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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Holding Curative and Palliative Intentions

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Abstract

When a patient is diagnosed with an advanced head and neck cancer, a decision about whether to have surgery can dominate what remains of that patient's life: prospective benefits can be limited, and complication risks can be high. Realizing dual curative and palliative intention with a single operation can be a reasonable surgical oncological care goal. In such cases, differentiating between the curative and palliative potential of surgery is key to developing dual intentional clarity. Informed consent should be generated by clear communication exchanges about patients' and surgeons' hopes and expectations, patients' and surgeons' risk tolerance, and the risk that surgeons or patients could experience regret.

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Case

Mr H, a 75-year-old former carpenter, was diagnosed with advanced cancer just above his esophagus. He had spent a long time in a rehab facility recovering from chemotherapy and radiation treatments. After 2 months, he could swallow soft foods again and recovered enough to move home. But 3 weeks later, he experienced pain, weight loss, and couldn't swallow his own saliva. A biopsy confirmed that the persistent cancer above his esophagus had now spread to a lymph node in his neck. It was unclear from imaging studies whether or to what extent the cancer was safely resectable from either site. Mr H was clear with his radiation oncologist, medical oncologist, and surgeon, Dr L, that he wanted everything done to try to remove the cancer.

Dr L explained, "We'd do a major surgery called a salvage laryngopharyngectomy,[1] in which we'd try to remove all of the cancer. We'd remove your voice box and pharynx, so you might never swallow again. We'd also try to remove cancer in the neck lymph node. Due to chemotherapy and radiation, your tissues are less likely to heal after surgery, so here is higher risk for complications with this surgery, but salvage surgery, after primary chemotherapy and radiation, is your best hope for a cure." Mr H consented to surgery.

Dr L presented Mr H's case at a multidisciplinary tumor board meeting that week. Dr L's colleague, Dr M, pointed out, "There's a good chance you'll find out intraoperatively that

the cancer encases the carotid artery or has spread to the spine fascia. Then you'll have to abort the case, and he will be worse. Either way, rates of successful salvage for hypopharyngeal recurrence go as low as 15%.[2] At the very least, I wouldn't call this surgery 'curative.'"

"He wants surgery," replied Dr L. "I agree that we could find unresectable disease, but we'll go in with intention to cure his cancer. So, surgery should be presented to him as curative."[3,4]

Colleagues in the meeting considered how to respond.

Commentary

We clinicians often begin simultaneously to diagnose and treat a patient's illness before we know exactly what is wrong. We titrate medicines to maximize their benefit and minimize their side effects, simultaneously reducing disease burden and limiting harm. But should surgeons' intentions be both curative and palliative at the same time? We argue that realizing dual curative and palliative intention with a single operation can be a reasonable surgical oncological care goal. However, during informed consent, surgeons must seek to understand a patient's expectations and hopes or their intentions are moot.

Concurrent Care

Characterizing Mr H's decision as either curative *or* palliative expresses an outdated understanding of palliative care as only offered subsequent to attempts to cure (ie, when disease-modifying treatment no longer works, palliate until death). This sequential model has evolved into a concurrent model in which treatments with both curative and palliative intent can be delivered simultaneously.[5,6] Patients like Mr H should thus be presented with a care plan that aims to cure their underlying disease, treat them as a whole patient, respond to their symptoms, and improve their quality of life.[5] Evidence suggests that a concurrent approach improves quality of life, patient satisfaction, and survival,[7] and palliative practices (eg, good communication, symptom management, and advance care planning) are beneficial throughout a patient's journey with life-limiting disease. The American Society of Clinical Oncology recommends early integration of palliative care with curative treatment for patients with cancer.[8]

Yet, especially for head and neck cancers, concurrent pursuit of curative and palliative interventions can seem antithetical. In cases, a surgeon is likely right to intend to eradicate a patient's cancer (ie, not to prioritize ease of reconstruction, aesthetic consequences, functional outcomes, symptom improvement). Nevertheless, surgeons performing operations primarily intended to be curative can achieve palliative goals (eg, relief from pain and suffering, mitigation of disfigurement, and improvement of some functions). Partial glossectomy, for example, can be both curative and palliative when pursued by a surgeon intending to delay growth of a painful, disfiguring, debilitating, fungating oral cavity mass. Historically, most surgical interventions have been palliative to some extent, as they did little or nothing to change a disease's underlying pathophysiology and instead sought to remove, bypass, or otherwise change the mechanics of end-organ damage suffered by a patient.[9] The clinical and ethical upshot here is that the terms c*urative* and *palliative* should be neither construed by surgeons nor presented to patients as opposites. Surgical interventions with concurrent curative and palliative goals can be described as falling along a spectrum. That is, some surgical interventions are most accurately presented as exclusively curative or exclusively

palliative, but many fall somewhere in between, where both health and experiential outcomes must be considered.

