When there should be no Emergency Laparotomy (No-Lap)

James Aitken

Sir Charles Gairdner Hospital, Perth

Chair, ANZELA-QI Working Party

Victoria Perioperative Consultative Council

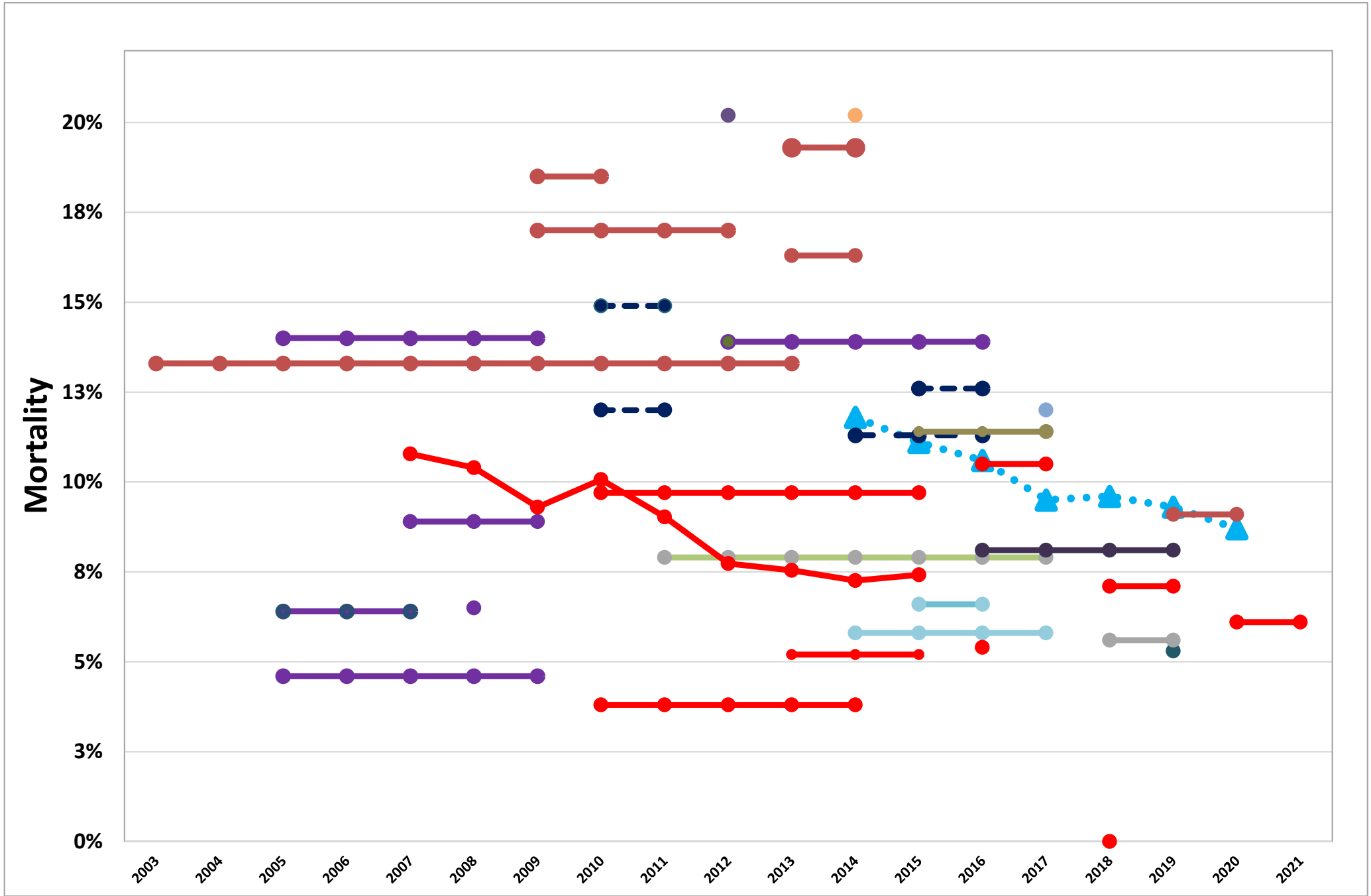
Workshop on Emergency Laparotomy Outcomes and Performance

10 November 2022

Competing interests

- Chair, Working Party
  Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement
- Clinical Director
  Western Australian Audit of Surgical Mortality

30-day and/or in hospital mortality after Emergency Laparotomy



Are Australian surgeons better?

