"From the Trough"

Perioperative Interest Group Notes

Based on Cases discussed at the Weekly PIG Clinical Meeting 22nd March 2018.
Publication date 29th March 2018.
Website: www.perioptalk.org

The imperfect opinions in these reports are only meant to stimulate discussion:- they should not be considered a definitive statement of appropriate standards of care.

TOPIC 1: End-of-life Shared Decision Making:- Reality or Myth?

73 year old man with #NOF. Eisenmenger's syndrome (PFO and large R to L shunt), Very poor RV function Torrential TR due to pacing lead. SaO2 70-80% in Room Air. COPD: Ex-smoker. FEV1 34%

Offered hemiarthroplasty vs non-surgical palliative care. Patient requested surgery for pain relief. Family against surgery but supportive of pt's choice. Long discussion of risk vs benefit of both surgical and non-surgical options. NSQIP and P-POSSUM risk assessments used to guide discussion including 25% mortality and up to 90% morbidity. Patient's GP was consulted along with palliative care specialist. Long discussions with procedural anaesthetists to consider appropriate anaesthetic plan. ICU consulted and agreed to provide very limited pressor support if required.

Outcome:- Surgery proceeded with slow epidural plus ketamine/remifentanil sedation. Required metaraminol for 24 hrs.

Discussion:- Shared Decision Making is important but difficult to support. Risk assessment tools such as NSQIP and P-POSSUM provide numbers but most patients and families will need help to interpret these. There was a range of opinions about whether decision-making is, in reality, shared. Even in a 'Shared Decision Making' model, Are we actually making decisions for patients. Further, should we make decisions for patients?
One of the greatest barriers in these end-of –life scenarios is the poor access to specialist palliative care which prevents the presentation of clear alternatives to surgical management.

TOPIC 2: Cardiac Tests vs Clinical assessment

80 year old female for shoulder surgery. Reasonably recent deterioration in shoulder function due to pain and good prospects of improvement from surgery. The patient has severe aortic stenosis on echocardiogram (0.6m2) however her exercise tolerance is "surprisingly" good. Able to walk up the long staircase non-stop. She had floor of mouth cancer surgery 12 months ago without trouble. ECG shows left bundle branch block. Questions:- is there a point in ventricular pacing? How can we resolve the echo findings with the observed exercise tolerance?

Discussion:- Based on previous similar cases, it was believed that biventricular pacing is unlikely to make any clinical improvement. CPET may have a role in objectively accessing the exercise tolerance, although the staircase test seemed reassuring. Pragmatically a cardiac consult is needed to clarify both questions, and in particular to review the echo findings. The general feeling is that exercise tolerance is generally a more reliable measure of risk than findings on an Echo.

TOPIC 3: Surgery in severe disability

A 60ish year old female with normal pressure hydrocephalus for VPshunt. The patient has severe 'Alzheimer's' dementia with resultant severe disability:- wheelchair bound, incontinent, dependant for ADLs and "has been like this for years". There is some family guilt about not having had the surgery years ago. A recent lumbar puncture caused some improvement and the patient has apparently since made "appropriate" verbal

responses. She does have some recognition of words and faces. The patient had been booked for surgery at short notice and was seen one day before the proposed operation. The husband appeared to have considerable misunderstanding of the procedure and expectations of improvement. He “just wants to do what is right”

Question:- Is this appropriate to go ahead? Have we considered the risks of neurological deterioration (POCD) associated with the anaesthetic?

Discussion:- There was considerable discussion back and forth with a variety of opinions. It would appear that the family dynamics may be of relevance, particularly the distant relatives pressuring the husband. There may be some guilt about lack of earlier medical intervention. It is not clear that there will be long term neurological deterioration from anaesthesia, although with a previous surgical procedure there was delirium for about a week after the anaesthetic. (but was this associated with the hydrocephalus, which may be resolved by this procedure?) The procedure itself (VP shunt) is relatively “superficial” and low stress surgery – if it gives some minor improvement, or does not make things worse, there may be worthwhile consolation for the family. However there may be unrealistic expectations of improvement by the family. Initial discussion with the neurosurgeon consultant showed that they had some degree of ambivalence about the procedure as well.

Plan:- There is no rush to surgery. It is appropriate to have a secondary consult with both the senior neurosurgeon and a perioperative anaesthetist in attendance to have a fully informed discussion with the family to clarify expectations, both of possible improvement and risks of delirium / decline precipitated by the procedure. There are no easy answers in this situation.