

Dr Linda Sheahan

FRACP FACHPM M Bioethics

- › Staff Specialist Palliative Medicine
- › Clinical Ethics Consultant SESLHD

- › Honorary Associate, Sydney Health Ethics, University of Sydney
- › Affiliated Ethicist, Joint Centre for Bioethics, University of Toronto, Canada
- › Conjoint SCPHM UNSW

Between a rock and a hard place..

RACP Congress Clinical Ethics 2018

Case Based Discussion: Mr JW

Mr JW

- 65 yo Macedonian descent
 - Owned his own business selling mattresses; retired; lives independently; non smoker
 - Central obesity, Mild hypertension (ACE)
- Presents with 1 mo haematuria
 - Elective cystoscopy
 - Large eroding mass post bladder
 - Biopsy: mod differentiated adenoCa
 - Colonoscopy
 - Large circumferential sigmoid colon tumour causing incomplete obstruction
 - Staging imaging: no distant metastasis

Surgical workup

- S/b surgeon in private rooms
- Scheduled for elective Sx
 - Booked and consented for elective anterior resection, cystectomy w formatn ileal-conduit
- 3 days prior
 - Did not want to go ahead with his operation
 - Multiple calls made to patient from rooms
 - Unable to convince patient to reconsider Sx

Emergency presentation..

- 4 months later:

ED: frank haematuria, PR bleeding, pyrexia

- Reports 24kg weight loss
- Bloods - Albumin 16

Re-staging CTCAP

Pelvic tumour significantly increased in size

Left hydronephrosis 2' left ureteric obstruction

No evidence of distant metastasis

Surgical discussion with the patient and family re options for treatment

Decision Making...

- Current staging suggests malignancy confined to pelvis
 - Curative treatment remains a potential option
 - Invasive surgical procedure
 - High risk of complications/morbidity
- “Choice” is given to the patient
 - JW decides to go ahead with surgery
 - 2 weeks – pre-op optimization
 - TPN and enteral drinks

Surgical Course

Laparotomy (Dec 2016)

Tumour originating from the sigmoid colon

Invading bladder , left ureter and caecum

Anterior resection, cystectomy, caecectomy performed.

- ileal conduit, end ileostomy and mucous fistula

Complications in ICU

^ vasopressors, bleeding, dusky stoma

Return to OT

2x segments of irreversibly ischaemic small bowel resected

Damage control and laparostomy

ICU Post operatively

- Poor progress
 - Febrile, acidotic, unstable haemodynamics
 - Elevated cardio-respiratory support requirements
- Return to theatre for relook Day 2
 - Further 50cm small bowel resected and remaining colon removed for ischaemia; ileal conduit and stoma
- Day 2-9
 - Functional bowel length – 110cm
 - Multiple abdominal collections
 - Renal failure
 - Intermittent bouts of sepsis
- Day 10 – Extubated and Step down to HDU

Poor outcome

- 3 weeks post op
 - Midline wound leakage of enteric contents confirming enterocutaneous fistula
 - Pelvic DC via urethral tract
- CT abdomen confirm multiple fistulas
 - Large pelvic cavity with communication with:
 - Ileum
 - Rectal stump

Long admission w recurrent issues..

Nutrition and TPN dependence

Fluid management and renal dysfunction high outputs of urine and fistula losses

Recurrent intra-abdominal infection → sepsis

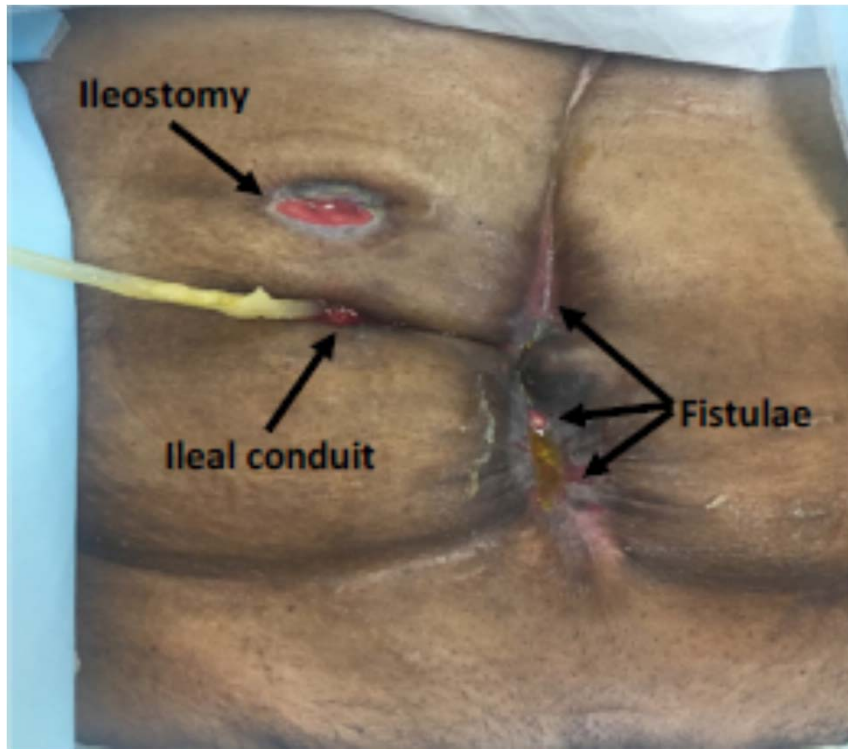
Ureteric disruption – urosepsis

Fistula appliance management and Stoma care

Intermittent ICU admissions for acute issues and post surgical interventions

Non healing fistula: why?