ANZASM focus on futile care

10	Was an operation performed within 30 days of death or during the last admission?		Yes ☐	No ☐	
	If **YES**, *go to Q11*. If **NO**: (*tick as necessary*)				
	It was not a surgical problem	☐			
	Active decision not to treat or operate	☐ →	Was this a consultant's decision?	Yes ☐	No ☐
	Patient/family refused operation	☐			
	Rapid death	☐	*If **NO** operation was performed, please go to Q18*		

A Symposium by the Western Australian Audit of Surgical Mortality

Futile Care and End of Life Matters

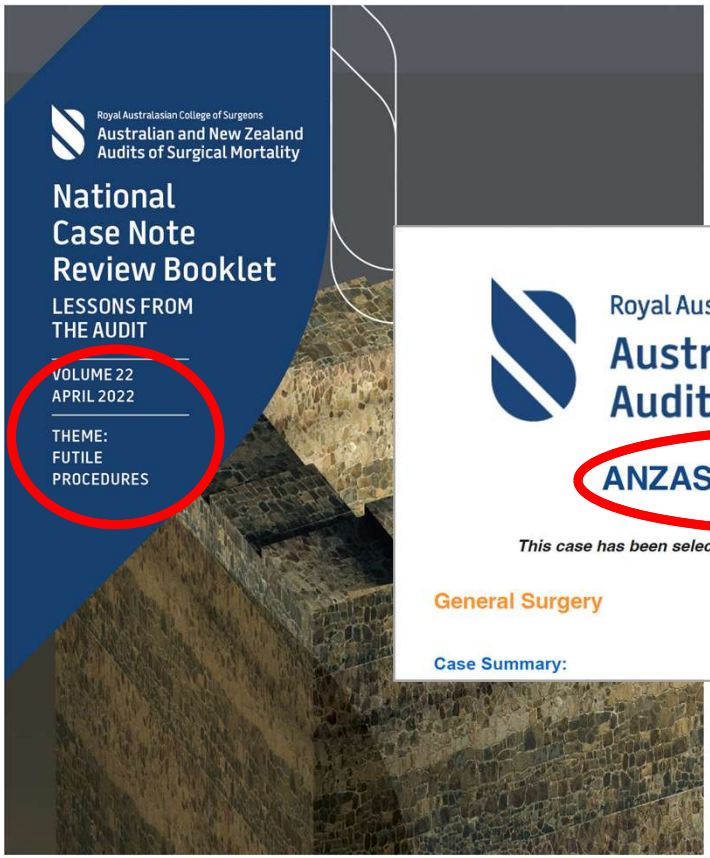
Commencing 6pm
Tuesday, 15 November 2016
Harry Perkins Institute of Medical Research (QEII)

Speaker	Title	Provisional Subject/Title
James Aitken	Chairman	Introduction
Preparing for the Inevitable		
Hon Jim McGinty AM	Former WA Minister of Health and Attorney General	Parliament's role in End of Life matters
Dr Penny Flett AO	Former CEO Brightwater Care Group	The aged care sector's role in preparing for the End of Life
Dr Matt Anstey	Senior Medical Advisor Australian Commission on Safety and Quality in Health Care	End of Life care - a national policy perspective
Managing Dying in the Acute Patient		
Dr Tim Paterson	Consultant in Intensive Care	Management of the patient with borderline outcome
Mr Stephen Honeybul	Consultant Neurosurgeon	Futile care or no treatment
Zaza Lyons Albie Lyons		Difficult decisions in stressful situations - a mother and son reflect
James Aitken	Chairman	Discussion (to conclude at 8.30pm followed by refreshments).

For more information or to register
Email: waasm@surgeons.org or call the WAASM on 08 6389 8650

Places are limited - please register your interest as soon as possible.

