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Research Article

### EVALUATION OF THE RESULTS AND TANGLES IDENTIFIED WITH PROPHYLACTIC INTUBATION BY A REVIEW CORRELATION

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**Abstract:**

***Aim:** There is limited evidence that recommends prophylactic intubation to improve understanding of the results despite wide use. Our research aims to evaluate the results and tangles identified with prophylactic intubation by a review correlation.*

***Abstract:** Urgent esophagogastroduodenoscopy (EGD) in cases of suspected varicose vein flow was selected for examination and classified into two combinations, one with prophylactic intubation.*

***Methods:** Our current research was led at Services Hospital Lahore from February 2017 to May 2018. The main results of the examination were rapid aspiration, post-EGD pneumonia, death and various complexities. Auxiliary outcomes, including those of the emergency unit after the ESC, remain, all intensive care units remain in place and the absolute medical clinic is still in place. A partner review was conducted.*

***Results:** A total of 120 critical ESC events were incorporated. Prophylactic intubation was performed in 68 cases. Socio-economics, clinical basis and noteworthy co-morbidities were compared in both partners. The rapid target, post-EGD pneumonia and mortality were comparable between the two companions. Non-cardiovascular and pneumonic difficulties related to prophylactic intubation were higher in the prophylactic intubation group than in the non-intubation group (42% versus 18.79%,  $p = 0.03$ ). In general, normal medical clinics remain of both partners and, in general, normal stays at the ICU were comparable. The ESC after a normal stay in the intensive care unit was significantly longer in the prophylactic intubation group than the absence of intubation ( $5.8 \pm 4.8$  days versus  $3.7 \pm 3.8$  days,  $p = 0.003$ ).*

***Conclusion:** Our review revealed that prophylactic intubation before pressing the EGD for varicose drainage (VH) did not improve clinical outcomes. Our finding recommends against routine prophylactic intubation in patients with HV with mild encephalopathy and without continuous drainage.*

***Keywords:** Variceal hemorrhage (VH); endoscopic variceal ligation (EVL); esophagogastroduodenoscopy (EGD); medical intensive care unit (MICU); model for end-stage liver disease (MELD); standard deviation (SD); upper gastrointestinal bleeding (UGIB)*

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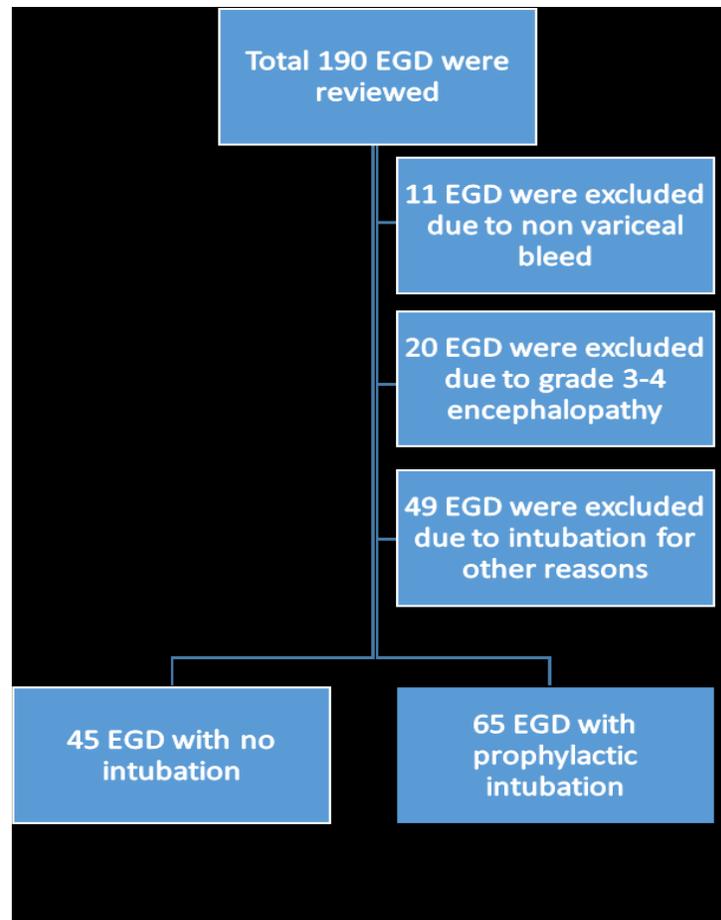
**INTRODUCTION:**

