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Dilemma of Care Givers of Critically Ill Patients in a Cancer ICU - A Case Report

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Abstract: ***60 days experience in ICU for a case of recurrent renal cell carcinoma subjected to aggressive approach is presented. Patient had one complication after another related to disease and the treatment which was successfully managed but the overall end result was sub optimal due to advanced age, malnutrition, failed weaning, progressive neuropathy and disease progression. Later realization of the medical futility by the caregivers, after counseling, lead to their compliance with the wishes of the patient. Such cases are better managed with early recognition and acknowledgment of medical futility and the patient's wishes.***

Keywords: Palliative care, futility, good death, comfort care, counseling, IVIG (intravenous immunoglobulin)

1. Introduction

Technological advances have made it possible to sustain organ function and vital signs indefinitely. But is this what 'life and living' is all about? A difficult moral question emerges- that of quality of death, legal issues of transition from aggressive to supportive care and judicious use of the precious resources.[1]

It is very easy to decide when a patient needs intensive care[2]. But, on the contrary to deny aggressive interventions, to convince care givers about medical futility and to reach consensus for comfort and palliative care are much harder. Transparency of communication and commitment to formal exclusion criteria is vital in order to invoke a sense of trust and credibility amongst patients and care givers.[3] Specific criteria for unilateral withdrawal of treatment have proved hard to define or defend. However, it is not unethical for doctors to decline treatment that is medically inappropriate or futile. Understanding the justification for a futility judgment may be relevant to deciding the most appropriate way to resolve futility disputes.[4] One such case is presented to highlight the degree of aggression modern critical care is capable of before it can be bridled for reasons of futility or irreversibility. A case occurring recently in our ICU is presented to highlight the predicament we face when patients and care givers refuse to acknowledge 'disease over mastery' and the certainty of failure of any therapy despite clear and concise counseling.

2. Case Report

A 60 year male, post cytoreductive radical nephrectomy/post TKI (Tyrosine kinase Inhibitor-Sutent) PET–CT shown metabolically active progressive disease was started on immunotherapy. He presented in ICU with shortness of breath requiring NIV (noninvasive ventilation).Failure of NIV lead to tracheostomy with invasive ventilation.

In ICU, Chest X-ray showed homogenous ill-defined opacity left upper lung field with erosion of 4th rib. Pleural based opacities were also seen in left lung. Pleural fluid cytology was positive for malignant cells. EBUS showed adenocarcinoma with clear cell morphology. Urine culture grew Enterococcus fecium.

On 10th day patient developed quadriparesis requiring neurophysician opinion and CSF study, which was clear. Nerve conduction velocity (NCV) study suggested severe mixed demyelinating and axonal motor sensory polyneuropathy of upper and lower limbs.

In view of NCV findings possibility of paraneoplastic or Guillan Barre Syndrome was considered, patient was started on IVIG for 5 days. There was marginal improvement for 2weeks then deterioration started requiring continuous ventilation.

On 45th day cardiac tamponade occurred requiring pericardiocentesis. After 4weeks from the first IVIG, immunoglobulin was repeated but this time showed no improvement. In view of coffee colored aspirate from ryles tube, Upper GI endoscopy was done revealing esophageal varices which was banded.

At 54 days, pain abdomen, hypotension and massive bleed per rectum, prompted NCCT abdomen revealing duodenal perforation with inferior pancreato- duodenal artery aneurysm. Successful fluoro-guided angio-embolisation was done. In view of patient poor general condition surgical intervention was ruled out by the gastro surgeon.

Repeated counseling of family was done about the irrevocable disease progression, futility of aggressive critical care and zero likelihood expecting any recovery or improvement. However, there was reluctance and denial, his son was a medical professional not accepting reality despite the patient's last wish to go home.

Finally, after 60 days in ICU the attendants consented to respect patient's wish of going home and dying a 'good death' under the supervision of identified and sensitized local medical practitioners along with continued support of our team. Patient survived for two weeks then died on 16thday post cardio respiratory arrest.

3. Discussion

According to the economist intelligence unit report, India has one of the lowest "Quality of Death index"[3]. Vast majority of population is far removed from medical care of any sort, there is unethical pressure and competition for bed occupancy in order to drive revenue; also care givers do not give heed to sane advice when their patients reach the stage

of untreatable medical condition. The situation in critical care units is further compounded due to lack of effective home care services for transitioning such patients to end of life and palliative care.

Comprehensive care ensuring a seamless continuum of care is paramount for effective health care. It is very satisfying to the person and family as it is an expression of whole person care, responding appropriately and ethically to the situation with good communication and teamwork. This is necessary to meet the needs of a person progressing through an incurable illness and facing death. Palliative and end-of-life care (EOLC) is geared for it, and an integrated care plan for the dying makes sure a good death is achieved. It also continues its support to the family after death of the person and makes provision for ongoing bereavement support. [5]

4. Conclusion

The above case highlights the need for stringent transparency [3] while counseling the family, realistic prognostication and accurate appraisal of the disease stage. Inappropriate prolongation of the dying process thus denying patient autonomy is unethical [2]. This will help patients care giver's decision making and prevent them from dilemma.

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