This activity qualifies for 3 RACS CPD points in *Maintenance of Knowledge and Skills*



Royal Australasian College of Surgeons
Australian and New Zealand Audits of Surgical Mortality

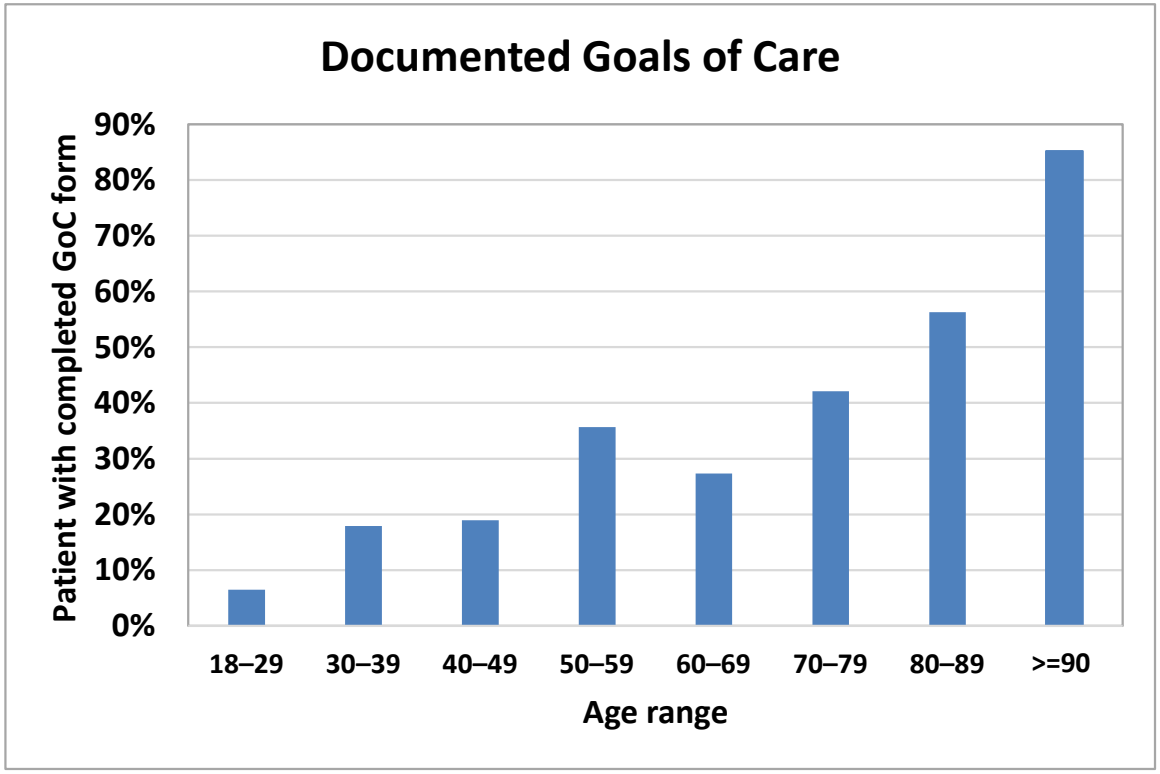
ANZASM Case of the Month
June 2022 Edition

This case has been selected by the ANZASM Committee for your information.

