may succumb during this 'cooling off' period.[2] Based on these observations we would encourage others to implement Skitt's excellent clinical practices but with the further addition of a one-week waiting list policy.

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