Checking the Facts

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Over the last few years there have been many reports advocating for improvements in the hospital care of dying patients and the need to incorporate palliative care consultation services and education into acute care hospitals (1, 2, 3). A more recent report documented an approach to develop and implement clinical, educational and research goals for a palliative care team (4). A report from the UK noted the extension of the hospice movement into the acute care setting with the development of hospital based specialist palliative care services with over 200 palliative care services in the acute setting, including many specialist palliative care teams (5).

However the nature of the acute care setting often drives a more rapid and hectic pace of activity than may be experienced within the confines of a hospice or palliative care unit. In some circumstances background history may be lacking, incomplete information available, and decisions made with less time available to dedicate to patient and family communication. The following recent experience in an acute care hospital in Edmonton is an example of how patients and families can be poorly served by the accessibility of a palliative care service if care is not taken to ensure we check background information and facilitate communication with patients and families in establishing goals of care. A 75 year old Korean speaking women was referred to the palliative care service on a Sunday. She had a history of cervical cancer diagnosed 11 years previously, which had been treated with radiotherapy. She had been admitted to a rehabilitation hospital one month earlier for falls apparently secondary to viral encaphalitis. She had then been transferred to the acute care hospital with hematuria. A large pelvic mass was noted on rectovaginal examination. The patient had developed acute renal failure over the previous two days with a creatinine of 117 umol/l (normal range 45 to 125) on admission increasing to 521, while the white blood count had increased to 22,600. An ultrasound on admission had demonstrated a large solid mass at the base of the urinary bladder and mild bilateral hydronephrosis.

The main reason for the referral was to control the patient's symptoms of agitation, pruritis, and suprapubic pain. The patient was noted to have mild myoclonus with extensive scratching on the chest and abdomen. The suggestions for symptom management were to discontinue the morphine and start the patient on hydromorphone 1 mg sc q1h prn for pain, haloperidol 1 mg sc twice a day and q1h prn for agitation. Metoclopramide 10 mg was ordered prn for nausea, and calamine lotion was suggested for prurits.

The palliative care service reassessed the patient the following day and found that she now required a security presence at the bedside due to her agitated behavior. Chart review indicated that there was no evidence of metastatic disease outside the pelvis. The patient was noted to be well nourished. Given these circumstances it was apparent that management of the obstructive renal failure had the potential to prolong the patient's life significantly, and there was no documentation of discussion with the family to clarify goals of care. As a result an urgent family conference with an interpreter was arranged to discuss possible intervention options. The family indicated that the patient had been highly functional, enjoying her quality of life and had looked forward to going home. The family agreed to pursue further intervention and investigation and urgent bilateral percutaneous nephrostomies were arranged through intervention radiology for later that afternoon.

During the next three days the patient's level of consciousness improved and she was able to recognize family members and sit up in a chair. Further diagnostic imaging was not possible, as the patient remained intermittently agitated. At that point the diagnostic imaging service declined to do a MRI as they noted that the patient was considered palliative. However they did agree to do a CT scan. During this recovery phase the patient had not required any prn opioids, and no longer required supervision for her agitation or pharmacological management with the haloperidol. The creatinine had improved to normal at 45. The CT scan did not demonstrate any pelvic metastatic disease, and ill-defined changes were noted to be nonspecific and thought to possibly result from post-radiotherapy fibrosis.

The palliative care service encouraged the attending staff to continue to pursue further investigation with the involvement of the urology service. Eleven days after first being seen by the

palliative care program the patient had a cystoscopy, which noted only some necrotic material in the bladder. This was biopsied and pathology was subsequently benign. At the same time bilateral ureteric stents were placed and the percutaneous nephrostomies removed. The patient was now able to get out of bed independently, remained comfortable and was increasingly interactive with her family. The gynecology/oncology service was involved and three weeks later the patient had an examination under anesthesia. Findings were consistent with fibrosis due to radiotherapy and there was nothing noted suggestive of tumor recurrence. There was some speculation that the acute event of hematuria had caused the bilateral ureteric obstruction. At this point the palliative care service advised that the geriatric program should assume supportive care and palliative care follow-up was discontinued.

We have previously published a case report on a patient admitted to the tertiary palliative care unit with an inoperable cholangiocarcinoma and intractable pain (6). Prior to admission to the palliative care unit this patient had undergone five coeliac plexus blocks and three epidural catheter insertions at different levels. Complications related to this management included loss of consciousness and focal seizures, as well as episodes of cognitive impairment and agitation. The patient was subsequently demonstrated to have a benign stenosis of the distal common bile duct as well as a history of heavy alcohol abuse. This patient was subsequently discharged from the palliative care unit with good pain control on plain acetaminophen. In this situation the palliative care staff were able to investigate, reassess and provide interdisciplinary support to this patient during a four week admission to a palliative care unit. In the acute care setting illustrated above, the palliative care service had very little time to assess the circumstances and discuss with the attending physician the need to reconsider the terminal nature of the patient's condition, and agree to an approach that allowed the family to participate in an open communication of possible intervention and goals of care. Initially the palliative care service intended only to assist in prolonging this patient's life if that was appropriate given her previous quality of life and written or expressed advanced directives. As circumstances unfolded, it became increasingly evident that not only did this patient not have extensive metastatic disease, in fact there was no evidence of a palliative diagnosis at all. Given the increasing advocacy for access to palliative care services in acute care hospitals, it is likely that we will encounter circumstances where the palliative care consulting service needs to question the history given by the referring physician, advocate for interventions that may prolong the patient's life, and once in a while "save" a patient from an inappropriate palliative care label and a premature demise.

Reference:

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