Great Lakes Palliative Care Conference
Fellows Difficult Case Presentation

J.A. – 33 Y.O. Hispanic American female recently diagnosed with multiple cancers presenting approximately 5 months after diagnosis with severe crampy abdominal pain

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No Disclosures

PMHx, HPI

- No medical problems prior to diagnosis in June 2023
- Dx in June with metastatic colorectal cancer, gastric adenocarcinoma, papillary urothelial neoplasm with bilateral hydronephrosis needing nephrostomy tubes, PE/DVT, bony metastasis

Background

- Clinical context – very young with multiple cancers, presenting with an acute change
- Relevance – very sick person and not getting the help she needs due to biases of the team, working on different diagnoses, passing the buck

Objectives

- See the Biases, Name the biases
- Understand/acknowledge they are affecting the plan of care
- Know the pt also has biases
- Consider the hallmarks of asking for and providing an effective consultation
- Consider medical causes, alternative explanations

Current psychosocial situation

- Lives with a nonbinary roommate – Jorge vs Evon vs Ashley
- Father visiting from Mexico, mother cannot get visa, he is Spanish speaking only
- Works as a hostess at a restaurant
- Believes chemotherapy curative even after being told many times was palliative only
- Giving conflicting messages of wanting to go home but refusing cares such as PT/OT or learning ostomy care, conflicting messages of pain control to different providers

PET on admission 11/17/2023

- Mildly decreased size of long segment, poorly defined rectal uptake associated with known adenocarcinoma
- Stable, minimal uptake along prior gastric biopsy site. No new focal gastric uptake.
- Significantly decreased size and avidity of mesenteric and retroperitoneal lymph nodes. Persistently mildly avid lymphadenopathy remains.
- Resolution of left supraclavicular and bilateral pelvic lymph node avidity. A few prominent pelvic lymph nodes remain and are non avid.
- Overall mixed osseous metastatic treatment response as above. Some small new avid lesions and areas of improved disease.
- Small amount of low-grade long segment uptake within the ascending colon, new from prior PET scan. Findings could be physiologic.

Timeline

11/17

- admitted with intractable abdominal pain, possible UTI
- Prolonged QT – limits medications
- Diarrhea with severe crampy abdominal pain, CT with mixed results
- HCPOA from July Jorge/Evonne/Ashley, unrelated roommate, unknown pronoun. Father is second POA– only Spanish speaking
- Language barrier, mother unable to come from Mexico due to visa issues, unable to talk to her mother due to pain

11/19

- Unable to participate in PT/OT or psychiatry consult due to uncontrolled pain
- Not using PCA because “It doesn’t work”
- Conflicting stories about pain from pt vs. pain behaviors from nursing, different stories for different providers

Timeline

11/22

- Seen by PsyD – no anxiety or depression dx, pain well controlled when seen

11/23

- ”I don’t want to perf the pat with flex sig
- GI fellow wants to give methylnaltrexone
- EGD/flex sig aborted due to severe anal stenosis (pediatric scope -> 0cm)
- Seen also this day by surgical oncology who offered diverting colostomy

11/25

- Diverting ostomy done in OR

11/28

- Chemical coping and refusing to engage – large amounts of opiates and benzodiazepines >20 mg IV dilaudid/24 hrs

Timeline

11/30

- LCSW visit

12/1

- Pain uncontrolled and now admitting anxiety and depression
- Abdominal abscess dx
- Cholelithiasis/thick GB wall -> cholecystitis

Timeline

12/2

- Plan: Pain co-managed with Pain management team
  Fentanyl patch 100 mcg q 72 hr
  Dilaudid 4-8 mg PO q 3 hr prn
  Dilaudid 0.5 mg IV q 2 hr prn- only to be used in crisis situation
  Tylenol 1000 mg tid on hold in view to not mask fevers
  Continue baclofen 10mg QID
  Continue gabapentin 300mg/300mg/600mg
  Continue duloxetine 30mg qd
  Continue simethicone 125 TID
  Continue carafate 1mg QID
  Valium 5mg q4h PRN per pain management
- Discharged from PT/OT due to refusal for the 3rd time
- Pt, father and HCPOA all refusing to learn colostomy care

