Abstracts

Papers appearing in the June 2017 issue

Early transition to comfort measures only in acute stroke patients: Analysis from the Get With The Guidelines–Stroke registry

Background Death after acute stroke often occurs after forgoing life-sustaining interventions. We sought to determine the patient and hospital characteristics associated with an early decision to transition to comfort measures only (CMO) after ischemic stroke (IS), intracerebral hemorrhage (ICH), and subarachnoid hemorrhage (SAH) in the Get With The Guidelines–Stroke registry.

Methods We identified patients with IS, ICH, or SAH between November 2009 and September 2013 who met study criteria. Early CMO was defined as the withdrawal of life-sustaining treatments and interventions by hospital day 0 or 1. Using multivariable logistic regression, we identified patient and hospital factors associated with an early (by hospital day 0 or 1) CMO order.

Results Among 963,525 patients from 1,675 hospitals, 54,794 (5.6%) had an early CMO order (IS 3.0%; ICH 19.4%; SAH 13.1%). Early CMO use varied widely by hospital (range 0.6%–37.6% overall) and declined over time (from 6.1% in 2009 to 5.4% in 2013; $p < 0.001$). In multivariable analysis, older age, female sex, white race, Medicaid and self-pay/no insurance, arrival by ambulance, arrival off-hours, baseline nonambulatory status, and stroke type were independently associated with early CMO use (vs no early CMO). The correlation between hospital-level risk-adjusted mortality and the use of early CMO was stronger for SAH ($r = 0.52$) and ICH ($r = 0.50$) than AIS ($r = 0.15$).

Conclusions Early CMO was utilized in about 5% of stroke patients, being more common in ICH and SAH than IS. Early CMO use varies widely between hospitals and is influenced by patient and hospital characteristics.

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➔ Editorial

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Preoperative evaluation for epilepsy surgery: Process improvement

Background Epilepsy surgery (ES) can improve seizure outcome. A prolonged duration of presurgical evaluation contributes to epilepsy-related morbidity and mortality. We introduced process changes to decrease evaluation time (ET) and increase ES numbers (excluding vagus nerve stimulation).

Methods The University of Colorado Hospital patient database was searched for ESs between January 2009 and May 2016. Measures to reduce ET included (1) increasing patient care conference (PCC) frequency; (2) faster intracarotid amobarbital test (IAT) scheduling; (3) dedicated ES clinic; and (4) adding a nurse navigator. ET from noninvasive video-EEG monitoring (P1) to IAT, PCC, and ES, and ES volume were determined and compared for a baseline group (P1 January 2009–March 2013) and a group exposed to process changes (P1 after March 2013), the postchanges group, to assess the effect of these measures.

Results ES number was 61 for the baseline group and 77 for the postchanges group, increasing the annual rate at 3 years after changes from 14.4 to 36.8 ($p = 0.0008$; 37% yearly increase postchanges). Interventions lowered average ET by 96 days ($p \leq 0.0001$), P1 to IAT by 39 days ($p = 0.0011$), and P1 to PCC by 58 days ($p = 0.0002$).

Conclusions Simple process changes, including more frequent patient care conferences, faster scheduling, a dedicated ES clinic, and a nurse navigator, significantly decreased evaluation times and increased ES numbers. Centers could utilize similar strategies to improve process and surgical volume and thereby increase patient seizure control and safety.

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Practice Current

The survey on our latest topic, “When do you suspect autoimmune encephalitis and what is the role of antibody testing?”, has received over 680 responses from over 72 counties to date. Explore this topic and others on our newly redesigned website; compare your practice with peers and see real-time results displayed on an interactive world map.

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