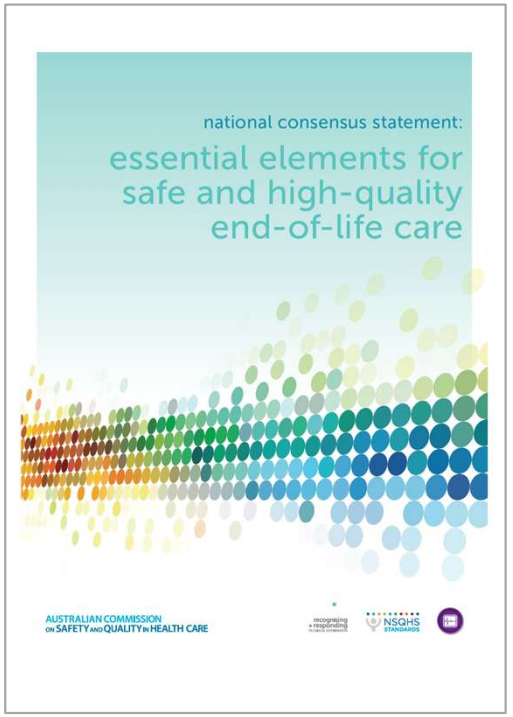
General Surgery

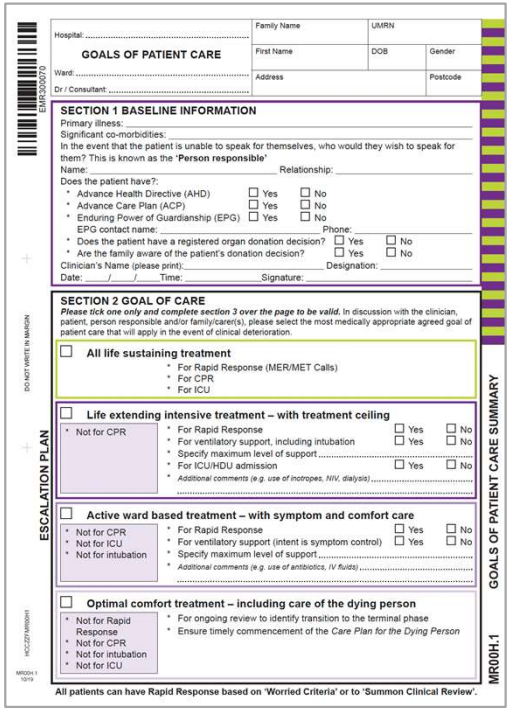
Case Summary:

Goals of Care



Discharge status	GoC documented
Alive	34.6%
Died	52.2%
No-Lap	91.3%





ORIGINAL ARTICLE

ANZJSurg.com

The Perth Emergency Laparotomy Audit

Katherine J. Broughton,* Oscar Aldridge,† Sharin Pradhan‡ and R. James Aitken*

*Department of General Surgery, Sir Charles Gairdner Hospital, Perth, Western Australia, Australia
†Department of General Surgery, Fiona Stanley Hospital, Perth, Western Australia, Australia and
‡Department of General Surgery, Royal Perth Hospital, Perth, Western Australia, Australia

