Case Report:
Effects of Morbid Obesity in Serious Illness

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Disclosures: none

Outline

- Overview: patient with BMI 80 with advanced cancer, examining effect of BMI on treatment course and outcome

- Initial Presentation
- Hospital Course
- Discussion
  - Effects of body weight
  - Intersectionality
  - Personal lessons
  - Larger lessons

Initial Presentation

“**43F** w PMH CHF, OSA poorly compliant w CPAP, HTN, morbid obesity, and metastatic colon cancer (possible appendiceal), s/p FOLFOXIRI x1 (poorly tolerated), FOLFOX x 4 (also poorly tolerated), omental mass in abdominal wall s/p XRT x2, p/f OSH with pain, clinical deterioration after a month hospitalization. [...] **BMI is ~80, which limited available interventions, and chemo was not available as an inpatient. Transferred to our institution for a higher level of care.**”

Course

10/28 accepted to oncology service from OSH after month-long stay. On admission:

- Poor documentation from OSH - difficulty obtaining full records
- Had received XRT x2; stopped due “to habitus,” further details unclear
- No chemo - they did not offer inpatient chemo
- Had developed gluteal abscess
- “Concern for” PE, unable to image, now on lovenox but ppx dosing
- Refractory pain

10/28 palliative, gen surg, anesthesia pain service, rad onc consulted

11/3 surg onc consulted

Summary of floor stay (~10 days)

- Primary Onc team: needed imaging for staging & discussion of chemo
  - Difficulty obtaining records from OSH
  - Desats/anxiety with lying flat - difficult to get imaging
- Palliative: adjusted regimen; pain control difficult due to hypoxia with increasing opiate doses
- APS: not much effect from ketamine gtt; interventions limited 2/2 lovenox, habitus
- RAD/ONC: unable to access XRT reports from OSH despite many attempts; eventually deemed too heavy for UCMC machines, not a radiation candidate
- Surg onc: not surgical candidate 2/2 habitus
- Other/general: wound care; DVT; AKI; anxiety
- Pt goals treatment-directed; hard to have larger GOC conversation w/o staging; felt like always waiting for some consult to weigh in

Course

11/8: CTAP under anesthesia; coded & intubated shortly after. ROSC -> MICU.

11/9 weaned to bipap.

11/11-17 reintubated, CVVHD; extubated again. Multi-organ decline/failure. Reintubated again. Intermittently responsive/interactive.

11/17: GOC between primary team and mom - changed to DNR, would not want long term institutional stay.

11/22: larger GOC discussion - decided on compassionate extubation.

11/25: extubated & passed w family in attendance.

Discussion

- Frustrating case - “could have done better”
  - Initial stay marked by waiting & logistical challenges
  - Role of BMI
  - Intersectionality

Role of body weight

- There is data that weight affects patient care & experience[1-4]
- Pt BMI 80 led to effects in multiple domains
- Physical/infrastructure effects
    - ?limited amount of XRT given at outside hospital
    - More labor-intensive to care for - 500+ lbs requires more people to clean, transfer, move, wound care, PT/OT, etc
    - Pt asked for trapeze bar to help position herself, but we didn't have that
    - Limited ability to get radiation 2/2 weight limits of tables
    - Limited size options for imaging even once intubated (ability to fit in machine)

Role of body weight

- Medical effects
  - Effects on health, incl hypopnea/apnea → limited ability to get adequate pain control with opiates
  - Pharmacokinetic differences
  - Weight caused discomfort when lying flat
  - Limited ability to get procedures/interventions for pain
  - Not a surgical candidate 2/2 habitus

Role of body weight

- Systemic effects
  - Likely delayed diagnosis of cancer
  - Implicit (& explicit) bias in at least some of her providers
  - “Hot potato” feeling between different teams
  - Helpless feeling w inability to get imaging; I suspect this feeling was shared & affected her care

Intersectionality

“The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.”

- *Kimberlé Crenshaw, 1989*

Intersectionality

This Pt had multiple intersectional disadvantages.

- Economically disadvantaged
- Remote area, small town - ?town surgeon was giving her chemo
- Woman of Color
- Low health literacy
- Obesity

We failed this patient.

“...I remember feeling a real and certain sense of helplessness in what I could do/say, all while trying to update the patient and her mother on how limited the available options seemed to be.”

I feel like we all knew where this was going on admission, and we were kicking the can until an inevitable event → decline.

Personal lesson

- May have been too paralyzed by lack of definitive “treatment options” from Oncology - we knew prognosis was poor
- Should have pushed for earlier GOC discussions even w/o all data
- It’s hard to acknowledge that body size would affect ability to treat cancer.

Larger lessons

- Recognize barriers for patients with high BMI
- Recognize implicit bias
- Appreciate intersectionality
- Palliative-specific research on the role of BMI in patient care[5]

Thank you

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Citations

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