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Journal of Cancer Policy

journal homepage: www.elsevier.com/locate/jcpo



Reviews

Palliative surgery

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ARTICLE INFO

Article history:

Received 21 September 2015

Accepted 30 May 2016

Available online xxx

Keywords:

Palliative
Surgery
Surgical oncology
Outcomes

ABSTRACT

Palliative surgery is defined as any invasive procedure with the major goal of relief of symptoms or to improve quality of life for patients with advanced illness. Palliative surgery is increasingly being recognized as important, in part, due to the significant frequency of inpatient palliative surgical consultations and palliative surgical procedures that surgeons are asked to perform. In addition, the morbidity and mortality associated with palliative surgery is higher than similar procedures performed in elective, non-palliative situations. Palliative care in surgery involves primarily two disciplines: communication and technical/clinical skills. Communication in palliative surgery incorporates the concepts of shared decision making and informed consent, difficult conversations in critically ill patients, and communication strategies for patients that want everything done in situations of medical futility. The specialty area of palliative surgery incorporating clinical and technical skills address the common indications for palliative surgical consultation such as gastrointestinal obstruction, gastrointestinal bleeding, wound problems, obstructive jaundice, and abdominal pain. Clinical trials are infrequent in palliative surgery and even prospective observational studies with patient reported outcomes are difficult to perform due to patient death and symptom burden that makes follow-up difficult. The focus of this review will primarily be on the clinical aspects of palliative surgery and the implications for future research and cancer policy. The purpose of this article will be to outline common indications for palliative surgical consultation, discuss treatment options, and summarize the research findings of variables associated with surgical intervention and outcome. In addition, we will highlight ongoing research projects that may help address the many questions regarding the optimal use of palliative surgery.

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1. Palliative surgery definition and background

Although there are many slight variations in the definition of palliative surgery, palliative surgery is simply defined as any inva-

sive procedure with the major goal of relief of symptoms or to improve quality of life for patients with advanced illness [1,2]. Sometimes included in the definition of palliative surgery is a procedure performed for anticipated symptoms or to prevent future symptom burden. It is controversial whether to classify this anticipatory palliative surgery as truly palliative. For purposes of research findings it is best to only include patients with current symptoms

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<http://dx.doi.org/10.1016/j.jcpo.2016.05.001>
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that need palliation or clearly define the inclusion criteria in the research methods.

Communication plays an important role in palliative surgery and is strongly influenced by the history and relatively recent advancements of palliative medicine as a specialty. Surgeons can gain much insight from palliative medicine regarding discussions with patients, family, and caregivers regarding decisions to withhold or withdraw life sustaining treatment. Surgeons must also gain expertise in shared decision making and informed consent in patients undergoing evaluation for palliative surgical intervention, since palliative surgery represents a significant and growing proportion of the cancer workload. There are also many ethical concepts that are important for issues of medical futility and determination of when to withhold surgery such as poor prognostic understanding, mistrust of the medical system, religious and cultural influences, and denial. Increasingly, surgeons are recognizing the importance of providing guidance and training in forming a therapeutic alliance with patients and families, assisting with dealing with emotion, and reframing hope in challenging emotional conversations.

Without question palliative surgery is a common clinical scenario for practicing surgeons and surgical oncologists. In a study by Miner and colleagues, palliative surgical or endoscopic procedures represented over 1000 cases in a year at a major cancer center, representing 6% of all such procedures [3]. Of note, is that this number exceeded the number of esophagectomies, gastrectomies, pancreatectomies, and liver resections combined at the same institution over that year. In a self-report survey administered to surgical oncologists, palliative surgery accounted for 21% of a surgeon's practice [4]. Palliative surgical consultations have been shown to represent 40% of all inpatient surgical consultations at another major cancer center [5]. The frequency of palliative surgery may be higher in patients aged 65 and older, recently reported as 25% in a study of patients undergoing abdominal cancer surgery, which has obvious implications for the expanding population of older patients at increased risk of post-operative complications and resource utilization [6].