Timeline

12/12

- New obstruction due to Narcotic ileus vs. External compression

12/23

- Duodenal stenosis with stent placement

12/27

- Bilirubinemia, elevated alk phos, PT Cholecystostomy tube placed
- Blood and urine cultures now + for MDRO E.Coli, peritoneal fluid culture with yeast

Specific aspects that were difficult

- Conflicting stories from the patient
- Refusing cares or to learn self care
- Blaming – physician to pt and pt to physician
- Sorting out personal biases vs pt behaviors
- Convincing other physicians there was an actual problem
- Physical pain control, emotional pain, social pain, spiritual pain

Teaching points

- What did you learn?
  - Always look for a medical explanation
  - Recognize your own and other peoples' biases
  - Patients are allowed to make bad decisions
- What can you/others apply to the care of seriously ill patients?
  - Look for the medical explanation, not all cancer patients' pain is the cancer, look for alternative diagnoses
  - Ask for help – from either multiple people or get your own second opinion
  - If pts are set on non beneficial choices…

Biases Regarding Patients

- Sexual Identity
- Sex and Gender
- Education
- Socioeconomic status
- Body Habitus
- Racial bias
- Geographic location
- Age
- Ableism
- Mental illness
- Hx of substance abuse

Samulowitz A, Gremyr I, Eriksson E, Hensing G. "Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. Pain Res Manag. 2018 Feb 25;2018:6358624. doi: 10.1155/2018/6358624. PMID: 29682130; PMCID: PMC5845507

- Gastroenterology
- Occupational therapy
- Physical therapy
- Pain management
- Psychiatry
- Hepatology
- Dietary
- Clinical psychology
- Hyperbaric Medicine
- Radiation Oncology
- General Surgery
- Infectious Disease
- Colorectal Surgery
- Palliative Care
- Oncology

Elements of a High-Quality Inpatient Consultation in the ICU

4 reasons for obtaining a consult

- Need for clinical or procedural expertise
- Explicit or Implicit protocol of the institution mandating the consult
- Opportunity to provide education to the primary or consulting team
- Family request

7 components of high-quality consult include the consulting teams'

- Decisiveness
- Thoroughness
- Level of Interest
- Professionalism
- Expertise
- Timeliness
- Involvement of the patient and the family

Stevens JP, Johansson AC, Schonberg MA, Howell MD. Elements of a high-quality inpatient consultation in the intensive care unit. A qualitative study. Ann Am Thorac Soc. 2013 Jun;10(3):220-7. doi: 10.1513/AnnalsATS.201212-120OC. PMID: 23802818.

5 C's of Consultation

- Contact – full name, service, supervising attending, consulting physician
- Communicate – concise story, accurate recount of information/case detail, speak clearly
- Core Question – specific need for consult, timeframe for consult
- Collaboration – open to and incorporates consults recommendations
- Closing the loop – reviews and repeats care plan, thanks

Kessler CS, Tadisina KK, Saks M, Franzen D, Woods R, Banh KV, Bounds R, Smith M, Deiorio N, Schwartz A. The 5Cs of Consultation: Training Medical Students to Communicate Effectively in the Emergency Department. J Emerg Med. 2015 Nov;49(5):713-21. doi: 10.1016/j.jemermed.2015.05.012. Epub 2015 Aug 4. Erratum in: J Emerg Med. 2016 Aug;51(2):222. Deiorio, Nancy [corrected to Deiorio, Nicole]. PMID: 26250838.

Consult Etiquettes in PC

- Remember your stake holders
- Make contact/clarify
- Negotiate Roles
- See the pt and gather your own data
- Call the referring service

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Guiding Framework

- Determine the question
- Triage urgency
- Gather your own data
- Brevity
- Specificity
- Plan ahead
- Honor Turf
- Teach -> with tact
- Personal contact
- Follow up

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Outcome

- Coded x 24 minutes, died after unsuccessful NG tube -> ? Aspiration
- Father at bedside, HCPOA at bedside

Objectives on Repeat

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How can we “debias”?

- Bias specific teaching sessions
- Slowing down
- Metacognition and considering/actively seek alternatives
- Checklists
- Teaching statistical principles
- Ask questions that disprove your hypothesis
- Consider what data is truly relevant
- Novel methods

O'Sullivan ED, Schofield SJ. Cognitive bias in clinical medicine. J R Coll Physicians Edinb. 2018 Sep;48(3):225-232. doi: 10.4997/JRCPE.2018.306. PMID: 30191910.