	#	%
Post-op mortality	19/354	5.4%
No-Lap who died	13	
Mortality in No-Lap/all eligible	13/29	44.8%

With respect to then NELA report

- Fewer older patients
- Fewer high risk patients

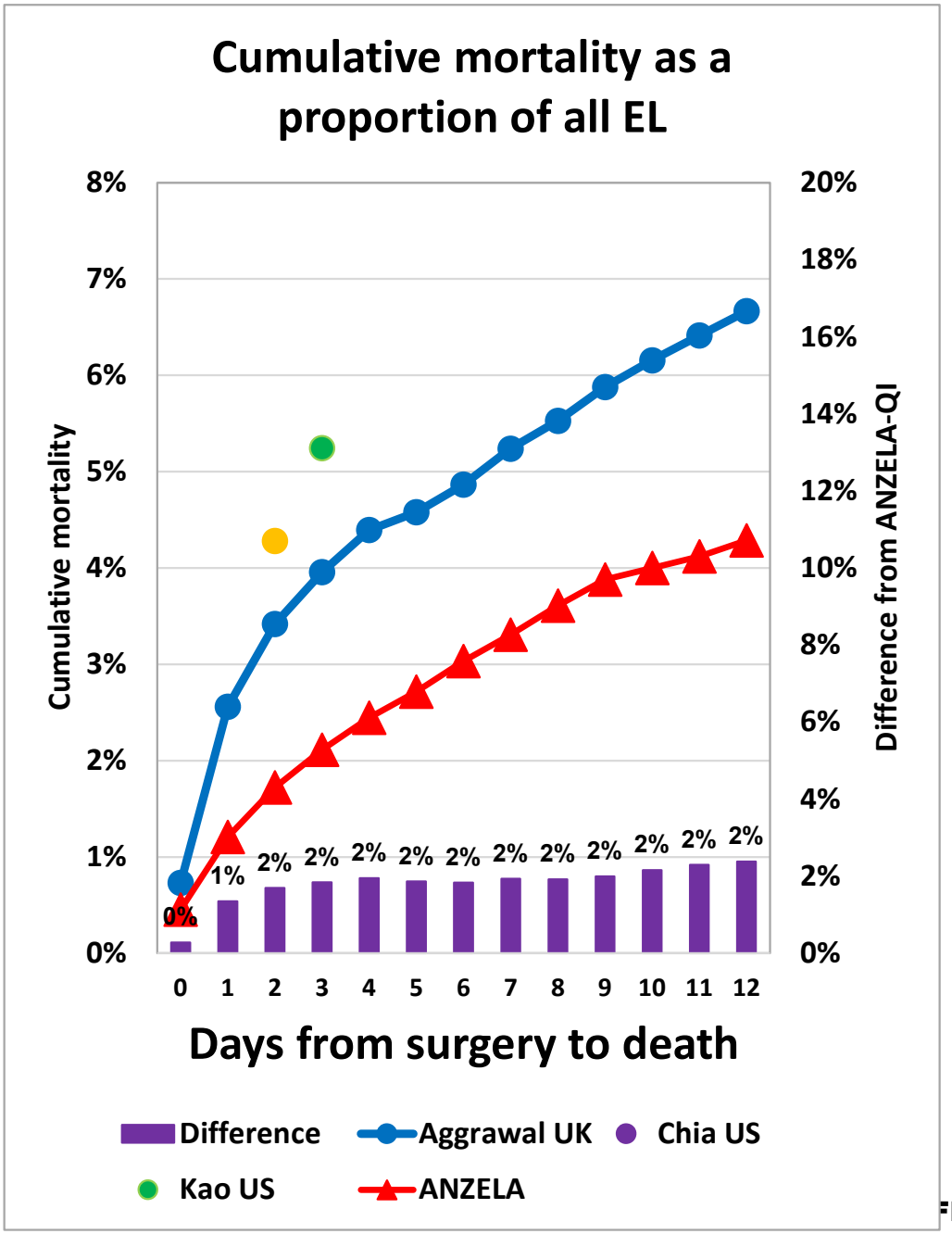
No-Lap studies

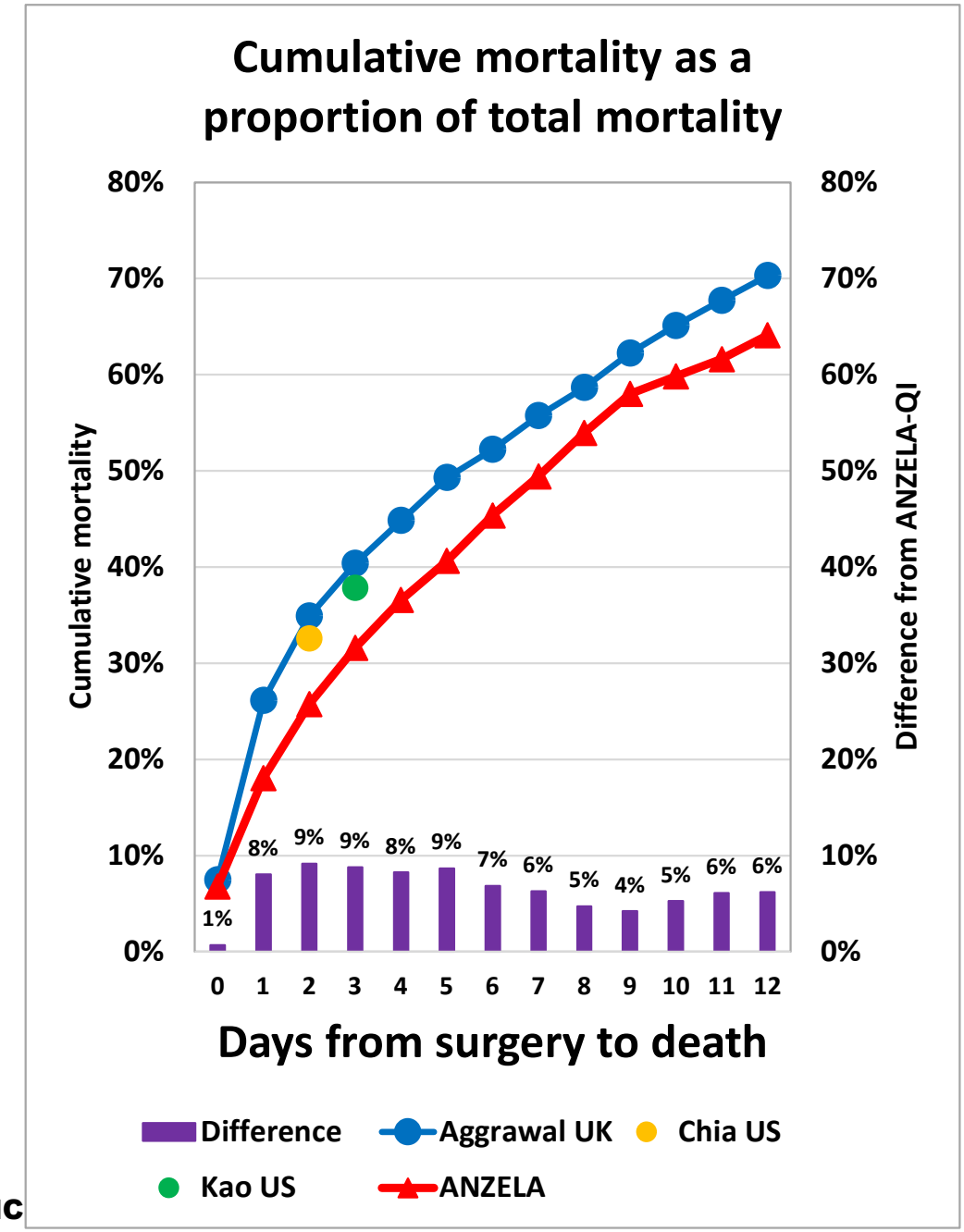
	Broughton WA 2016	Broughton WA 2010/15/16	ANZELA-QI 2018/20	McIlveen, Glasgow 2015/16	Ebrahim Copenhagen 2020/21
EL	354		2886	214	231
Post op mortality	19	190	196	27	21
30-day Mort	5.4%		6.8%	12.6%	9.1%
No-Lap	13	202	68	100	21
Post-op mortality in all 'EL eligible'	8.7%		8.9%	40.4%	16.7%
No-Lap/all death	40.6%	48.5%	25.8%	70%	48.8%

