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REVIEW

Abdominal surgical emergencies in patients with advanced cancer



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Summary Abdominal emergency in an advanced oncologic setting is defined as an acute life-threatening abdominal pathology in a patient with incurable cancer. These include bowel obstruction, infections and, more rarely, hemorrhage. To benefit the patient, surgery should both increase the survival and improve the quality of life. These two goals are of equal importance and must be achieved together. This is difficult because these patients are frail, often malnourished and have a poor performance status. They also have a high risk of post-operative morbidity and mortality, a major risk of symptom recurrence and a limited life expectancy. For patients near the end-of-life, a therapeutic decision for surgical intervention must respect ethical and legal standards. This review reports the surgical outcomes and median survival of these patients, specifies rules that must be known and respected, and presents non-operative interventional alternatives.

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Introduction

The surgeon is regularly confronted with abdominal emergencies that arise in palliative situations. These emergencies include intestinal obstruction [1,2], septic complications (abscess, peritonitis, fistula) [1] and, more rarely, hemorrhage [1–5]. The high prevalence of advanced stage cancer and longer survival in these patients has led to an increasing frequency of such abdominal emergencies. Over a five-year period in France, nearly one million people will develop cancer and half a million will die [6]. The median survival of these patients has steadily increased in recent years and

now exceeds two years for many metastatic tumors (breast, colon-rectum, prostate, stromal cancers). Improved survival is linked in part to treatment with anti-angiogenic agents [7], a treatment that entails an increased risk of bleeding complications and intestinal perforation [7,8].

Increased survival is the main objective of curative surgery, so morbidity and sequelae are seen as acceptable risks. This differs from palliative interventions where there are two objectives of equal importance: prolongation of survival and sustainable symptomatic improvement [9] with improved end-of-life quality. Failure to simultaneously achieve both objectives amounts to a surgical failure, and the risk of failure is high [1]. In this challenging environment, multidisciplinary consultation is very important although the urgency of the situation makes this difficult to achieve in practice. The surgeon often stands alone in the front line to deal with the patient and family to make the therapeutic

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decisions. It is both necessary and a legal requirement to fully discuss with the patient and/or supporting family the implications of any invasive therapeutic strategy. This communication is fundamental and must realistically explain the often-modest objectives of surgery and the situations where surgery may be futile or even harmful to the patient.

Ethics and legislative mandates

The context of end-of-life care is a delicate situation where performance of invasive procedures demands compliance with ethical rules. French law has established such rules, modified in April 2005 by Law No. 2005-370, the so-called Leonetti law. The spirit of the law is to place the patient and/or his family at the center of the therapeutic choices and to permit refusal of unreasonable or futile treatments. The assessment of unreasonableness of a given treatment is based on inter-collegial consultation. Despite its importance, the Leonetti law is poorly understood by 70–80% of all physicians [10,11]. Every French surgeon called upon to care for these patients must be fully aware of this statute, the text of which is available on the internet [12].

The anticipation that such emergencies may arise in a palliative situation is also inadequate. Advance directives are only rarely implemented [11,13] and physicians rarely request the appointment of a trusted person with legal standing to aid in decision-making [11]. Patients should be made aware of these measures, and they should be systematically implemented and recorded in the medical record; this is currently not the case in 60% of cases [14].

The surgeon often plays the role of primary physician for both the patient and the family, and must endeavor to obtain the informed input and consent of the patient while assessing the reasonableness or futility of invasive treatments that can be offered. This assessment should be made with the help of collegial consultation, especially since the operative decision and death are intricately intertwined [15,16]. Inter-collegial consultation is very important and much progress is needed in France. For example, even though 60% of intensivists in the Rhône-Alpes claim to have good knowledge of the Leonetti Act, 70% of them do not regularly seek consultative advice from a physician outside their intensive care unit, and 60% report that they make therapeutic decisions alone without collegial consultation [15].

Operative indications and informed consent

The decision for surgery is a major step requiring evaluation of operative morbidity and mortality, the chances of success in controlling symptoms, possible post-surgical sequelae, the possibility of medical or non-surgical interventional alternatives, the anticipated medium-term survival, the wishes of the patient and his family, and the opinion of physician colleagues (collegiality). Wish to be informed and full information is a fundamental factor for consent [13]. This information facilitates patient care without necessarily increasing anxiety [14,17]. It is important to set realistic goals and these should be clearly explained to the patient. The patient and family can better understand and accept limited but realistic objectives than dramatic but highly unlikely outcomes [10]. Several rules of good patient communication have been published that the surgeon can consult [10].

Operative morbidity and mortality and long-term survival

Operative morbidity and mortality are high after abdominal emergencies in the palliative setting. Post-operative mortality ranges from 5 to 30% [1,4,5,18–20] and morbidity from 20 to 60% [1,4,5,18–20]. Hospital deaths are related either to surgical complications or to tumor progression [2]; half of the complications are infectious [1,18]. Mortality risk factors are dominated by general patient condition (WHO status), and the risk in terms of morbidity and mortality could be predicted by the P. POSSUM scoring and nutritional status [1,2]. These elements reflect the severity of the acute illness and the degree of oncological advancement. Patients with advanced cancer who are hospitalized or undergo emergency surgery have a median survival of 3 to 5 months [1,4,21]; three-quarters of the patients die within one year [1,4,21]. In abdominal emergencies, the type of primary cancer does not have a major effect on prognosis [1,21,22]. However, it is still important to obtain the opinion of the referring oncologist since goals differ depending on the possibilities and hopes of further oncologic treatments, and these can vary greatly. Some incurable advanced cancers have median survivals of up to two years (breast, colorectal, prostate, stromal tumor), and the survival for some cancers with typically poor prognosis (lung, melanoma) may be significantly improved if they have a mutation amenable to a specific targeted therapy.

Our team has developed a nomogram [1] to calculate the risk of death at three months post-operatively to serve as a defined point of reference when discussing the indications for operation with the patient and family. This nomogram should be used cautiously since it has not been validated in an independent cohort study.

Quality of life and symptom improvement

Surgeons tend to overestimate the ability of their procedures to improve the patient's symptoms [23]. There is need for objective knowledge of the outcomes of surgery with regard to the rate and duration of symptom improvement. Surgery provides moderate improvement of symptoms compared to non-surgical treatments, but has little impact on the quality of life [3,24,25]. Badgwell et al. [3] reported symptomatic improvement for patients who were treated palliatively by non-operative management, radiological or endoscopic procedures, and surgery; the rate of symptom improvement rate 60% (49/81), 69% (24/35), and 78% (67/86), respectively. Surgical treatment was associated with moderately higher symptom control in comparison to other treatments. A study from the Memorial Sloan-Kettering Cancer Center [2] concerning more than 1022 non-urgent palliative procedures (70% surgery) showed symptom improvement in 80% of patients for a median of 3 months while 20% obtained no benefit because they died in the hospital due to complications or tumor progression.

Bowel obstruction

Obstruction may be caused by a primary colonic tumor or by isolated local or peritoneal recurrence.

The tumors that most commonly result in bowel obstruction are primary colorectal and gynecological cancers or

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