

Clinical Cases

Palliative Surgery

Physicians must express compassion when discussing risk and success rates of palliative surgery.

Commentary by David P. Jacques, MD, and Murray F. Brennan, MD

Dr. Ramirez, a GI surgeon at Lutheran Hospital got a call from the medical director of Sunset Hospice, Dr. Whitehead. "I've got a patient here that I want you to look at. Her name is Mrs. Macias; she's 59 and was diagnosed with Stage IIIb ovarian cancer 3½ years ago. She's now Stage IV with distant metastases. She had an initial debulking surgery followed by 3 rounds of chemotherapy with disease recurrence. To be honest, she's doing better than I expected, given the late diagnosis. Her current prognosis is for 3-6 months, and she requested that we stop aggressive treatment. For the last few months she's been able to stay with her sister."

"Has she changed her mind about aggressive therapy?"

"No, but the cancer has spread through her abdomen and she's developed a couple of bowel obstructions. We had to admit her to hospice care for an IV and NG suction. She's had bouts of nausea and vomiting with some colicky pain. She's been refractory to pharmacologic therapy and doesn't want a PEG tube because she'd like to eat food normally. I'm not sure if she's a good candidate for palliative surgery or not, but she's requested it, so I'd like you to come and take a look."

Dr. Ramirez agrees and visits Mrs. Macias that afternoon.

When he arrives, the hospice director isn't around, so Dr. Ramirez looks through Mrs. Macias's chart. Just as he's finishing up, Dr. Whitehead comes in.

"So what do you think?"

"Looking through her chart, it doesn't look like she's a particularly good candidate for palliative surgery. She's got at least 2 different obstructions, mild to moderate ascites, a pleural effusion, and her functional score is lower than I'd like."

"Well, let's go in and talk to her," Dr. Whitehead responds.

As they enter her room, Mrs. Macias looks up and says, "Are you the doctor who's going help me eat again?"

Dr. Whitehead responds, "Well that's what were here to talk about."

"I'll be honest," Dr. Ramirez says, "I'm worried about the toll the surgery will take on your body, given your weakened condition right now. And I'm also concerned that the surgery might not accomplish what you want it to, at least not right away. You may not be able to eat right away or even eat what you want. It will take at least a month to recover from the surgery, if everything goes smoothly. And a number of complications could occur, some of which are very painful and others that may keep you from eating."

Mrs. Macias gives Dr. Ramirez a hard look. "I have been living through medical treatments for too many years and

now, now I am getting ready to die. I love the taste of food and even if it's just for a little while, I want to enjoy myself at least a little bit. I'm not asking you to save my life, I'm asking you to let me have some meals with my visitors before I die."

Commentary

How do we assist a patient's transition from a reasonable desire to a more realistic expectation without eliminating all hope? This is the challenge faced by Mrs. Macias and her surgeon, Dr. Ramirez. The case frames the problem in human terms—our patient only seeks an operation for the modest gain of an opportunity to eat with her friends in her final days. Who among us in medicine would not feel compassion in such circumstances and not be tempted to defy the futility of the situation?

There is a popular business book, *Getting to Yes*, that describes the negotiation process as 2 parties try to find common ground and cut the deal that gives both groups a victory. Mrs. Macias's doctors are struggling with Getting to No. The American College of Surgeons Statement on Principles Guiding Care at the End of Life cite the important need to recognize the physician's responsibility to forgo treatments that are futile. In this case, the presence of distant metastases, multiple sites of small bowel obstruction due to tumor implants, ascites, and a poor performance status argue strongly that the solution to the problem requested by the patient, an operation, has an extremely low probability of providing the desired outcome. Faced with such futility, it is seldom reasonable to proceed with a surgical intervention. This course of action should be abandoned, but the patient should not.

In approaching such circumstances it is critical that the patient, physician team, and family have appropriate expectations about anticipated outcomes from the various treatment options that are to be considered. This requires a very detailed discussion with Mrs. Macias about her current needs, placed in the context of the ability of the health care team to meet her expectations. In framing such a discussion, it is important that everyone share the same information. In our studies of palliative surgical decision making, we have tried to identify the probability of successfully relieving the targeted symptom at 30 days and describe its durability at 100 days, along with the probability that the patient will experience a new or recurrent major symptom during that period. In addition, the associated morbidity and 30-day post-operative mortality would be described to complete the value equation that must be considered when making such challenging decisions.

The probability of relieving this patient's obstruction with a major operation is extremely limited. The probability that the effects of the surgery would last for the duration of her life is even less likely—when performed in the setting of ascites, the probability of complication is nearly 50 percent, and the probability of 30-day post-operative mortality is approximately 10 percent. This does not mean that alternative care options should not be considered. Mrs. Macias describes a need for the social value of eating. This is a fundamental human concern, and efforts to assist should not be discarded, even as the means are reconsidered. The placement of a PEG tube may allow her to avoid impending vomiting and permit some modest oral intake. In this way we can set expectations in such a way that we do not promise what we cannot deliver.

In summary, I would sit down with the patient, her family, and her hospice physician and have a frank discussion about the inherent limitations in providing for her needs while empathically avoiding her abandonment of hope. When the proper time is shared with the patient and the expectations are managed appropriately, these decisions often become more straightforward than they first appear. So, yes we can and will help.

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