Variceal discharge (VH) is the most terrible result of entry hypertension, which speaks to the main source of death in cirrhotic patients. Despite the improvement in indicative and restorative measures, the mortality rate of HEVs remains high at 17-23% [1]. Endoscopic varicose vein ligation (EVLV) is present in the first line for the treatment of VH. A serious endoscopy (within 14 hours of confirmation) is prescribed for suspected bladder hemorrhage cases. Honeycomb endoscopy for upper gastrointestinal drainage has been associated with inconvenience rates several times higher (9%) than non-critical endoscopy (0.8%) [2]. It has been found that in these circumstances, cardiopulmonary complexities account for half of each unfriendly occasion and are responsible for 55-65% of the passages. The objective during endoscopy and the resulting goal pneumonia are considered to be serious cardiopulmonary entanglement problems [3]. Huge volumes of blood located in the stomach and near the lower esophageal sphincter are considered the potential danger of desire during a serious esophagogastroduodenoscopy (EGD) for variceal drainage. In order to avoid the desire, prophylactic intubation is all the more normally received in the days preceding the SSC [4]. However, despite wide use, there is limited evidence that prophylactic intubation improves tolerance results. Our review plans to evaluate the impacts and tangles identified with prophylactic intubation prior to serious endoscopy for HV by correlating the grouping of patients who have undergone prophylactic intubation with those who have not undergone intubation in our organization [5].

**METHODOLOGY:**

Our current research was led at Services Hospital Lahore from February 2017 to May 2018. The main results of the examination were rapid aspiration, post-EGD pneumonia, death and various complexities. The approval of the institution's audit board for the review

agreement was obtained before the information set was available. We verified the therapeutic records of patients who suffered from severe ESC at the bedside within 14 hours of the suspected HT being reported in the medical emergency unit of the Rutgers-New Jersey University Medical School Hospital, Newark from 1/1/2008 to 31/12/2013. Intake criteria included known cirrhosis and hematemesis with the discovery of ESCs for dynamic drainage of varicose veins or blood into the stomach in addition to the proximity of varicose veins with high-risk stigmas. The prohibition criteria included (1) hematemesis for reasons other than varicose drainage; (2) intubation for other conditions prior to ESC, for example, respiratory suffering, unstable cardiopulmonary status, air safety justified by a huge volume of blood in the proximal GI tract; (3) the presence of hepatic encephalopathy in the vicinity of 3 or more assessments; (4) indications of pneumonia or deviation from the lung radians of the standard preceding the EBD. The West Haven Grading System rating scale was used to legitimize the assessment of hepatic encephalopathy. In most cases, the ESC was performed by a related learner under the supervision of a staff gastroenterologist. Prophylactic endotracheal intubation was mentioned by the gastroenterologist performing the technique. The intubation was completed by the staff's anesthesia providers. Patients were generally calmed down with propofol. The main results of the examination were rapid nostalgia, post-EGD pneumonia, death or various complexities. Ancillary outcomes included intensive care after the ESC, intensive care after the ESC, all intensive care after the ESC and all medical clinics after the ESC. Pneumonia was characterized as a new invasion of the X-ray beam of the chest in addition to the two findings that accompanied it within 48 hours of the ESC: fever (temperature > 100.8 Fahrenheit), leukocytosis (white platelet control > 10,000 / mm<sup>3</sup>) or purulent sputum.



#### Information survey:

Frank information was provided to some extent. Constant information was abbreviated as an average  $\pm$  standard deviation (SD). The sub-study t-test was used for the examination between two consistent information collections. An accurate Fisher test was used for the review between two collections of all the information. The immensity of the facts was considered to have been accomplished with a self-esteem of  $<0.06$  (two tails).

