

An Assessment of the Frequency of Palliative Procedures in Thoracic Surgery[☆]

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OBJECTIVES: Palliative care is a medical specialty focused on improving the quality of life of patients and their families with life threatening illness by preventing or relieving suffering. An assessment of a thoracic surgery service was performed to identify the scope and frequency of care that was considered palliative and any implications the findings might have on the current thoracic surgery residency curriculum.

METHODS: A retrospective review of a prospectively collected database of general thoracic surgery procedures performed over a 5-year period at a single institution was performed. Procedures considered palliative were reviewed for demographics, diagnoses, palliative prognosis score, treatment, morbidity, operative mortality, and survival. Excluded were referrals from thoracic surgery to other specialties for palliative procedures.

RESULTS: During the study period, 3842 procedures were performed of which 884 (23%) were palliative. Indications included pleural or pericardial effusion or both, dysphagia, hemoptysis, tracheobronchial obstruction, bronchopleural fistula, and tracheoesophageal fistula. The majority was related to a malignancy. Only 127 patients (14%) had a palliative care assessment before thoracic surgery consultation. Mean survival following thoracic surgery intervention was 110 days for patients with malignancy.

CONCLUSIONS: This investigation found that thoracic surgeons commonly care for patients when the intention or indication or both is palliation. Most of these patients have an associated malignancy, a poor performance status and a projected significantly decreased survival compared with the general population. Thoracic surgeons should be familiar

with the concepts of palliative care and consideration should be given to expanding exposure to the principles of palliative care in the cardiothoracic residency training curriculum. (J Surg Ed ■■■■-■■■. © 2017 Published by Elsevier Inc. on behalf of the Association of Program Directors in Surgery)

KEY WORDS: palliative procedures, cardiothoracic curriculum, palliative care, thoracic surgery palliative

COMPETENCIES: Patient Care, Medical Knowledge

INTRODUCTION

Palliative care has evolved into a boarded medical specialty that focuses on an interdisciplinary approach to preventing and relieving suffering as well as supporting the best possible quality of life for patients and their families facing serious illness. Palliative care can be appropriately offered to patients at any time along the course of a serious illness, even concurrent with restorative, life-prolonging therapies. It is not limited to end of life/hospice care.

It has been reported that in some general thoracic surgery practices, greater than 80% of patients referred for evaluation have a diagnosis of a malignancy.¹ Furthermore, most thoracic surgeons perform some surgical procedures that would be considered palliative rather than having curative intent. We define palliative surgery as a procedure which should decrease the symptoms and improve the quality of life of a patient and their family resulting from an incurable disease process without offering the possibility of curing the underlying condition. This investigation sought to determine the frequency such patients are cared for by thoracic surgeons and the rate palliative care providers were involved in these patients' treatment decisions. Such information would provide insight into whether awareness of the principles of palliative care would be beneficial for thoracic surgeons and if consideration should be given to incorporating such principles into the curriculum for cardiothoracic surgery residents.

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METHODS

A retrospective review of a prospectively collected database of general thoracic surgery procedures performed over a 5-year period at a single institution was performed. The institution's Institutional Review Board approved this protocol and waived individual patient consent for this investigation. Procedures considered potentially palliative were identified from a prospectively collected database of all patients undergoing thoracic surgery at the study institution. Individual patient records were also reviewed for demographics, diagnoses, palliative prognostic score, treatment, morbidity, operative mortality, and survival^{2,3} (Table 1). A potentially palliative procedure was defined as one which could possibly decrease the symptoms and improve the quality of life of a patient and their family resulting from an incurable disease process without offering the possibility of eliminating the underlying condition. The presence of a palliative care service assessment before and/or after thoracic surgery evaluation or both was also documented.

Excluded from this investigation were patients deemed not appropriate for surgical intervention. However, included were patients who refused surgical intervention for a palliative procedure. Patients undergoing a palliative

Table 2. Indications and Procedures for Patients Undergoing Palliative Procedures

Indication	Procedure	N
Recurrent pleural effusion	Tunneled pleural catheter	366
	VATs pleurodesis	35
Symptomatic pericardial effusion	Subxiphoid drainage	87
	VATs drainage	29
Bronchopleural fistula	VATs pleurodesis	27
	Endobronchial valve	8
Dysphagia	Esophageal dilatation	114
	Esophageal stent placement	39
Hemoptysis	Argon plasma coagulation	23
	Cryotherapy	11
Tracheoesophageal fistula	Esophageal stent placement	16
	Operative repair	2
Tracheobronchial obstruction	Argon plasma coagulation	26
	Cryotherapy	11
	Stent placement	19

VATs, video-assisted thoracoscopic surgery.

Table 1. The Palliative Prognostic Score (PaP)

Criteria	Assessment	Partial Score
Dyspnea	No	0
	Yes	1
Anorexia	No	0
	Yes	1.5
Karnofsky performance status	≥30	0
	10-20	2.5
Clinical prediction of survival (wk)	>12	0
	11-12	2
	7-10	2.5
	5-6	4.5
	3-4	6
	1-2	8.5
Total white blood cell count (10 ³)	<8.5	0
	8.6-11	0.5
	>11	1.5
Lymphocyte percentage	20%-40%	0
	12%-19.9%	1
	<12%	2.5
Risk group	30 day survival	Total score
A	>70%	0-5.5
B	30%-70%	5.6-11
C	<30%	11.1-17.5

procedure not associated with a malignancy were included in this article.

Analysis of data was carried out using GraphPad Prism software 4.02 (San Diego, CA) for Windows (Microsoft, Redmond, WA). Continuous data are expressed as the mean $\pm$ the standard deviation except where otherwise indicated. Differences between categorical variables were evaluated by the Fisher's exact test. Differences between continuous variables were measured by the two-tailed Student *t*-test or the Mann-Whitney test for nonnormally distributed data. A *p* < 0.05 was considered significant.

RESULTS

Between January 1, 2007 and December 31, 2012, 3842 procedures were performed at the study institution by 3 general thoracic surgeons. Of those procedure, 884 (23%) met this investigation's definition of palliative on individual review (Table 2). Indications for intervention included pleural or pericardial effusion or both, dysphagia, hemoptysis, tracheobronchial obstruction, bronchopleural fistula, and tracheoesophageal fistula. The majority was related to a malignancy but also included end stage cardiac and respiratory failure patients as well as nonmalignant end stage liver failure patients. During that same time period, 31

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