References


Acknowledgments

Role of sponsors: The content of this manuscript is solely the responsibility of the authors and does not necessarily represent the official views of the National Heart, Lung, and Blood Institute.
suggest that PEG tube insertion (and all of its attendant risks) may have been avoided completely in some patients by deferring simultaneous insertion.

Nasogastric feeding tubes are widely regarded as safe and should be the preferred option for short-term nutrition delivery. We feel that the policy of simultaneous PEG and tracheostomy tube insertion should not be advocated until it has been proven to be superior to a watch-and-wait approach in prospective randomized trials.

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Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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DOI: 10.1378/chest.13-2134

REFERENCES


Response

To the Editor:

We thank Drs Slattery and Seres for their interest in our article regarding the placement of percutaneous endoscopic gastrostomy (PEG) tubes by interventional pulmonologists. Although there are no prospective randomized trials addressing the efficacy and safety of combined tracheostomy/PEG within critically ill patients, to our knowledge, no randomized data have demonstrated it as unsafe/unfeasible, and designing noninferiority studies of this type would be extremely difficult and expensive. We agree that, like tracheostomy placement, decisions regarding timing for PEG tube placement remain difficult for providers; PEG tube placement should be reserved for those likely to need enteral nutrition for >30 days. We believe our data suggest appropriate patient selection, with removal occurring in 73% of surviving patients (after a median 76 days) and long-term PEG tube utilization in an additional seven patients. Data on ICU admission to PEG placement time were not collected; rather, the time period cited is time to death or follow-up after placement. Unfortunately, 11% of this cohort died within 30 days (five patients receiving tracheostomy and PEG, three patients receiving PEG only); however, this remains favorable when compared with larger PEG studies.2,3

We would like to point out that the main objectives of ourarticle remain as discussed by Dr Kovitz in the accompanying editorial. Tracheostomy, once limited to surgeons, has experienced successful expansion to other subspecialties through the appropriate breakdown of health-care silos, potentially allowing for improved health-care efficiency and decreased costs.2 We believe this same approach can be taken with a procedure such as PEG placement (or combination tracheostomy/PEG) as described.4 The field of interventional pulmonology continues to expand, as does our role within the health-care system, and the main goal of this study was to show the safe and feasible performance of this procedure in the hands of trained interventional pulmonologists in a procedure historically limited in most institutions to gastroenterologists or surgeons.

Although not currently defined well in the literature, use of this approach may potentially decrease costs and expedite efficient patient care. As suggested,4 the procedural performance by one team at one encounter has potential for significant improvements in cost, decreased ICU stay, decreased anesthetic exposure, and so forth. The use of this team may also help expedite patient transfer to other levels of care. Within the authors’ current and previous practice environments, it remains the general practice of long-term ventilator facilities to refuse admission of patients to their facility without the placement of a long-term feeding tube. The continued use of a nasogastric tube only delays transfer and discharge from the hospital, often at a significantly higher cost to the health-care system.

We believe PEG tube placement remains a safe procedure when performed by an experienced team with careful regard to patient selection. We disagree with the complaint made by Drs Slattery and Seres of excessive mortality in this population. Mortality remains a poor marker for this procedure due to the critically ill nature of every patient within this cohort. We suggest further study to help answer these difficult questions of who would best be served by PEG placement as well as analyses of health-care costs.

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Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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