#### RESULTS:

A total of 190 ESCs (171 patients) for suspected HBV cases were verified. 120 ESC events met the review consideration criteria. 69 cases of ESC were treated with prophylactic intubation and 48 cases were treated without intubation. 13 cases were rejected because it was not varicose vein death. 24 cases were banned because of extreme hepatic encephalopathy (grade 3-4). 53 cases were rejected due to the fact that patients had been intubated for different reasons before endoscopy. Figure 1 shows how the cases were attached to the investigation. Restorative co-morbidities are comparable between the two

accomplices, with regard to dynamic substance abuse, intense contamination, dynamic pneumonia, heart disorders, aspiratory disorders, diabetes, danger, neurological and gastroenterological disorders. The clinical seriousness of the statement is comparative in both meetings. The Kid Pugh score was  $11 \pm 4$  for prophylactic intubation and  $8 \pm 3$  for intubation without intubation ( $p = 0.055$ ). The fusion score was  $21 \pm 10$  for prophylactic intubation and  $19 \pm 8$  for intubation ( $p = 0.537$ ). Ascites was observed in 53.9% of patients who received prophylactic intubation and 47.8% of patients who received no intubation ( $p = 0.813$ ). All patients with encephalopathy greater than grade 3 encephalopathy are considered not ready to protect the airway and could not be studied. In patients recalled for the study, grade 2 encephalopathy was introduced in 22.6% of patients with prophylactic intubation and 9.8% of patients with no intubation ( $p=0.118$ ). Table 1 presents the socio-economic characteristics, clinical highlights and co-morbidities of two partners. All deaths were found to be related to cardiovascular disease. Only one case of rapid aspiration was reported during a prophylactic intubation session. Pneumonia created in 7 out of 65

cases in prophylactic intubation and 1 out of 48 cases in the absence of intubation (10.78% versus 2.3%,  $p = 0.143$ ). The main special cases were generally non-cardiac and aspiratory complexities that were discovered in 40% of cases during prophylactic intubation and in 18.79% of cases without intubation ( $p = 0.03$ ). The length of stay was the auxiliary result of this survey. We found that, overall, the number of normal emergency days for both partners was comparable ( $11.7 \pm 8.8$  days versus  $9.7 \pm 8.6$  days,  $p =$

0.234). The overall normal length of stay in the intensive care unit was also compared in both encounters ( $5.4 \pm 5.0$  days versus  $5.4 \pm 3.4$  days,  $p = 0.171$ ). It is intriguing to note that the normal stay in intensive care after an ESC is much longer in a prophylactic intubation session ( $5.8 \pm 4.8$  days) than in an absence of an intubation session ( $3.5 \pm 2.7$  days,  $p = 0.003$ ). Table 2 summarizes the key results and second results of the review.

**Table 1 Demographics, etiology of cirrhosis and comorbidities of cases.**

Characteristics	Less than 5 total admissions (N = 500)	5 or more total admissions (N = 87)	P value
Age*	56.7±12.6	53.1±12.0	0.01
Male gender N (%)	278 (56)	39 (45)	0.97
Race N (%)			0.02 <sup>‡</sup>
Caucasian	438 (88)	69 (79)	
African-American	44 (9)	15 (17)	
Other	4 (1)	2 (2)	
Married N (%)	270 (54)	41 (47)	0.28
Diabetes	52 (10)	35 (40)	0.03
BMI*	26.5±5.3	27.3±6.2	0.43
Etiology of Liver Disease			0.24
Alcohol	121 (24)	28 (32)	
Viral +/- Alcohol	176 (35)	25 (29)	
Other	203 (41)	34 (39)	
Alcohol-related etiology	139 (28)	34 (39)	0.045
MELD score N (%)			<0.0001
<15	276 (55)	12 (14)	
15–20	141 (28)	44 (51)	
21–30	79 (16)	27 (31)	
31–40	4 (1)	4 (5)	
MELD score index admission*	14.4±6.0	19.1±4.8	<0.0001
Blood Type			0.39 <sup>‡</sup>
O	180 (36)	35 (40)	
A	155 (31)	31 (36)	
B	46 (9)	10 (11)	
AB	7 (1)	4 (5)	
Initial length of stay (days)* <sup>+</sup>	5.0±5.1 3.8 (2.0, 6.0)	5.4±4.5 4.1 (2.7, 7.2)	0.43 0.10
Non-cirrhosis-related index admission	248 (50)	22 (26)	<0.0001
Encephalopathy-related index admission	74 (15)	21 (24)	0.04
Volume-related index admission**	91 (18)	31 (36)	0.0004
Bleeding-related index admission	38 (8)	6 (7)	0.99
Length of follow up (days)*	232±82	281±70	<0.0001
Death during study N (%)	28 (6)	14 (16)	0.001
Transplant during study N (%)	30 (6)	14 (16)	0.002

