An audit of splenectomies in a teaching hospital in North India. Are postsplenectomy guidelines being complied with?

M Deodhar, N Kakkar

Aims: Patients with an absent or dysfunctional spleen are at risk of infection by encapsulated and other bacteria. Overwhelming postsplenectomy infection (OPSI) causes most concern because it can result in significant mortality. A retrospective review of splenectomised patients in a tertiary care setting over an eight year period was carried out to determine whether current postsplenectomy guidelines were being followed.

Methods: The cases were identified from the medical records and pathology files and data such as the reason for splenectomy, the preventive measures taken regarding vaccination, and antibiotic prophylaxis, together with their documentation in the discharge notes were assessed.

Results: Fifty six patients were studied. Trauma, both blunt and penetrating, was the most common reason for splenectomy. Thirty six patients received pneumococcal vaccination, with 20 patients having no mention of vaccination in their case notes. The discharge notes of 50 patients mentioned their splenectomised status; however, documentation of vaccination details in the discharge summary was poor, with only three patients having the relevant information recorded. Documentation of the need for future vaccination and precautions required in the asplenic condition was also lacking. Nine patients had postsplenectomy complications, although there were no cases of OPSI.

Conclusions: Adherence to standard guidelines for the management of splenectomised patients was unsatisfactory. There is a need for an improvement of the vaccination rate and careful documentation of this important health risk in the discharge summaries. Maintenance of a splenectomy registry could aid in optimising the management of these patients.
Table 1 Reasons for splenectomy among the 56 patients in our study group

<table>
<thead>
<tr>
<th>Indication for splenectomy</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic</td>
<td></td>
</tr>
<tr>
<td>Blunt trauma</td>
<td>47</td>
</tr>
<tr>
<td>Penetrating trauma</td>
<td>3</td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>1</td>
</tr>
<tr>
<td>Non-haematological</td>
<td></td>
</tr>
<tr>
<td>Portal hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Carcinoma, stomach</td>
<td>1</td>
</tr>
<tr>
<td>Carcinoma, pancreas</td>
<td>1</td>
</tr>
<tr>
<td>Carcinoma, kidney</td>
<td>1</td>
</tr>
<tr>
<td>Haematological</td>
<td></td>
</tr>
<tr>
<td>B cell non-Hodgkin lymphoma</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2 The complications encountered in nine patients after splenectomy

<table>
<thead>
<tr>
<th>Postsplenectomy complication</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute renal failure</td>
<td>2</td>
</tr>
<tr>
<td>Wound infection*</td>
<td>2</td>
</tr>
<tr>
<td>Subacute intestinal obstruction*</td>
<td>1</td>
</tr>
<tr>
<td>Incisional hernia*</td>
<td>1</td>
</tr>
<tr>
<td>Hepatic encephalopathy</td>
<td>1</td>
</tr>
<tr>
<td>Subphrenic abscess*</td>
<td>1</td>
</tr>
<tr>
<td>Malaria (Plasmodium falciparum)</td>
<td>1</td>
</tr>
</tbody>
</table>

Five patients who had non-traumatic indications—both haematological and non-haematological. Table 1 lists the details.

Along with the splenic injury, 23 patients also suffered from skeletal injuries, including fracture of the pelvis, ribs, and long bones, whereas 11 patients had associated soft tissue and visceral trauma.

Thirty-six of the 56 patients included in our study received prophylactic vaccination. Only pneumococcal (PNEUMOVAC) vaccination was used for prophylaxis. None of the patients received vaccination for Neisseria meningitides or Haemophilus influenzae. Thirty-four patients received the vaccine postoperatively and two were vaccinated in the preoperative period. Both the patients who received preoperative vaccine prophylaxis underwent elective splenectomies for non-traumatic indications. Postsplenectomy vaccination was given within a time frame of 1–26 days, with 17 of the patients receiving the vaccine within 48 hours of surgery and three patients being vaccinated more than two weeks after splenectomy. The case records of 20 patients did not reveal documentation of vaccination.

Fifty-three of the 56 patients received a discharge summary; 50 of these patients had their splenectomised status mentioned in the discharge notes. The vaccination status was documented in only three patients. The discharge summary in only two patients mentioned the need for future vaccination, and two patients were advised regarding the necessity of lifelong antibiotic prophylaxis.

None of the patients was given a card highlighting the precautions to be taken after splenectomy, as is recommended.

The follow-up period ranged from seven to 790 days (mean, 116.1). Four patients were lost to follow-up. Nine patients had postoperative complications, which were related to the surgical procedure itself in five. However, none of the complications qualified as overwhelming post splenectomy infection (OPSI). Table 2 lists the complications encountered.

DISCUSSION

The asplenic state is a health risk increasingly being recognised by health professionals all over the world. Infection in patients with an absent or dysfunctional spleen remains largely preventable. Many measures have been proposed to reduce the risk of sepsis after splenectomy, which include chemoprophylaxis, immunoprophylaxis, and patient/clinician education.

Other than the known susceptibility of splenectomised individuals to encapsulated bacteria (Streptococcus pneumoniae, N meningitides, and H influenzae), there is evidence to suggest that other organisms, such as Gram negative bacteria and Capnocytophaga canimorsus, in addition to intraerythrocytic parasites, such as babesia and plasmodium, can cause infections and carry considerable morbidity.

The pneumococcal vaccine, first introduced in the 1970s, presently includes 23 serotypes responsible for approximately 88% of pneumococcal infections. However, the most virulent pneumococcal serotypes tend to be the least immunogenic, and there is clear evidence that vaccine efficacy is poorest in younger patients who, unfortunately, also comprise the highest risk group.

