
Introduction: Total gastrectomy for gastric cancer is associated with significant perioperative morbidity. Patient factors associated with morbidity and mortality after total gastrectomy have not been well characterized. Identification of patients who are at particularly increased perioperative risk may inform decisions for more thorough staging including separate diagnostic laparoscopy, and for consideration of perioperative chemotherapy. Methods: The American College of Surgeons National Surgical Quality Improvement Program Participant Use File (ACS NSQIP PUF) (FY 2005-2011) was queried for all patients with a gastric neoplasm (ICD-9 Codes 151 and 1510-1519) undergoing total gastrectomy (CPTs 43620-43622) or diagnostic laparoscopy (CPTs 49320-49322, 49329). 30-day M+M was considered the primary outcome. Risk factors and M+M were compared using the Chi-square test or the Fisher’s exact test, as appropriate. Multivariate logistic regression analyses were performed to identify factors associated with an increased risk of M+M. Results: Of 5,696 patients with gastric malignancy, 1,165 underwent total gastrectomy. Independently, 229 were reported as undergoing separate staging laparoscopy. The mean age of total gastrectomy patients was 64 and the majority were male (60%). 789 complications and 55 deaths (4.7%) occurred in 421 patients, for an overall M+M rate of 36%. The most common complications observed were respiratory (16%), sepsis (15%), and abdominal infections (9%). By univariate analysis, age, functional status, body mass index (BMI), diabetes, chronic obstructive pulmonary disease, and preoperative weight loss, chemotherapy, albumin, bilirubin and hematocrit were all associated with M+M (p<0.01). By multivariate analysis, age >70 (OR = 1.48), BMI < 30 (OR = 1.74), preoperative weight loss (OR = 1.80), and preoperative albumin <3 g/dl (OR = 1.68) were significantly associated with increased M+M (p < 0.05 for each). In patients without these significant risk factors (n=332) the M+M rate was 24%. M+M was significantly increased in patients with one risk factor (41%, n=416), two risk factors (47%, n=156), or three or more risk factors (77%, n=26) (p<0.0001). In patients with 3 or more risk factors, the 30-day mortality was 31%. Conclusions: Total gastrectomy for malignancy is associated with an M+M rate of 24% in even the lowest risk patients. In elderly patients, those with obesity, and those with poor preoperative nutritional status, M+M is significantly increased (upwards of 40%). Given the high M+M rate, appropriate patients should be selected for a separate staging laparoscopy. Further, in high-risk patients, consideration should be given for perioperative chemotherapy as morbidity may preclude successful adjuvant therapy.
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