\*Mean ± sd, p value calculated using t-test.

<sup>‡</sup>Fisher's Exact test used, numbers do not sum to 100% given missing values.

\*\*Volume-related index admission = renal failure, ascites, or hydrothorax.

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**Table 2:** Length of stay and medical results of cases.

Variable	No Intubation	Prophylactic Intubation	P Value
Death >24 hours	6.7% (3)	18.5% (12)	0.097
Death< 24 hours	2.2% (1)	4.6% (3)	0.643
Over-all demise Cardiac	2.2% (1)	4.6% (3)	0.643
problems< 24 hours	8.9% (4)	23.1% (15)	0.072
Intubation Pneumonia	17.78% (8)	40.0% (26)	0.020*
Other complication	0.0% (0)	1.5% (1)	1
Immediate Aspiration after	2.2% (1)	10.77% (7)	0.142

**DISCUSSION:**

VH is known to be identified with a huge volume of blood in the upper gastrointestinal tract and a high risk of aspiration. Meanwhile, simultaneous hepatic encephalopathy exacerbates the patient's ability to ensure the aviation route, which reasonably concerns the clinician about the desire triggered by ESCs. The AASLD (American Association for the Study of Liver Diseases) and ASGE (American Society for Gastrointestinal Endoscopy) have hypothesized in their training rules that intubation before an ESC is energetically recommended for goal aversion [6]. In any case, the level of proposal is extremely low due to the lack of solid evidence. There are just a few small investigations to inspect the suspicion of prophylactic intubation can avoid the desire. The results are questionable. Lipper et al. found that 20% of the 30 patients with severe upper gastrointestinal bleeding (IUBU) without intubation had new pneumonic penetration and no cases in intubated patients [7]. It is important to note that the use of prophylactic intubation for ESC was becoming more and more common nowadays. Rodolph et al. found that, in his organization, the number of patients who underwent intubation before ESC was significantly lower in 1989 than in 1994, regardless of the extent of intubation during hospitalization and that it had not changed. Koch et al. also found that more intubated patients were available for his evaluation study than non-intubated patients. Our discoveries are predictable with the above [8]. Between 2012 and 2015, 69 cases were treated with prophylactic intubation and only 47 cases were treated without prophylactic intubation in our foundation. There are some qualities of our exam. The first is that it is so far the largest investigation into the outcome of prophylactic intubation in an explicit population with varicose death [9]. Our investigation prohibited patients whose mental state had been severely altered or whose progressive discharge had been interrupted, who had requested prophylactic intubation for airway insurance and who had focused on a subgroup with varicose oozing with a relatively stable mental and hemodynamic state, from having intubation from which they could be abused. The other

quality is that we evaluated the clinic and intensive care unit as an optional outcome, which has never been examined in a previous survey. We found that it should be noted that intensive care units after intubation are still in the process of collecting intubations, which can lead to an increase in the cost of medical services [10].

**CONCLUSION:**

Our review revealed that prophylactic intubation prior to pressing the ESC for HV did not improve clinical outcomes. In addition, he demonstrated that the rate of non-cardiorespiratory difficulties was higher and that the duration of post-technical intensive care was longer. We advise against routine prophylactic intubation in patients with HV with mild encephalopathy and without continuous discharge, as routine prophylactic intubation has no advantage and does not allow appropriate use of social insurance assets.

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