Small change in No-Lap
Big change in post-operative mortality

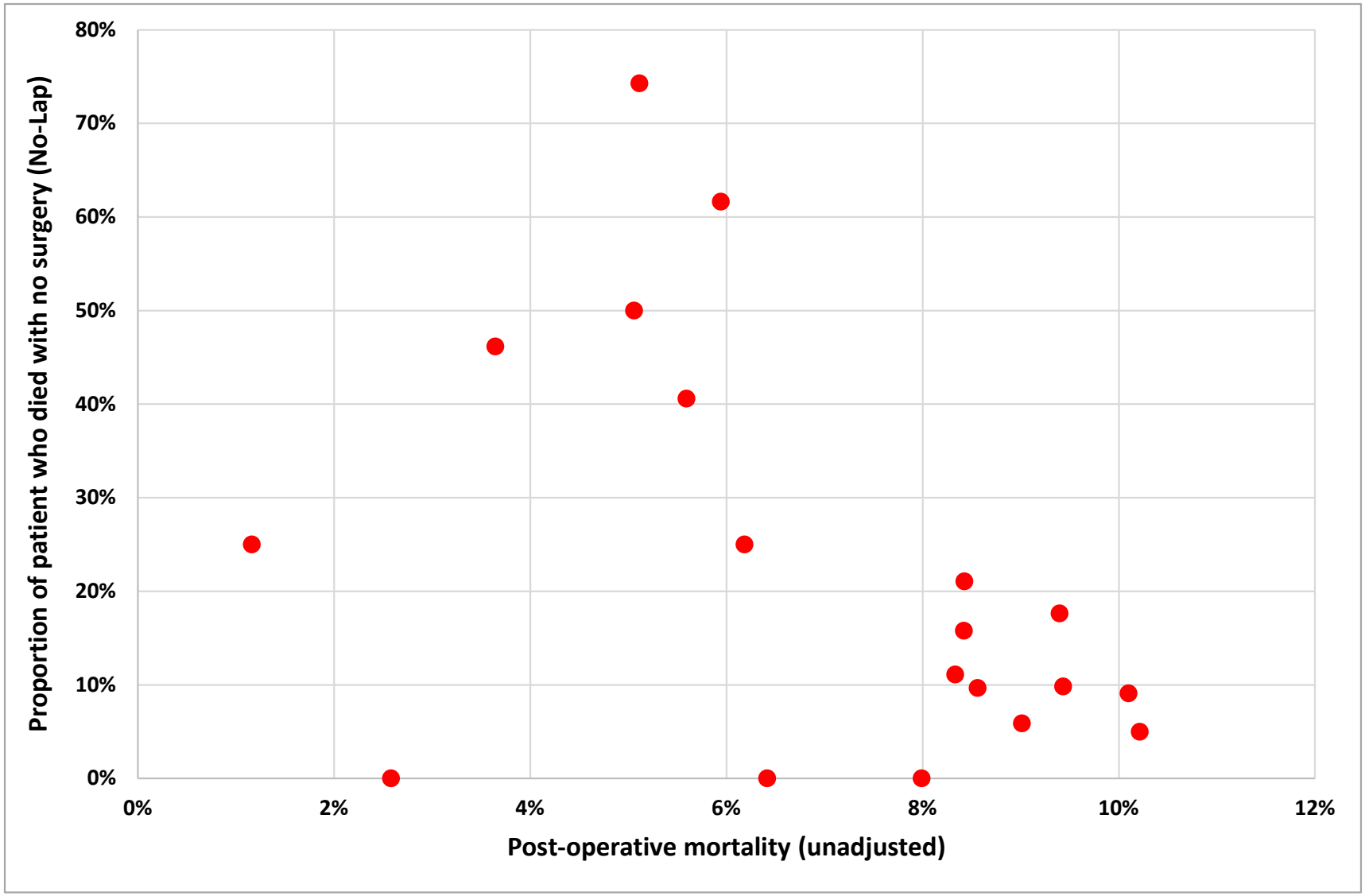
	Hospital A	Hospital B
'EL eligible'	100	100
No-Lap		4
Emergency Laparotomy	100	96
Died	10	6
Mortality	10.0%	6.3%

