Patients scheduled for admission to intensive care unit: satisfaction with the information and frame of mind

Editor—From the time of diagnosis through to treatment patients and their family or primary caregivers may experience emotional stresses,1 such as anxiety. It is broadly recognized that preoperative anxiety experienced by patients can have a negative impact on their subsequent recovery.2 After surgery, some patients are admitted to the intensive care unit (ICU), an environment which is considered to have a negative psychological effect on patients. In this setting, patients can develop a number of psychological alterations3 which can even lead to prolonged hospital stay,4 may continue to cause distress for several months after the patient is discharged from hospital,5 and may even constitute a post-traumatic stress disorder (PTSD).6

Information is a useful tool for facilitating the patient’s adaptation to the situation and the prevention of problems.5 However, although satisfaction with information seems to be the key aspect for the patient’s benefit, account must be taken of individual patients.7 That is, although the amount of information provided is effective for some individuals in diminishing their anxiety and facilitating their recovery, the same information may not be effective for other patients.

We have carried out a survey-based descriptive study focused on assessing the degree of satisfaction and need for information, and the anxiety and depression levels, of a series of consecutive 158 patients whose elective surgical procedure includes an ICU stay in the Valencia General University Hospital, Valencia, Spain (CHGUV). All subjects were interviewed at the end of the pre-anaesthesia visit conducted by the anaesthetist. The results showed that patients showed significant levels of depression (mild, 28%; moderate, 8.3%; and severe, 3.2%) and anxiety (22.5% females). Patients had a medium level of satisfaction (mean=6, sd=2, min=0, max=10) with the information received at that time about the disease, surgery, anaesthesia, hospital stay, and recovery, whereas their need for information was higher (mean=8, sd=2, min=0, max=10). Subjects were assigned to two groups based on their satisfaction with information scores (high or low satisfaction), and statistical analysis were made to compare depression and anxiety between the groups. Patients grouped as having a low level of satisfaction with the information showed higher levels of depression (mild depression) than the high level of satisfaction patients (low satisfaction group: BDI=10, sd=8; high satisfaction group: BDI=7; sd=6; two-sided significance=0.011), which shows the role of information as a variable involved in the patients’ mood, in terms of depression, but no significant differences were found in the level of anxiety.

On the basis of these results, and previous literature, we argue that intervention for these patients should be considered in order to improve their psychological status and the recovery process, and to prevent the development of long-term problems, such as PTSD, by implementing the following two key aspects.

1. First, the significant level of anxiety and depression in these patients emphasizes the need to conduct an assessment before surgery to detect this and, if necessary, provide the appropriate psychological support. Several studies have shown the negative impact of these alterations on the subsequent recovery process and the associated higher risk of postoperative complications (infection, slower wound healing, etc.).8–10

2. Secondly, our results show that satisfaction with the preoperative information received can influence the emotional status of the patient. Therefore, it is of fundamental importance to provide patients with the appropriate information tailored to their needs. Patients should be assessed before operation for their information needs to determine the amount of knowledge they wish to receive and their preferences for coping with the situation. Some patients prefer to have only general information, but others request more comprehensive details. However, in some cases, providing patients with more information than they need or want may aggravate their levels of anxiety.7

This intervention should be included within the framework of a multidisciplinary team approach, covering both their physical needs related to the disease and their psychological needs. It would be interesting to evaluate the potential contribution of a psychologist as a member of this multidisciplinary team in charge of the integrated management of these patients in acute care units.1,2

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Drug-eluting stent thrombosis in patients undergoing non-cardiac surgery

Editor—I read with great interest the recent article by Godet and colleagues on drug-eluting stent (DES) thrombosis. Recent literature indicates that barring neurosurgery, the risk of bleeding is small if the antipatelet medication is continued, but the risk of acute coronary event due to stent thrombosis is high if the medication is discontinued. The risk of a cardiac event is greater in patients with recent stents.

The results of Godet’s study suggest that the risk of specific thrombotic complications of DES is uncommon, despite discontinuing the antipatelet medicines. However, analysis of the results reveals that the delay between DES and surgery was 14 months. The details of this delay are not provided, but the risk of acute coronary event due to stent thrombosis (IST) and increased bleeding. As a result, we did not observe an increased risk of bleeding in our patients (bleeding is a well-known factor for postoperative cardiac complication in such patients). Concerning our attitude for management of antipatelet agents, the low incidence of IST in this series does not allow us to demonstrate a strong relation between IST, on the one hand, and both delay between DES insertion and surgery, or discontinuation of antipatelet agents, on the other.

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Editor—We would like to thank Dr Tempe for his interest in our paper. In our article, the mean delay between DES insertion and date for non-cardiac surgery is 14 months (see Table 1 in Godet and colleagues). However, both SD (11 months) and range (1 week–36 months) show that the ideal 1 yr duration for clopidogrel treatment was not always attained in our series of patients. In fact, clopidogrel was discontinued mainly because of the need for surgery which was unplanned at the time of coronary revascularization. In contrast to the more dogmatic AHA-ACC guidelines, a short discontinuation of clopidogrel was decided on by the anaesthetists and surgeons of our team, with the advice of a cardiologist, in relation to the relative risks for (i) in-stent thrombosis (IST) and (ii) increased bleeding. As a result, we did not observe an increased risk of bleeding in our patients (bleeding is a well-known factor for postoperative cardiac complication in such patients). Concerning our attitude for management of antipatelet agents, the low incidence of IST in this series does not allow us to demonstrate a strong relation between IST, on the one hand, and both delay between DES insertion and surgery, or discontinuation of antipatelet agents, on the other.

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