Palliative Care Principles for Thoracic Surgery

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KEYWORDS

- Thoracic surgery • Oncology • Pain and symptom control • Palliation • Palliative care

KEY POINTS

- Thoracic surgical practice, heavily oncological in nature, is two-thirds populated with patients who do not survive their illnesses—embedding this practice in palliative medicine.
- Palliative care medicine, now a distinct specialty of its own, was late in forming, launched initially in the United Kingdom in 1967.
- At an international level, palliative care services are woefully inadequate: 5 billion of the world's 7 billion people have minimal or no access to opiods for pain control. Global awareness and advocacy are imperative.
- Research informs that the early identification of patient needs for palliative care services not only improves the quality of care but also saves money.
- A significant part of thoracic surgery practice is specifically aimed at procedures designed to alleviate symptoms and relieve suffering, procedures that are entirely palliative in nature.

Thoracic surgeons have always had an open window into the world of palliative care: 80% of patients referred to a thoracic surgeon have malignant diseases of the chest, and 80% of those patients die of the disease not able to be cured, not even with the support of the multibillion dollar pharmaceutical and radiation industries available.[1]

This worldview says more about the virulence and complexity of lung and esophagus cancer than it does about failure to cure. Nevertheless, whether tasked with the diagnostics of advanced stage cancer, undertaking surgical procedures that are inherently palliative in nature, or undertaking potentially curative surgeries of the chest, from a historical perspective, thoracic surgeons have had a front row seat into the developing world of palliative medicine.

It is surprising that among the various subspecialties of medicine, palliative care is one the most recent to have evolved. It was not until 1967, when Dame Cicely Saunders launched the first hospice unit in the United Kingdom, that this new discipline emerged.[2] In the years since then, there has been an explosion of research, public policy enactments, and World Health Organization directives, culminating in a fascinating Quality of Death Index, published in 2010 by the Economist Intelligence Unit, commissioned by the Lien Foundation in Singapore.[3]

Because of Dr Saunders' founding work, the United Kingdom leads the world in terms of research, funding, and policy. Australia and New Zealand enacted legislation for palliative care integration into their health care systems in 1988 and 1990, respectively, soon after Britain's actions.[4,5] It is not unanticipated then that these 3 countries should lead the Quality of Death Index, a summation of the basic health environment, availability, costs, and quality provided for end-of-life care. Canada and the United States are ranked coequally at 9th on the index. This Quality of Death Index is measured in only 40 countries where data are consistently available. Palliative services are low in the bottom 4 on this list: China, Brazil, Uganda, and India. Recognizing that no data

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were available from the remaining 146 countries in the world, palliative services worldwide are woefully inadequate.

The World Health Organization describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. This is done through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial, and spiritual."[6]

It is no surprise then to find advocates for palliative care assemble under the banners of pain and symptom control or of psychosocial, spiritual, or existential advocacy.

The embodiment of both paradigms of care can be concurrently adopted. "Pain management opens the gate to bringing in all the rest that we know—the social, spiritual, cultural issues that are there," say Merriman and Harding.[7] "With pain control, people can start to think again."

Cultural and historical differences explain why there is such diversity in the ways that people approach death and dying and, therefore, the way they enact laws and practice palliative medicine.

Even talking about death and dying is taboo in China, Japan, and India, making it virtually impossible for those countries to legislate policies. In a great many countries, the availability of opioids for the control of pain is restricted for fear of abuse and criminal access to these drugs.[3] In India, fewer that 1% of the public can access narcotic drugs.[3] Despite the World Health Organization's pain ladder for treatment, 5 billion of the world's 7 billion people live in countries with insufficient or no access to medications for the control of severe or moderate pain.[8]

In other parts of the world, in particular Africa, there is a strong sense of community support for the dying, augmented perhaps by the disease endemics that shorten life expectancy. In North America, there is a tendency to medicalize palliative care because of the availability of analgesic drugs, prompted also by the for-profit motives of pharmaceutical companies.[3]

Clarity surrounding any discussion about palliative care blurs in the modern era as topics, such as assisted suicide and euthanasia, enter the debate. Values and attitudes along with historical and religious beliefs vary from one jurisdiction to another, guaranteeing that no worldwide consensus about palliative care is established. This is different from practice guidelines for the treatment of lung cancer informed by scientific evidence.

As the population ages and chronic diseases proliferate, the need for palliative services will skyrocket. Between 50% and 70% of adults older than 70 suffer from chronic pain alone.[9] Although the funding of palliative care services even in first world countries is becoming a challenge, research shows that early intervention in the palliative care cycle can improve quality of care and decrease costs.

Patients receiving early palliative care consultations in intensive care settings had experienced shorter hospital stays, incurring lower costs with no decrease in their overall hospital mortality.[10] By identifying issues quickly on admission to hospital, their initial resolution facilitated early discharge.

A direct quote from the Economist Intelligence Unit report sums up the state of affairs succinctly: "The Governments and providers are in a race against time—however quickly they can beef up their end-of-life care infrastructure, they may still not be able to meet the even faster pace at which their citizens are reaching an age or condition where they need those services. So although calls echo around the world for end-of-life care to become enshrined in national and international policy as a human right, the reality is that even if it achieves that status, for much of the world's population, such a commitment will exist on paper only."[3]

Returning to the theme of palliative care in thoracic surgery, special notice is taken of those operations and procedures designed to relieve suffering and to improve quality of life.

The historical role of bypass procedures for advanced-stage esophageal cancer has given way to stenting, a technology that itself has undergone significant improvement over time. Esophageal stents have proved helpful in managing patients with dysphagia and tracheoesophageal fistulae.[11] A multicenter prospective randomized trial compared the self-expanding metal stent with the newer and self-expanding plastic stents in palliating malignant dysphagia. Both were effective in their palliation of symptoms, although the more-expensive metal stent migrated less frequently than its plastic alternative, with better dysphagia scores.[12]

The successful placement of second self-expanding stents has been reported in dealing with tumor overgrowth of previous stents.[13]

Both Nd:YAG laser débridement, and photodynamic therapy (PDT) have been evaluated in cases of bulky endoluminal tumor.[14] Both offered equivalent relief from esophageal obstruction, the PDT treatment leading to greater tumor ablation. Both treatments have been useful in control of bleeding from esophageal tumor erosion.[15]