CRNA Symposium

PBLD – # 3

PBLD Title: Palliative procedures in patients with Do Not Resuscitate status – To Do or Not to Do!

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Objectives

1. Define the components of Do Not Resuscitate (DNR) orders and how they relate to informed consent

2. Discuss anesthetic goals when caring for a dying patient and the potential conflict with DNR status

3. Learn the value of establishing a therapeutic patient relationship including an advanced directives discussion PRIOR to administering an anesthetic for a palliative procedure

4. Determine when to involve other services (palliative care, primary caregivers, ethics board, risk management) when discussing end of life issues as part of a collaborative care model

5. Consider the terminally ill adolescent's ability to assent/consent to advanced directives and anesthetic plans

Case History:

EM is a 14yo male with a history of thoracic primitive neuroectodermal tumor who presented for management of superior vena cava (SVC) syndrome. Despite ten years of invasive treatment, his tumor grew to cause symptoms of orthopnea, cough, and facial edema. He presented to the interventional radiology suite for a SVC venogram with stenting to palliate his symptoms.

Questions:

1. What information should be obtained regarding this patient's physical and psychosocial preoperative status?
2. Describe the developmental stage of this adolescent patient.
3. What is important to him developmentally at this stage?
4. How will chronic illness affect his developmental stage?
5. How should communication begin with this patient and his family regarding his DNR status?

Case Progression:

Preoperatively, EM and his parents met with a collaborative care team for a discussion regarding his prognosis, procedure risks, and limits of resuscitation. This team consisted of physicians from radiology and oncology, in addition to the authors above from the anesthesia team. EM and his family decided that resuscitation was to include medications, defibrillation, and fluids, without CPR or intubation.

Questions:

1. Who are the key stakeholders in EM's care?
2. Who should be invited to his collaborative care preoperative DNR conference?
3. Who should invite the conference attendees?
4. What are some of the potential roles the health care team members attending the conference might adopt that could benefit the patient and family?
5. What if the anesthesia providers had felt morally conflicted about honoring EM's DNR choice?

Intraoperative Care:

A single preoperative dose of versed and an intraoperative dexmedetomidine infusion was the only sedation administered, along with lidocaine injected by the surgeon. The patient was reassured throughout the procedure with a good deal of hand-holding.

Questions:

1. What are the anesthetic goals of caring for this terminally ill adolescent?
2. What if the surgeon was not "on board" with the predetermined anesthetic technique?
3. What if the patient insisted upon a general anesthetic or minimal sedation was not possible?
4. What is the most important aspect of this particular anesthetic technique (minimal sedation)?

Postoperative Course and Case Reflection:

The procedure was successful, with three brachiocephalic stents placed, and the patient was able to go home the same day. By discussing end-of-life issues prior to the procedure, the anesthesia team was empowered to enact EM's wishes of withholding resuscitation had the outcome been different.

Question:

1. What would you have done differently?

References

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