COMPLEX ABDOMEN



Slide 10

DL4

Daniela Levido, 6/11/2017

7 months post pelvic clearance..

Endoscopic biopsy from rectal stump at time of insertion of ileal stent

Confirms a Cancer recurrence in the pelvis

Surgical Discussion with the family:

likely poor outcome overall

'futility' of further surgical intervention

Suggest shift in the focus of management toward palliative measures

The Geri's Consult - 'Will you take over care?'

Medical Snap Shot:

- Non healing wounds and multiple fistulas
 - 3 hours per day on dressing change – nursing+
- Fluid management: high output stomas with 5L per day in losses
 - IVF to match losses via central access (life sustaining/dependent)
 - Unstable BP w ongoing renal impairment and bilateral nephrostomies
 - Severe peripheral oedema in context of extremely low albumin (Alb 8)
- Local rectal recurrence of CRC. At primary site only, No evidence of visceral disease.

Medical Snap Shot (2)

- Functional status & mobility at plateau
 - Sit to stand independently
 - Mobilise with IV pole
- Goals of Care: discordant
 - Cognition intact when not delirious
 - Medical knowledge and understanding of surgical journey poor
 - “in the dark” “feel like I’m being experimented on”
 - Insight and judgment poor
 - Strong religious belief; faith in a miracle cure
 - Wishes to continue treatment even if burdensome
 - Does not want to involve family in decision making

Where to from here?

- Now 9 months post surgery...
- Discharge planning
 - Home VS Nursing home Vs Hospital
 - Wife – unable to manage
 - Hospital care needs
 - IVF, stoma care and trouble shooting

Palliative Care Referral

Pall Care CNC review

- Symptoms well controlled
- Functional status deteriorated slightly
 - ECOG 3
 - Recent reduced activities and perceived withdrawal of interest
- Future Care Planning:
 - Very high care needs; required 3 hours per day for dressing management.
 - Three nursing homes refused him after a trial of care on the ward.
 - Care needs too difficult for his wife to manage
 - Likely to remain an inpatient until he dies of an acute interceding issue – conservatively managed

Clinical ethics referral

Questions for clinical ethics

1. Should we continue to provide IV fluid (life sustaining treatment) to JW?
2. What should the ceiling of care be?
3. How should we understand quality of life and burdens of treatment in this context?

Question to audience (1a)

JW “wants to live” and says he wants to continue all treatments offered to him. Presume he is capable.

Should we continue to provide IV fluid to JW?

- a. Yes we should - life sustaining treatments should not be withdrawn
- b. Yes - we should if he wants to continue
- c. No - it is essentially a futile treatment
- d. Not sure

Question to audience (1b)

Presume JW is not capable and his wife is the legal substitute. She says JW “wants to live” and she wants to continue maximal treatments.

Should we continue to provide IV fluid to JW?

- a. Yes we should - life sustaining treatments should not be withdrawn
- b. Yes we should - if she wants us to continue
- c. No - it is essentially a futile treatment
- d. Not sure

Questions to audience (2)

In your opinion, which of these options is the most appropriate ceiling of care?

Analgesia

Stoma and wound care

High volume IV fluid replacement (life sustaining)

Antibiotics for Rx of sepsis

Albumin and blood product replacement

TPN

Surgery

HDU/ICU

Question to audience (3)

How should we understand 'quality of life' and the burdens of treatment in this context?

a. JW has a poor quality of life and his treatment burden is unacceptable

b. JW believes he has an acceptable quality of life, and that is what matters

c. Not sure

Question to audience (4)

Do our responsibilities to our patients change when poor outcomes/health states are iatrogenic?

- a. Yes – if we caused the problem we are obligated to treat wherever possible
- b. No – we should decide what we think is the best decision at each point in time, regardless of how we got there
- c. Not sure

Question to audience (5)

Should we consider the resource implications in deciding what is the best decision in regard to JW?

- a. No – we should consider what we think we consider is in the best interests of JW, and resource implications should not weigh in
- b. Yes – we are all responsible for considering the resource implications of healthcare decisions
- c. Yes - but I'm not sure how to do this
- d. Not sure

Outcome...

- Clinical ethics helped 'map the terrain' for the clinical teams involved
- Treating clinician (geriatrician) remains responsible for assessing what they believe is in the the best interests of their patient
 - Continued fluids, albumin, and ward based measures for sepsis/reversible issues
- Functional status deteriorating over 3-4 weeks; Albumin 6
- Died 4 weeks later in the hospital

