

Early integration of palliative medicine into emergency care: Is it a feasible option

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ABSTRACT

Patients with advanced malignancy often experience symptoms of disease and treatment that contribute to distress and diminish their quality of life. Most of these patients present to the emergency department thus raising its importance in providing such care especially at the end of life situation. An approach that is aimed at controlling these symptoms, whether or not undergoing curative therapy, is a key feature of high-quality patient-centered care. This paper explores the potential role of palliative medicine in the emergency room and how early integration with emergency care can help improve the quality of life of patients and thus achieve better outcomes.

Key words: *Emergency care, palliative medicine, quality of life, symptom control*

INTRODUCTION

Palliative care is a subspecialty of medicine which focuses on improving the quality of life of patients with life-threatening illness. The spectrum of care extends from the curative stage to end of life and bereavement. It cares for patient and family as a single unit. Research has shown that palliative care interventions initiated early in the disease trajectory helps improve the quality of life of patients by providing good symptom control and reducing the costs of treatment and the duration of hospital inpatient stay.^[1-5]

Palliative care is often used interchangeably with hospice or terminal care. Palliative care alleviates acute and chronic symptoms due to the underlying disease and treatment-related complications whether or not the patient receives curative treatment whereas hospice care looks after patients who are terminal or imminently dying. Thus, palliative care is a domain whereas hospice care is a subset of palliative care.^[6] The potential role of palliative care in the emergency room is well reflected in the definition.

For many patients with advanced malignancy, emergency rooms are an accessible portal for acute medical care and where necessary, end of life care. This is largely due to their 24 h availability of service, access to analgesia and specialists and inpatient care. Thus, integration of palliative care service with emergency care will be vital due to the vast spectrum of care that it provides.

The cases discussed below affirm the potential role of palliative care in emergency medicine where early intervention restored the patients to good quality of life.

CASE REPORTS

Case 1

A 35-year-old female patient, known case of metastatic ovarian adenocarcinoma with peritoneal and omental deposits was brought to the emergency room with a history of drowsiness, restlessness, and inability to recognize her family members. On probing further into the history of symptoms, she had bilious vomiting since 4 days with six episodes of vomiting per day followed by constipation for the last 2 days. On examination, the patient was drowsy and disoriented to time, place, and person. She was tachycardic (heart rate: 125 beats/min) and had a low blood pressure (90/60 mmHg). Abdominal examination revealed distended abdomen with sluggish bowel sounds. Except for drowsiness, her other neurological examination was within normal limits. Other systems such as the cardiovascular and respiratory systems were normal. Blood investigations revealed hyponatremia (S. Na: 106 mmol/L) and hypokalemia (S. K: 2.5 mmol/L). X-ray abdomen revealed multiple air fluid levels with loss of gas shadow in the rectum. She was started on intravenous (IV) dexamethasone to reduce the peritumoral inflammation and edema, IV ranitidine and continuous IV infusion of metoclopramide as a prokinetic agent to induce peristalsis. She was given IV haloperidol with IV Phenergan for her restlessness (only one bolus dose had to be administered) after which she had no more episodes of restlessness.

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Sodium and potassium correction was initiated. Two days posttreatment her condition improved; she was conscious and oriented to time, place, and person. She had complete resolution of bowel obstruction and was discharged home after 4 days. She continues to follow-up with the palliative medicine and medical oncology clinic for her routine check-up.

Case 2

A 43-year-old female patient, a diagnosed case of advanced carcinoma of the base of the tongue presented to the emergency room with shortness of breath and drowsiness and was referred to the palliative care team for the terminal condition. She was drowsy, disoriented, and restless. On examination, she was tachypneic (respiratory rate of 36/min) and tachycardic (heart rate of 126/min). She had a tracheostomy *in situ* and foul smelling oral cavity with pus exuding from the oral cavity. She had tracheal rales on auscultation. Her tracheostomy was filled with viscid secretions. We gave her a bolus dose of injection Haloperidol with phenergan to reduce her restlessness followed by breakthrough doses. We then nebulized her with hypertonic (3%) saline followed by suctioning of the secretions. The nebulization was continued every 4 hourly followed by suctioning of the secretions for the first 24 h. She was given continuous oxygen support through T-piece. We advised the nurse to rinse her oral cavity with metronidazole solution 4 times a day. Her secretions liquefied with two hypertonic (3%) saline nebulization and the secretions were suctioned out. The patient started showing signs of improvement in 6 h. Within 12 h, she was conscious and oriented to time, place, and person. Her heart rate reduced to 96/min and respiratory rate to 22/min. Her oxygen requirements reduced to 2 L/min (requiring only intermittent oxygen support). After 24 h, the nebulization was reduced to twice a day and given intermittently for breakthrough symptoms. Her oral hygiene improved with metronidazole oral rinse. By day 2, her supports (oxygen and nebulization) were stopped. We advised the nurse and the family members to cover the tracheostomy port with thin, moist gauze piece (as this would avoid drying of secretions and prevent maggot formation). By day 3, she was discharged from the hospital with necessary instructions on tracheostomy care and medications. We continued following her up on the phone (as she was from a remote village in Odisha). She did well with occasional symptoms which were handled well by the local physician with our advice.

