

Palliative care consults in oncology: what are we waiting for? A case report

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Abstract

Palliative care focuses on symptom management and decreased suffering in all aspects of health. Although it has been shown that palliative care improves emotional and clinical outcomes for patients and families, it remains an underutilized specialty particularly in the field of oncology. Involving cancer patients in palliative care can sometimes be confused with the idea of giving up, or losing hope. This is especially true when patients are young. The following case report provides an example of a patient who may have benefited from palliative specialists' involvement early in his disease, potentially sparing him and his family prolonged, physical, and emotional suffering.

Keywords

End of life, palliative care, oncology

Introduction

The World Health Organization defines palliative care as

an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.¹

In a phase III randomized control trial (RCT) of patients with metastatic non-small-cell lung cancer, the author found that early involvement of patients in palliative care combined with standard cancer care lead to better patient outcomes evidenced by decreased distressing symptoms, improved quality of life, patient and family satisfaction, decreased caregiver burden, and survival despite less aggressive end-of-life care.² In the United States, a total of 577,190 deaths from cancer are projected for the year 2020.³ Globally, there will be 15 million new cancer cases, and most will die within one year.⁴ By 2020, demands for oncology services are expected to significantly outweigh the supply of oncologists available to provide complex cancer care in an era where oncologists are already feeling the effects of caregiver burnout.^{5,6}

Case report

This is a case of a 40-year-old Asian man with parotid cancer metastatic to his brain, lung, liver, and bone. Over a 10-year period, he completed several courses of radiation,

chemotherapy, and palliative whole brain radiation (XRT). He presented to the hospital with a complaint of urinary retention and ascending paralysis to his waist over a period of 3 h. A magnetic resonance image (MRI) revealed a large spinal tumor. The patient received emergent XRT to his spine and developed rapid upper body weakness and respiratory distress. The neuro-oncology team discussed his prognosis in great detail offering palliative supportive measures versus intubation. The patient was cognitively intact and chose to be electively intubated, without sedation, in anticipation of his wife's arrival from overseas. When she arrived, the neuro-oncology team updated her on her husband's medical issues and grave prognosis. The following day the patient stated, "I want to die today." When the team restated his wishes, the patient replied, "I want you to take this tube out, and I want to die today." The patient's wife requested we allow her and her husband privacy to discuss his wishes and absorb the gravity of the situation. The next day, when asked if he wanted to discuss withdrawal of life support, the patient mouthed, "I changed my mind, I want to live as long as possible, I want you to do whatever my wife wants." He received a feeding tube and tracheotomy the following day, and his postoperative course was complicated

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by pneumonia, hypotension, and sepsis requiring intensive care. On day 19 of his hospitalization, the patient again stated, “I want to die.” The team advocated to his wife that his wishes be honored, but she believed he was confused despite our assessment that he was cognitively intact. On day 21, the patient said, “I want you to take away the tube and let me die.” A family meeting with the neuro-oncology team, a palliative care specialist, and the patient’s wife was called. She did not agree to extubation and was unavailable to the team and her husband for the next 48 h. On day 24, the patients’ condition deteriorated, and he became confused and agitated. His wife asked for a meeting with the health-care team and requested withdrawal of life support. He was transferred to a private room and died peacefully within 2 h after extubation, surrounded by his wife, family, friends, and several members of the neuro-oncology team.

Discussion/conclusion

Cancer patients and their families present the oncologist with often complex ethical, emotional, spiritual, cultural, and medical concerns. The issue of patient and caregiver burden is especially relevant in this case, supporting the need for early intervention of palliative care as part of a multidisciplinary team approach in the oncology setting. With palliative care involvement over various stages in this patient’s disease course, the goals of treatment could have been more clearly redefined, and options for oncological treatment and supportive care explained in an open and honest way, so that new plans could have been made together with the patient and his wife, alleviating the burden of decision-making in crisis mode. Several RCTs comparing standard oncology care to oncology care with palliative measures have shown that in the palliative care groups, patients and families reported increased completion of advanced directive, improved spiritual well-being,⁷ reduced emergency room visits and hospital stays,⁸ greater satisfaction with care experience and provider communication,⁹ improvement in quality of life, lower symptom intensity, and a reduction in depressed mood.^{2,10} In a physician survey regarding utilization of an inpatient palliative care service, the majority of respondents felt that while all physicians should be expert in managing symptoms of advanced disease, most rated their level of training and perceived expertise in the delivery of palliative care as deficient.¹¹ Palliative care specialists are in an excellent position to support oncology professionals in providing comprehensive care with a focus on dignity and a goal of improving patients’ and families’ quality of life. The American Society of Clinical Oncology is now recommending the integration of

palliative care throughout the experience of cancer as part of their mission to achieve the best comprehensive cancer care by 2020.¹² The best time to implement this addition to comprehensive cancer care is now.

Declaration of conflicting interests

The author declares that there is no conflict of interest.

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