Concurrence and Communication

"One-choice" situations. When confronted with a new serious diagnosis or when asked to consider choices regarding their cancer care, patients tend to focus on whether to do something rather than on specifically what to do.[10] Cases in which only one treatment choice is medically reasonable can lead to disagreement between patient and physician, especially when a patient wants a procedure that offers no clinical benefit or rejects palliative goals as unworthwhile.[11] In such cases, in order to help refocus discussion on possible outcomes of treatment and treatment refusal, a surgeon might consider adumbrating a possible time down the line in a patient's illness trajectory when surgical intervention would be too high risk to be offered. In our experience, the following open-ended questions have also been helpful in discussions with patients and surrogates:

1. *If, at the end of this year, you die of this disease, how would you have wanted to spend this time?*
2. *If we perform an operation that fails to cure you or fails to make you feel more comfortable, you might look back and be glad we tried it. Or you might look back and regret being in the hospital, away from your home. What do you think about those possibilities?*
3. *If we do not operate and focus on managing the symptoms that are most distressing to you, you might look back and be glad. Or will you look back at the end of the year and regret not having tried one last treatment? What do you think about those possibilities?*

Sharing decisions well with patients and their surrogates can also mean canvassing preferences (eg, in terms of "least bad" options or "least acceptable" outcomes)[12] and imagining possible outcomes (eg, as best- or worst-case scenarios).[13]

Health outcomes variation. Curative effects of surgeries vary widely. The oncologic literature contains uncertainty and can be difficult to apply to individual patients' cases.[14] Five-year survival rates after salvage surgery for hypopharyngeal cancer, for example, range from 16% to 40%.[2,15,16,17] Yet, even when curative surgical interventions fail to completely eliminate (cure) disease in patients, their lives can be extended. Medical palliative interventions (eg, immunotherapy or chemotherapy) can provide durable progression-free or indolent progression survival for some patients.

Experiential outcomes variation. Interventions' risks and benefits must be discerned, interpreted, and conveyed by surgeons, and decisions must be carefully considered with patients or appropriate surrogates. Especially with head and neck procedures, wounds and iatrogenic aesthetic insults are often visible; clear communication is key to helping patients and their loved ones prepare visually for what they're likely to see postoperatively. Furthermore, when data are lacking about whether surgery can palliate current symptoms (eg, motivate wound healing, mitigate pain, limit obstruction) or prevent future suffering (eg, diminish risk of death by hemorrhage), clinicians should avoid promises to keep patients comfortable, especially when patients' symptoms are difficult or impossible to palliate without proportional sedation to the point of unconsciousness.

Intending to Mitigate Regret

Regional recurrence of Mr H's cancer in a previously treated surgical field worsens his prognosis, but surgical intervention could palliate his symptoms (ie, improve his swallowing, delay or prevent onset of additional symptoms, or mitigate pain).[18] Communicating clearly with patients like Mr H who might experience both health and experiential outcomes of surgeries is key to managing patients' expectations, learning about their priorities, and mitigating later regret about current decisions. Most head and neck cancer patients initiating treatment with curative intent have prioritized survival; secondary goals include preserving vocal and swallow function and controlling pain, with patients' rankings being largely unrelated to clinical or demographic factors.[19] Patients' priorities, however, do influence their experiences of regret.[20] Whether surgery is actually palliative for patients like Mr H depends on their priorities and how they define suffering.[21]

Such goals-of-care conversations are hard to complete satisfactorily during 30-minute outpatient surgery consultations, so early integration of palliative principles in oncologic care will help facilitate fuller discussion and promote better understanding. Since surgical interventions often serve multiple goals, it is reasonable and helpful in our relationships with patients to have both curative and palliative intentions.

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Editor's Note

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