Thus, prompt identification and management of symptoms alleviated the distress, facilitated recovery and discharge, and improved the quality of life of the patient.

Case 3

A 56-year-old male patient, diagnosed case of adenocarcinoma of the lung with metastasis to the bone and

liver presented to the emergency room with breathlessness. The patient was dyspneic (Edmonton Symptom Assessment Score of 9/10) and restless in bed pulling out the oxygen mask as he felt suffocated. On examination, respiratory rate was 38/min, heart rate 140/min, extensive rattling sound in B/L chest field interspersed with rhonchi. X-ray chest revealed multiple lung metastases in bilateral lung fields which corroborated with the computed tomography scan of the thorax done 1 month back. All measures including oxygen, nebulization with bronchodilators and steroid and injectable hydrocortisone failed to reverse his breathlessness. The patient was then referred to Palliative Medicine Department for intractable dyspnea. The team after assessment started the patient on continuous IV infusion of morphine to reduce the “air hunger” and anxiety associated with the respiratory distress and round the clock IV glycopyrronium to dry the chest secretions. Within 3 h, there was marked reduction in the breathlessness. The respiratory rate reduced to 22/min and heart rate reduced to 102/min. On auscultation of the chest, there were no secretions and rhonchi and the doses of the medications were titrated and stopped. He continued to receive oxygen at 2 L/min intermittently. The palliative care team held a family meeting with patient and family to discuss the graveness of the prognosis and the possible treatment options available for the patient including resuscitation if the patient opted for. Following repeated discussion over 3 days, the patient and family opted out of resuscitation and opted for supportive care to comfort him. The patient was discharged home after 3 days. The patient finally succumbed after a week peacefully without any distress. The family felt contented about the fact that they were by their patient’s side attending to his needs and fulfilling his demands.

Thus, the intervention by the palliative care team helped control the acute symptoms in the patient, the team also helped the patient and family transition through the end of life and ensured that the patient had the autonomy for decision-making regarding treatment options and finally a dignified death with family by his side in the last hours of life.

DISCUSSION

The basic premise of emergency medicine is to provide initial and definitive treatment to patients of any age, gender, disease, and injuries, provide initial aid for assessment and resuscitate patients before discharge or transfer to other facilities.^[7-9] However, these principles cannot always be adhered to for patients with advanced malignancy or any chronic, life-threatening illnesses due to the complex pathophysiology and social conditions.^[7-9] This, in turn, demands sensitive communication or even negotiation about the treatment options including resuscitative actions

which may be undesirable for such patients.^[10] Some of these patients might present at the end of life care situations raising the importance of the environment to provide such care. Thus, it is essential to have knowledge in symptom management, expertise in communication skills and difficult clinical decision-making.

There are multiple advantages to early integration of palliative medicine/care with emergency care some of which include; the patient's and family's wishes are supported, and this can hugely impact the plan of care, the interdisciplinary team focuses on open communication to attain symptom management, choice of interventions and the treatment plan and the intervention also helps reduce duration of hospital inpatient stay and overall cost.^[1-5]

Potential barrier in accessing palliative medicine/care service is the misconception that palliative care is synonymous with the end of life care. In standard oncology practice, discussions regarding end-of-life care and advanced symptom management often occur within days to weeks of the patient's death, but the initiation of palliative care earlier in the course of disease can lead to improved symptom control and reduced distress throughout the disease-directed therapy.^[11-13] In addition, these discussions result in increased referral and use of hospice and reduced use of intensive medical care in the end-of-life setting when the disease is no longer amenable to cure.^[14]

This comes back to the basic questions; are we prepared for this? Do we have the enough manpower to overcome these barriers? In a busy emergency room, will end-of-life care decision and discussion be possible? Who will lead the entire transition?

There is tremendous paucity of specialists in palliative care in developing countries, and most busy tertiary hospitals might have one palliative care specialists or none at all.^[15] However, the need is so immense that emergency staffs express the need for integrating palliative care with emergency care.^[10] This would mean that medical and paramedical staff needs to be sensitive to the needs of individual patients and family as they are the first point of contact for the patients. There is, thus, a need to empower the emergency staff. This could be achieved by continually educating the emergency staff in principles of palliative care. The education program will include; identification of palliative care needs of the patients, pain, and symptom management and communication skills. This will thus equip the staff with the knowledge and skills of palliation.

In addition, a data log comprising training schedule, appropriateness of patients selected for nonescalation, appropriate referrals to palliative care team and optimization and quality of services provided will help in validating the service provided in the emergency rooms and also sow

seed for further research in this area. Finally, the success of the program will depend on the popularity that it has gained among primary treating and emergency teams which in turn will depend on the advocacy of palliative care. Thus, the program will need a team leader who will involve in organizing training, addressing the barriers, and promoting inclusion and continuity of the program within the hospital structure.

CONCLUSION

Early involvement of palliative care with emergency care can help reduce the symptom burden and thus improve the quality of life of patients. At the end of life care situation, effective communication between the patient, caregiver, primary team, and palliative care team can avoid unnecessary resuscitative actions and ensure a dignified and peaceful death. Palliative care must thus be an integral component of emergency care.

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Conflicts of interest

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