Poor Prognosis vs. The Second Opinion

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- Clinical Interests:
  - chronic pain management, palliative care interface with benign/malignant hematologic disorders, neoplastic disorders/medical oncology, growing field of palliative care globally, particularly implementation in developing sub-Saharan countries

*Disclosures

- **Mentors:** Dr. Mackie, Dr. Deamant: Palliative Medicine Attendings (Stroger/Cook County Hospital)

- The author of this presentation has **no financial or personal relationships with commercial entities** that may have a direct or indirect interest in the subject matter of this presentation

Objectives

- Early integration of palliative care -> improve end-of-life patient outcomes
- Alleviation of symptom distress, clear and sensitive communication, alignment of treatment with patient preferences, family support and continuity across clinical settings.
- Early in a patient's disease course, Palliative care specialists can identify patient goals within the 'domains of palliative care', as well as optimize symptom management

Objectives

- This presentation aims to discuss an oncology patient dealing with symptoms related to advanced, incurable cancer while they seek a second opinion for treatment

- Defining interventions:
  - Curative vs Rehabilitative vs Palliative vs ?Psycho-sociotherapeutic?

- Balancing hope vs. Quality palliative care
  - Fostering patient trust

Meeting Angela

34yr old F (Angela)

- Cowden syndrome (PTEN gene carrier)
- Unresectable metastatic colonic adenocarcinoma (dx'd 2015)
- s/p R.hemicolectomy (2015)
- c/b recurrence at anastamosis s/p resection of anastamosis
- Rectal stricture s/p diverting loop colostomy and L.salpingo-oopherectomy (2020)
- c/b proximal colonic stricture s/p colonic stenting at hepatic flexure
- s/p diverting loop ileostomy (2021)
- c/b peritoneal carcinomatosis
- Bilateral hydronephrosis 2/2 tumor burden s/p bilateral PCNs
- Severe protein-calorie malnutrition (on chronic TPN via port-a-cath)
- Multiple recurrent SBOs s/p venting G-tube --> high G-tube output (> 2,500cc/day)
- Recurrent GI bleeding
- Intractable nausea/vomiting

Meeting Angela

- Social History
  - Parents divorced, in a contentious co-parenting relationship
  - Patient previously living with her partner, family not involved in her care, unaware of extent of disease
  - Complex family grief: recent loss of patient's sibling (sudden death while sleeping, etiology unascertained

Meeting Angela

- Physical Exam:
  - Chronically ill-appearing, emaciated
  - Bitemporal, periorbital wasting, conjunctival pallor
  - Distended abdomen, large volume billious output per G-tube, scant mucosanguinous stool per stoma, dark concentrated urine in PCNs
  - Diffuse MSK wasting

Meeting Angela

- Palliative consulted for complex medical decision making and symptom management
- Fentanyl TD dose escalated to 150mcg/hr q72hr
- Patient on Hydromorphone PCA 2mg q15min, 8mg 1hr lockout
- Limited options for neuropathic adjuvants (high Gtube output, poor PO tolerance
- Rush Med-Onc deemed patient unsafe for further cancer-directed therapy

Family Meeting

- Patient's parents with limited understanding of extent of disease
  - (she has <u>many bags to relieve pressure from some blockages</u>, but **<u>they are now refusing to treat her cancer</u>**)

- Patient's family received a "<u>miraculous call</u>": a doctor reached out to us suggesting chemo drug called "Keytruda"

- Family perceiving <u>cultural barriers to care, mistrust for healthcare system</u>

Family Meeting

- Described extent of disease, declining functional status (ECOG 2-3), symptom burden

- On introduction of hospice: family adamantly against comfort-focused care, elect to seek a second opinion with alternative oncologist.

- Volatile meeting; family asking palliative team to exit the room

Second Encounter

- Patient admitted to Cook County ~ 2 weeks later
- c/o worsening abdominal distension, intractable diffuse abdominal pain, poor PO intake, and moderately increased venting G-tube output
- imaging findings of developing small bowel obstruction, new onset ascites.
- seen by Surg-Onc in the ED: conservative mananagement
- 6000cc abdominal ascites drained
- Palliative on consult for symptom management

Angela seeks a second opinion

- Seen by Med-Onc at County while admitted
- Med-Onc agreeable to offering psycho/socio-therapeutic chemo given family distress
- Family offered psych-oncology co-counselling
- KRas wildtype (+) --> Cetuximab infusion administered inpatient
- Pain anesthesia: considering intrathecal pain pump vs celiac neurolysis to augment pain control

Second Encounter

- 48hrs post-chemo patient with persistent febrile episodes, tachycardia (SIRS 2/4)
- Acute onset pleuritic chest pain, acutely worsening abdominal pain
- CTPE: bilateral subsegmental pulmonary emboli
- CT ABP: no frank obstruction, large volume ascites
- Primary team requesting family meeting for complex medical decision making (anticoagulation, MICU transfer)

Second Family Encounter

- Family amenable to meeting for shared decision making

- Patient's father immediately recognizing me
  - "are you going to be blunt again and try to tell me my daughter's dying?"

- Patient decisional: elects to initiate therapeutic anticoagulation; understands concern for bleeding

- Started on heparin gtt

Plot Thickens…

- Persistent fevers/tachy, acute anemia
- Worsening abdominal pain; diminishing stoma output c/f complete obstruction
- Fentanyl patch removed 2' fevers --> Hydromorphone PCA 2mg q15min, 8mg 1hr lockout
- MICU transfer --> 2 units pRBCs
- TTE showing apical mass concerning for ventricular thrombus
- 6000cc drained on therapeutic paracentesis

Plot Thickens..

- Patient blood cultures: (+) MRSAand candidemia

- Port-a-cath removed

- TPN discontinued --> switched to D5 --> started on PPN

- Pain anesthesia : unsafe to proceed with intrathecal pain pump or celiac block

Plot Thickens…

- Patient repetitively stating "Thank you for not giving up on me, thank you for helping me fight this"
- Parents expressing gratitude for all County providers for not "leaving our daughter to die like those Rush oncologists"
- MICU requesting a discussion of code status

Plot Thickens..

- Patient's father requesting individual discussion outside patient's room

- "I know my daughter is dying... please be honest with me; how much longer do you think she will be around? Do you think she is suffering?"

Crosscheck and Reflect

- Balancing hope vs providing quality palliative care

- Patient goals not aligned with medical recommendation
  - Provider distress, keeping your feelings in check

- Clarity in intent of therapeutic intervention:
  - Curative vs Rehabilitative vs Palliative vs Psycho-therapeutic
  - Managing expectations

- Fostering patient trust through the "second opinion"

Circling the drain

- Angela remains in the MICU
- Distributive shock, acute thrombocytopenia
- Rapidly reaccumulating ascites, oliguric renal failure
- Dual pressor support...

Thoughts in conclusion

- Brody (1981): 'Hope means different things to different people, and different things to the same person as they move through stages of illness'

- Listen to the patient
  - Affirmation & Respect
  - Emphathic curiosity

- Listen to yourself. Be aware of your own emotions
  - (sadness, anger, anxiety, fear or happiness are often the first clue that a patient is communicating an important emotional message)

- Refocusing hope away from long-term towards short-term or spiritual goals

- 'When we talk to patients and find out what is really worrying them, we can almost always give them realistic assurances'

Hope and Truth Telling - Palliative Care Network of Wisconsin (mypcnow.org)

Any questions??

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