INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE CASE OF THE MONTH

"You're Not Going to Let Her Starve to Death, Are You?"

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Case: Mrs. SS is a 55 year old woman who was diagnosed with ovarian cancer in 2006 with recurrence in 2008 with metastatic disease. She was admitted several weeks prior to her Palliative Care consult with failure to thrive, bowel obstruction and sepsis. Her recent course has been complicated by persistent bacteremia, UTI, recent pulmonary embolus with new onset of atrial fibrillation and pneumonia. She also received a right percutaneous nephrostomy and placement of a G-tube. Patient was experiencing ongoing pain, nausea and intermittent delirium. She had not been out of bed in weeks and had difficulty tolerating repositioning in bed. On initial visit with patient, husband, mother and adult daughter, focus was centered on trying antibiotics for a few more days to see if the bacteremia cleared. If no improvement, they were interested in taking patient home with hospice.

Several days later blood cultures came back negative and remained so. The primary service began to discuss placing a PICC line and consideration of TPN (total parenteral nutrition). At times the family was divided between wanting her to go home to be comfortable and having aggressive therapy. Patient was able to tolerate only small amounts of oral fluids, she denied feeling hungry and stated it did not bother her to not eat. Her other adult child, a son, repeatedly stated "we can't just let her starve."

Discussion: Ovarian cancer is the fourth leading cause of cancer deaths in women. Up to 42% of these women die as a result of bowel obstruction associated with advanced malignancy. When surgery is not an option, medical management is initiated to relieve symptom burden. Maintaining the patient NPO or minimal intake with a venting g-tube or naso-gastric tube is indicated in conjunction with pharmacological treatment. Many family members, more so than patients, become distressed that the patient is unable to eat and feel that something should be done to provide nutrition. It is difficult for them to comprehend that not using TPN may be more beneficial than harmful to the patient.

The primary goal of TPN is to restore or maintain a person's nutritional status and to correct or prevent malnutrition-related symptoms. In a very select population of patients with cancer related bowel obstruction, TPN may provide benefit.

In general, the patient would have a prognosis of at least one month and a Karnofsky status exceeding 50. Given that in cancer patients, loss of appetite and weight loss can be part of the dying process, the addition of TPN will not change the course of advanced cancer and may add more symptom burden.

Infusion of TPN in patients with weight loss due to cancer cachexia has failed to show any benefit in improving either survival or quality of life. Yet the risks and complications are many. Infection is the most common complication due to the nutrient content, which may cause line infection, bacteremia and even subacute bacterial endocarditis. The volume of fluid may cause worsening edema, fluid overload and shortness of breath. Metabolically, hyperglycemia, electrolyte imbalances and hepatic abnormalities may occur.

As in all cancer treatments, sometimes there may be a psychological benefit to the patient or family in providing TPN even if there are no medical benefits. Having a clear, careful discussion with the family and patient, if able, should occur to focus on the patient's goals and wishes. It is important to determine what is hoped to be gained by starting TPN. The discussion should be sensitive to the family's concerns regarding starvation and abandonment. Reinforce that there are other ways for the family to show love and support to the patient besides feeding. If possible patients can place favorite foods or drink in their mouth if they desire the taste. If the decision is made to initiate TPN, the discussion should also include how the decision will be made to stop it. A short time frame should be considered to re-evaluate the benefit versus harm to the patient.

Back to the case: Mrs. SS's primary oncologist agreed to a trial of TPN. A PICC line was placed and TPN was initiated. Four days later the patient had increased edema in both lower extremities and her abdomen was noticeably more distended and firm. She was less responsive and more restless. The decision was made to stop all aggressive therapies and discharge the patient to home with hospice care. She passed away 48 hours after returning home.

References:

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