Early mortality in ANZELA-QI



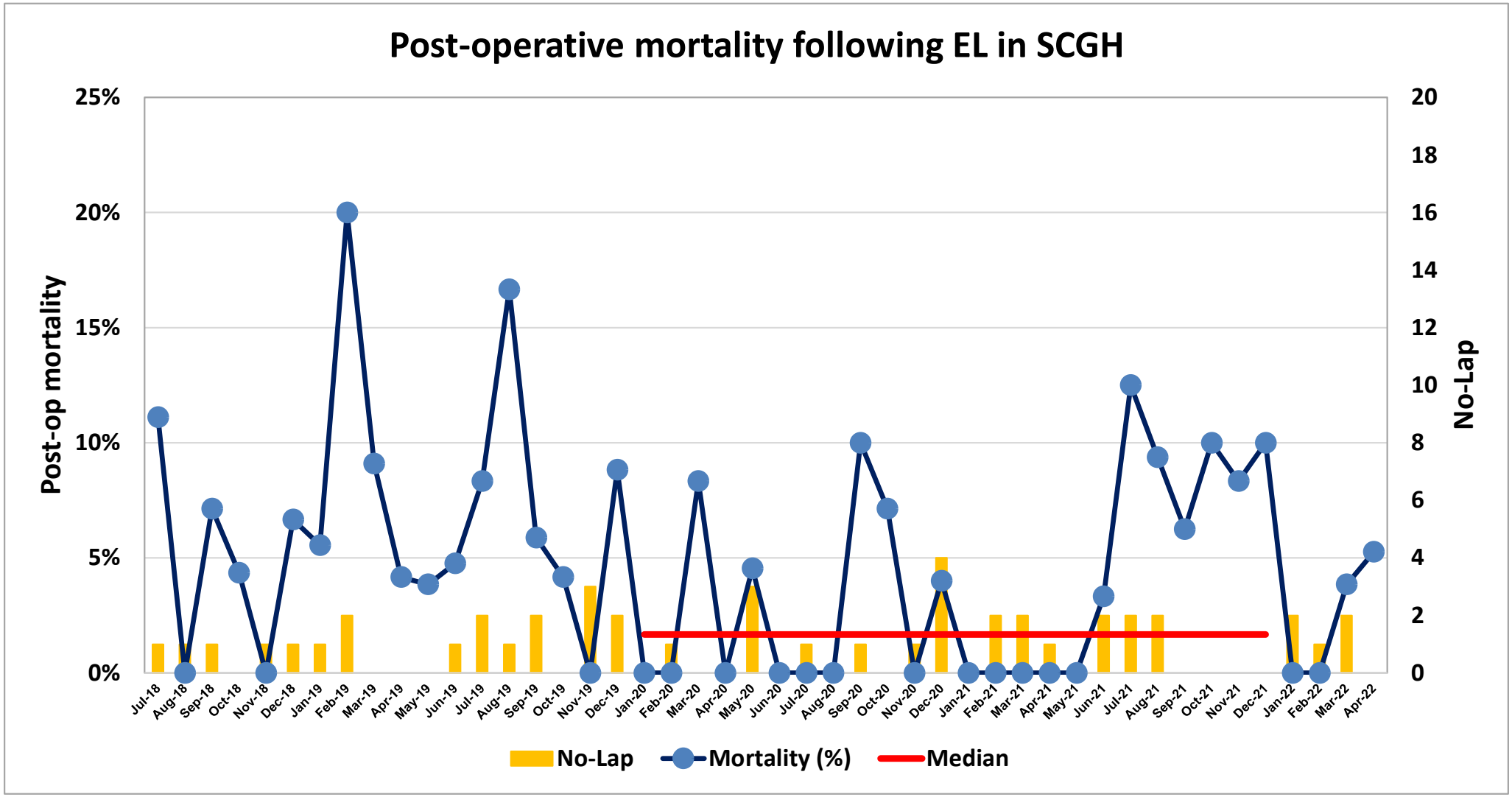


Relationship between post-op and No-Lap mortality



Only includes hospital with at least 1 No-Lap

Mortality run chart



Post-op mortality - 5.4%

Non-op/operation mortality ratio - 46/43

Emergency Laparotomy and Frailty study (ELF2)

International Journal of Clinical Trials
Reeves N et al. Int J Clin Trials. 2021 May;8(2):138-144
http://www.ijclinicaltrials.com

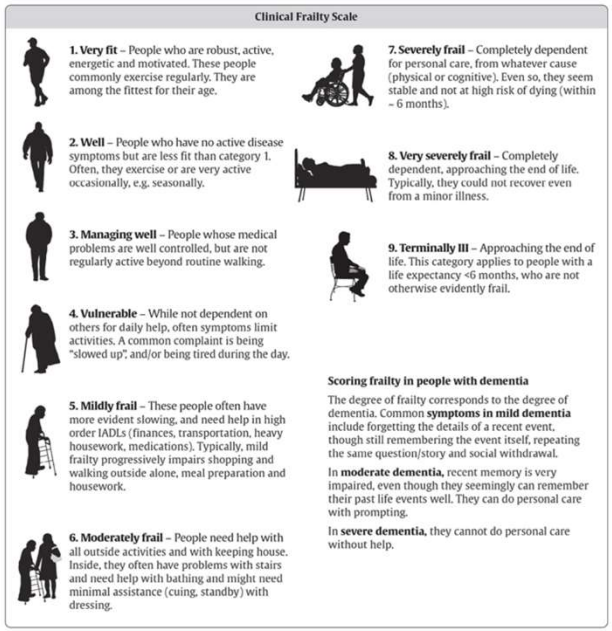
pISSN 2349-3240 | eISSN 2349-3259

DOI: https://dx.doi.org/10.18203/2349-3259.ijct20210977

Protocol

Defining the older patient population that require, but do not undergo emergency laparotomy: an observational cohort study protocol

Nicola Reeves[1], Susan Chandler[2], Elizabeth McLennan[3], Angeline Price[4], Jemma Boyle[5], Stephen Knight[6], Lyndsay Pearce[7], Susan Moug[8]*



Clinical Frailty Scale

1. Very fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5. Mildly frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very severely frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

After discharge

- Mortality
  - Mortality 90-day as/more important as 30-day
- Quality of Life
  - post discharge QoL unknown
  - patients feel abandoned
  - 40% change/loss of employment
  - no support/communication
    - those requiring further surgery
  - PROM's
    - 32% 'no disability' at 12 months
  - multiple unappreciated readmissions
    - Days Alive Out of Hospital

POLO study
Julie Cornish (Cardiff) &
Susan Moug (Glasgow)


RESEARCH Open Access

Emergency Laparotomy Follow-Up Study (ELFUS): prospective feasibility investigation into postoperative complications and quality of life using patient-reported outcome measures up to a year after emergency laparotomy

D. I. Saunders[1*], R. C. F. Sinclair[1], B. Griffiths[2], E. Pugh[1], D. Harji[2], B. Salas[3], H. Reed[4] and C. Scott[4]


Validation of the days alive and out of hospital outcome measure after emergency laparotomy: a retrospective cohort study

Leigh-James Spurling[1,2,*], S. Ramani Moonesinghe[1,2] and C. Matthew Oliver[1,2]

Conclusion

- End of Life Care now recognised as an important care standard
- Need for Australian post-discharge data
  - Goals of Care Forms
- No-Lap patients may influence post-operative mortality
- Influence of ANZ Surgical Mortality Audit?