Pneumococcal vaccine protection rates are 70% in a healthy immunocompetent host because approximately 10% of possible antibody responses to individual antigens do not occur. The British Committee for Standards in Haematology first published guidelines for the prevention and treatment of infection in asplenic and hyposplenic patients in 1996. The salient aspects of these guidelines are related to anti-infective prophylaxis, immunisation schedules, and treatment of confirmed or suspected infections. These guidelines have recently been updated with minor amendments. A newer recommendation has been to include the use of the meningococcal vaccine in previously non-immunised patients and a need to consider the use of the seven valent pneumococcal vaccine.

However, vaccination should not result in a false sense of security because vaccine failures are frequent. There are relatively fewer studies previously carried out to determine the vaccination status and use of antibiotic prophylaxis in splenectomised subjects.

Brighden et al performed an audit on 164 hospitalised patients who underwent splenectomies in British Columbia, Canada. Sixty-eight percent of patients had received pneumococcal vaccination. Of the 55 patients who underwent elective surgery, only 11 received preoperative vaccination. Most (95%) of the patients had documentation of their splenectomised status in their discharge summaries. However, documentation of the vaccination status, the need for future vaccination, and information on future infection risks was inadequate, with only 21%, 6%, and 5% of the discharge notes giving this information, respectively.

Ramachandra et al studied postsplenectomy prophylaxis status in 76 patients from a general hospital. Fifty-five of the patients had received vaccination, whereas 48 were discharged on prophylactic antibiotics. Eighty-one percent of the surviving patients in their study had adequate communication with the general practitioner regarding their splenectomised status. In their study, patients undergoing non-elective splenectomy were less likely to be vaccinated or to receive prophylactic antibiotics.

In another study, among 28 patients who underwent splenectomy in a district hospital, trauma was the indication in only four patients. The remaining 24 patients either had haematological indications or had their spleen removed as part of other abdominal surgery. Most patients were prescribed pneumococcal vaccine (24) or prophylactic antibiotics (26).
A study to evaluate postsplenectomy vaccine prophylaxis in Lothian, UK, revealed that 80.6% of the patients were vaccinated against *S. pneumoniae*. The vaccination rates for *H. influenzae* and *N. meningitidis* were 65.9% and 48.2%, respectively. Three quarters of the splenectomised patients were prescribed longterm antibiotic prophylaxis.16

Ejstrud et al evaluated pneumococcal vaccine prophylaxis in 555 patients who underwent splenectomy over a 10 year period.17 Vaccination rates were 62%, with patients undergoing splenectomy during cancer surgery or after inadvertent intraoperative trauma particularly at risk of not receiving vaccination. Only 23% of the patients were vaccinated at the appropriate time, with the splenectomy status unrecorded in 10% of cases. Vaccination status was mentioned in 35% of the discharge notes, whereas only 2% mentioned the precautions to be taken for asplenic patients.

“Although 50 of the 53 discharge summaries issued mentioned the splenectomised status of patients, only three mentioned the vaccination status”

Waghorn18 studied data on 77 asplenic patients who developed OPSI by means of a questionnaire survey among microbiologists across the UK. Overall mortality with OPSI was 50%. Only 24 patients had received prophylactic pneumococcal vaccination before OPSI. There were seven cases of pneumococcal vaccine failure. Accepted guidelines were not being followed, with only a few patients being adequately advised on antibiotic prophylaxis or other measures. Most similar published studies in patients who have undergone splenectomy have shown that standard guidelines regarding vaccination and antibiotic prophylaxis are not followed strictly. Our study has also shown inadequacies in the adherence to currently accepted postsplenectomy management strategies. The overall vaccination rate in our study was 64.3%, which is comparable to most other reports. However, alarmingly, 20 of the 56 patients in our study did not receive vaccination. Most of the patients received the vaccination postoperatively, which is understandable, because most splenectomies were carried out as emergency procedures for splenic trauma. Although 50 of the 53 discharge summaries issued mentioned the splenectomised status of patients, only three mentioned the vaccination status. The need for future vaccination and antibiotic prophylaxis was also poorly documented. Documentation of extra caution to be taken by patients in the wake of any infections was poorly documented. Similarly, there was no record in the case notes to suggest that the patients were given a card and/or bracelet specifying their asplenic condition, information that could be vital for their general practitioner. Medical personnel dealing with asplenic patients need to be more vigilant in ensuring that prophylactic vaccination and antibiotic schedules are followed and in educating patients about their asplenic state. Maintenance of a hospital splenectomy registry can aid in keeping track of the health status of this potential risk group. A protocol sheet could be included in the case notes of the patient and the subsequent follow up should be documented on it. This should help to ensure compliance with regard to postsplenectomy guidelines (appendix 1).

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APPENDIX 1
SUGGESTED PROTOCOL FOR AFTERCARE OF THE SPLENECTOMISED PATIENT

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Protocol sheet to be included in the patient’s case notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Hospital identification number</td>
<td></td>
</tr>
<tr>
<td>Splenectomy performed on (date)</td>
<td></td>
</tr>
<tr>
<td>Indication</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal vaccination given (yes/no)</td>
<td></td>
</tr>
<tr>
<td>If vaccinated, vaccination given on (date)</td>
<td></td>
</tr>
<tr>
<td>Type of vaccine</td>
<td></td>
</tr>
<tr>
<td>Next booster due on (date)</td>
<td></td>
</tr>
<tr>
<td>Any other vaccination (meningococcal/influenza)</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Antibiotic prophylaxis (received/not received)</td>
<td></td>
</tr>
</tbody>
</table>

**Information to patients (check list)**

- Patient informed about risk of infections.
- Information on booster dose given.
- Educational booklet/leaflet given.
- Splenectomy card/bracelet.
- Education about risks of overseas travel.
- Importance of lifelong antibiotic prophylaxis.

REFERENCES

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