2. Indications for palliative surgical consultation

2.1. Bowel obstruction

Bowel Obstruction, defined here as a blockage of the small or large intestine in a patient with advanced cancer, is the most common indication for palliative surgical consultation and comprises 43% of all palliative inpatient surgical consultations at major cancer centers [5]. One of the first diagnostic maneuvers in the management of patients with advanced cancer and bowel obstruction is to determine if tumor is directly causing the obstruction. Approximately a third of patients with a history of cancer and bowel obstruction can have benign causes of obstruction such as adhesions or hernias [7]. Malignant bowel obstruction is most often defined according to the following criteria: (1) clinical evidence of a bowel obstruction via history, physical exam, or radiographic examination, (2) bowel obstruction beyond the ligament of Treitz, (3) intra-abdominal primary cancer with incurable disease, or (4) non-intra-abdominal primary cancer with clear intraperitoneal disease [8].

Regardless of the definition, treatment for malignant bowel obstruction is primarily nonoperative based on retrospective reviews that highlight the significant morbidity and mortality associated with operative intervention. In a review by Ripamonti et al., the rates of operative mortality range from 9 to 40% and morbidity is as high as 90% [9]. Bowel obstruction in patients with advanced cancer typically allows time for thorough evaluation with imaging.

Although there are no commonly accepted absolute contraindications to surgical intervention, there are numerous variables associated with poor outcomes such as carcinomatosis, ascites, previous abdominal surgery that identified diffuse metastatic cancer, advanced age, hypoalbuminemia, and low performance status [10]. Thankfully, there are good non-surgical options for symptom palliation such as venting gastrostomy tube placement, stents, antiemetics, octreotide, and analgesics. Therefore, a key function of a surgeon specializing in palliative surgery is to identify when surgery may not be appropriate in advanced malignancy.

The primary surgical options for gastric outlet obstruction are open or laparoscopic gastrojejunostomy. Venting gastrostomy tube is another surgical option, but can often be placed via endoscopic means without the need for surgical intervention and does not allow the patient to maintain adequate oral intake. To restore gastrointestinal continuity, the primary decision is between a gastrojejunostomy and endoscopic stent placement. Although it is difficult to prognosticate accurately, patients with a limited life span are more likely to benefit from the lower morbidity and length of stay of an endoscopic stent procedure [11]. Patients with an expected longer length of life would likely benefit from gastrojejunostomy, although there is no high-level data to support this common practice pattern.

Small bowel obstruction is the most common site of malignant bowel obstruction. Stents are typically not an option and surgical intervention must be used selectively as many obstructions can be multifocal and occur in patients with many indicators of poor surgical outcome. The most common treatment pattern for patients with advanced cancer and small bowel obstruction is medical palliative management and venting gastrostomy tubes are placed in up to a quarter of patients referred for surgical consultation [10].

Large bowel obstruction has benefited from the recent advancements in endoluminal stent placement with the corresponding low rate of adverse events and shorter length of hospital stay compared to open surgery. The overall oncologic prognosis again factors into surgical decision-making as stents do have the risk of recurrent obstruction and migration. The advantages of colorectal stent placement compared to surgery include shorter hospital length of stay and the avoidance of surgery. However, the clinical success rate is higher for surgery and colorectal stents have a perforation rate of approximately 6%, reobstruction rate of 2%, and migration rate of 2%, based on a recent Cochrane Review [12]. The primary surgical options for large bowel obstruction including diverting colostomy, resection with primary anastomosis, and bypass.

3. Bowel perforation

Patients with advanced cancer are at risk of iatrogenic bowel perforation due to their frequent need for endoscopic and interventional procedures and from the side effects of radiation, chemotherapy, and steroid administration. In addition, patients with advanced cancer can experience bowel perforation from general medical conditions such as peptic ulcer disease and diverticulitis. Prognosis and the potential for successful treatment of the malignancy again are integral in surgical decision-making. The majority of patients are treated according to standard surgical principles of exploration with repair. However, nonoperative management is an option that does not always correspond with short-term death and comfort-directed care is appropriate for patients with an anticipated short survival [13].

4. Biliary obstruction

The treatment of patients with resectable and potentially curative causes of biliary obstruction is focused on resecting the primary

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