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Tyler M. Bauer, MD  
Thomas Jefferson University, tyler.bauer@jefferson.edu

Adam P. Johnson, MD  
Thomas Jefferson University, adam.johnson@jefferson.edu

Chris Wirtalla, MD  
University of Pennsylvania

Jordan E. Goldhammer, MD  
Thomas Jefferson University, Jordan.Goldhammer@jefferson.edu

Rachel R. Kelz, MD  
University of Pennsylvania

See next page for additional authors

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Authors
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Preventing Isolated Perioperative Reintubation: Who is at highest risk?

Tyler M. Bauer¹, Adam R. Johnson¹, Chris Wirtalla², Jordan E. Goldhammer³, Rachel R. Kelz², and Scott W. Cowan¹

¹Department of Surgery, Thomas Jefferson University Hospital; ²Department of Surgery, University of Pennsylvania; ³Department of Anesthesia, Thomas Jefferson University Hospital

Background

- Postoperative respiratory complications occur in 1.03% of surgery patients with an average costs of $62,794 per patient, per event.³
- Post-operative respiratory failure is often secondary to a concurrent severe complication, such as cardiac arrest, sepsis, pneumonia, aspiration, or pulmonary embolism.³
- Isolated perioperative reintubation (IPR), defined as unplanned intubation in the first 24 hours of surgery without concurrent complications, has not been well characterized in the literature.
- IPR likely occurs due to one or a combination of the following:¹:
  - Opioid overdose
  - Over-sedation
  - Residual paralysis
  - Fluid overload.
- IPR represents a rare but possibly preventable cause for respiratory failure in the immediate postoperative period.

Objectives

1. We aim to characterize IPR nationally through a retrospective review of the National Surgical Quality Improvement Program (NSQIP) 2014 participant user file (NSQIP PUF).
2. Identify risk factors for IPR including analysis of procedure type and preoperative characteristics.

Methods

- The 2014 NSQIP PUF was queried for all observations.
- Study and event exclusions were applied as below (Figure 1A and B).
- Procedures were grouped by Current procedural terminology (CPT) code, as recommended in the NSQIP appendix B file.
- IPR was analyzed with known risk factors and procedure grouping using chi square analysis (p < 0.001).
- Multivariable logistic regression analysis identified 12 patient factors and 8 operation types significantly associated with an elevated likelihood of IPR (p<0.05).

Results

- Chi-squared analysis identified 22 patient covariates and 18 CPT procedure groups that were associated with IPR (p<0.01) and included in the multivariable analysis.
- Multivariable logistic regression analysis identified 12 patient factors and 8 operation types significantly associated with an elevated likelihood of IPR (p<0.05).

1.44 0.001 1.2 - 1.72
1.25 0.023 1.03 - 1.51
1.76 0.001 1.41 - 2.19
2.22 0.039 1.04 - 4.74
1.88 0.001 1.49 - 2.37
1.89 0.002 1.27 - 2.81
1.44 0.001 1.19 - 1.75
2.87 0.001 1.94 - 4.26
1.32 0.007 1.08 - 1.62
3.10 0.001 2.44 - 3.93
1.65 0.001 1.38 - 1.99
1.34 0.019 1.06 - 1.72
1.45 0.009 1.1 - 1.92
3.79 0.001 1.95 - 7.36
7.92 0.041 1.08 - 57.89
2.37 0.001 1.15 - 4.73
2.36 0.001 1.4 - 3.98
0.62 0.046 0.39 - 0.99
1.74 0.026 1.07 - 2.84
2.07 0.039 1.04 - 4.12
0.31 0.001 0.15 - 0.65
1.79 0.020 1.1 - 2.93

Discussion

- We identified a national IPR of 0.1% in all eligible patients.
- Ten procedures demonstrate a higher than average likelihood of IPR, and two, spine and knee arthroplasty, demonstrate a lower likelihood.
- TKA and Spine Surgeries had an odds ratio of < 0.01 (protective). We believe this was due to a low amount of on-board anesthetics and enhanced operative management of anesthesia with somatosensory evoked potentials respectively.
- Further chart review and prospective analysis may be required to understand the mechanism for increased likelihood of IPR in other general and vascular procedures.
- Many of the patient comorbidities overlap with risk factors for IPR.

Limitations

- Retrospective review of registry data is limited to data collected by the registry and may not have generalizability outside of participants in the ACS NSQIP patient registry.
- Since there is no explicit variable for IPR, it was inferred by exclusions. Further chart review at an institutional level may be necessary to validate the application of the exclusion for this purpose.

Next Steps

- Perform institutional review of IPR events and compare to national trends and benchmarks. This will allow us to better understand:
  - Interplay and overlap of underlying etiologies.
  - Cost an average IPR event.
- Combining the identified risk factors with physiologic parameters during emergence from anesthesia to help develop a high risk pulmonary pathway in the immediate perioperative period.
- Traditionally, neostigmine has been used to promote anesthesia reversal in high risk patients.
- New, novel neuromuscular blockade reversal agents have demonstrated more effective at reversing the neuromuscular blockade than neostigmine, albeit at a higher price.
- As the price for neostigmine rises, and becomes more comparable to these new agents, it may become beneficial to treat high risk groups, such as the ones identified in our study, with the newer agents.
- Develop and validate robust anesthesia and surgery outcomes.
- Many outcomes require appropriate patient selection, preoperative optimization, and intra-operative management by anesthesia.
- Outcomes such as IPR require close coordination and collaboration between anesthesia and surgery.
- Sharing and benchmarking outcomes like these may help to promote collaboration for improved outcomes in these two specialties.

References