

Saving a Life: Balancing Risks, Harms, and Benefits in Palliative Care

Paul A. Glare, *Art of Oncology* (*Journal of Oncology February 2014)

The letter from the hospital's Office of Development was marked "Confidential." No, we had not been offered the \$10 million endowment I had been hoping for. But the letter, signed by the vice president of Development, was to inform me of a gift of \$100 in my honor from a grateful patient.

It read: "You are my special angel. Thank you for saving my life."

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The donor was a woman in her sixties with metastatic breast cancer. She had been a patient of mine for only a few months. She was referred by her breast oncologist for assistance with pain management, and I had seen her in the clinic on only a handful of occasions. Hers was an unusual cancer story, at least in my experience. She had been diagnosed with triple-negative breast cancer six years ago, and it was metastatic to the bone at the time of diagnosis, but with only a solitary lesion in the sternum. This lesion had gotten progressively bigger over time, but her disease had never been found to have spread elsewhere. She had had multiple lines of chemotherapy, the prescription of which had been compromised by her comorbid coronary artery disease. Because her tumor was androgen receptor positive, she had been treated with hormonal therapies on two protocols, but these had had to be discontinued because of intolerable hot flashes. She was now on expectant observation.

At the first consultation with me, the patient complained of long-standing pain in the sternum, which had increased in recent months and was excruciating, especially with movement, radiating to both breasts and into the right axilla and upper extremity at times. The latest positron emission tomography scan had again shown the large sternal lesion (5.2, 4.6, 5.2 cm), which had increased in size compared with the previous scans but with stable [18F] fluorodeoxyglucose (FDG) avidity. A soft-tissue component extended both superficially and deep toward the sternum. There was associated increase in central FDG photopenia in the mass, representing central necrosis. There were no other FDG-avid foci of concern.

Her oncologist had tried a fentanyl patch, but even at a dose of only 12 mcg per hour it caused bothersome adverse events (dizziness, dry mouth), so the treatment had been switched to oxycodone, which made her nauseous. Non-opioid analgesics were going to be challenging to use in her case, because of interactions with her cardiac medications and the antidepressants she was taking. Palliative radiation therapy to the sternum had already been given last year to the maximal dosage. Aside from pain and the adverse effects of the pain medicine, she was otherwise without complaint and had an excellent performance status. After a prolonged discussion about the pharmacologic options, she preferred to try fentanyl patches again rather than rotating to morphine or methadone.

At the second clinic visit 3 weeks later, she continued to complain of sternal pain with associated numbness. She was tolerating the fentanyl better this time around but had no real improvement in the pain, despite titration of the dose to 37g per hour. I informed her I would present her case at our monthly Combined Pain Services meeting to inquire about the possibility of intercostal nerve blocks, but I warned her they might not be feasible given that the lesion was so large and invasive. At the conference, my anesthesiology colleague opined that nerve blocks could be offered, but he also raised the option of palliative surgery. So I reached out to our cardiothoracic surgeon who reviewed the imaging and told me she would need a sternectomy, but the procedure could provide good palliation. When I communicated this to my patient, her initial reaction was unexpected. Rather than expressing anxiety, she expressed surprise and consternation, informing me that she had previously asked her oncologist about the possibility of surgery but that her request had been dismissed as an option.

The patient called me back a few days later, asking for a referral to the cardiothoracic surgeon. When I informed her primary oncologist of my plan, he told me I was crazy because of her coronary artery disease and the fact that the tumor was abutting the pericardium. Nevertheless, the patient met with the surgeon and chose to have surgery. The procedure went smoothly, clear margins were obtained, and the reconstruction went well. The patient went home after 5 days and, over the next few weeks, tapered down and discontinued her narcotics. Her computed tomography scans 2 months after surgery was unremarkable. She happily called my office to cancel her future appointments with me.

Pain is one of the most common complaints of patients with advanced cancer, is often moderate to severe, and is usually managed with opioids and adjuvant analgesics; these are effective in the majority of cases. *As palliative care becomes increasingly integrated with oncology, patients referred to palliative care specialists live longer, have a better performance status, and are less likely to accept sedation and other adverse events associated with opioids and adjuvant analgesics.* In this situation, the possibility of using more invasive palliative interventions may arise. The decision to offer an invasive procedure for symptom control in a patient with advanced cancer is a complex one requiring much deliberation. *The burdens, risks, and benefits of the procedure must be communicated and carefully weighed by the physician and the patient.* Invasive techniques are part of the palliative care armamentarium, provided the harms and risks do not outweigh the benefits and the intervention is consistent with the patient's goals, priorities, and expectations for their care at this stage of illness.

Although I was excited for her that she had decided to go ahead and see the surgeon, it also troubled me on three levels. As others have described, I was very concerned about the emotional rollercoaster I was placing my patient and her family on by putting surgery back on the table. I was also concerned about the impact this development would have on *my relationship with her oncologist, which is the cornerstone of successful integration of specialist palliative care with oncology.* He had accepted the surgeon's decision that surgery was feasible. But given that he is not someone I work with often, I was unsure whether that was the kind of recommendation he was looking for when he asked me to see his patient; *referral to palliative care is still the prerogative of the oncologist, and there is nothing surer for stopping referrals - and impeding patient access to services - than poorly conceived, inconsistent advice from the palliative medicine clinician.*

Most of all, I was questioning my own decision making when I suggested the surgery. *Cancer pain guidelines recommend interventional strategies for patients with poorly controlled pain, intolerable adverse events, or when a procedure is preferred over a chronic medication regimen.* But the procedures that are typically applied—nerve blocks, kyphoplasty, cryoablation, intrathecal pumps—are based on evidence and much less invasive and risky than what was proposed. In addition, unlike resecting solitary liver, lung, or brain lesions, I was unaware that resecting bone lesions in breast cancer conferred any survival benefit (admittedly, isolated sternal involvement may be an exception). *So was I creating the kind of false hope that my oncology colleagues are frequently accused of, proposing an invasive, expensive intervention just because it could be done, because that was easier than making more of an effort to help my patient accept the reality of her situation and that the options are limited?* The surgery would certainly be painful, had no guarantee of being effective, and could risk her life. *In short, was I behaving like a narrowly focused, biomedical interventionist and not the holistic palliative medicine physician I aspired to be?*

It is well-documented that patients with advanced cancer frequently misunderstand the goal of palliative treatments. As her thank you note implied, that seemed to be the case here, despite my explaining to her that removing the painful tumor would not cure her cancer. *Have I saved her life? As kind as it was for her to thank me for it, I do not think I have, and I did not embark on a career in palliative medicine to save lives.* But as a result of the surgery, she has gotten back - at least for a while - the life she once had without the unsightly sternal mass, free of pain, and without the adverse events and other inconveniences of being on narcotics.

I am not her special angel. Her oncologist, the cardiothoracic surgeon, even my anesthesiology colleague are more deserving of that accolade. *Maybe I am even her devil. Good palliation has been achieved so far but I still wonder if my advice was reckless and unwise,* and when she will be back in my office.

***comment:**

("... I do not think I have, and I did not embark on a career in palliative medicine to save lives.")

- On the contrary, all who embark on a career in palliative care, do so to save lives, ...maybe not to save lives from death, but certainly to save lives from suffering from pain, misery and fear.

* M.Yoong

- We've been wrong about what our job is in medicine. We think that our job is to ensure health and survival. But really it is larger than that. It is to enable well-being.

* Atul Gawande

- If you save a life, you are responsible for that life thereafter.

* Chinese proverb