INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE CASE OF THE MONTH

When a lot of small things make a big difference

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Volume 6, No. 6 **August 2006**

Case: CK was a previously healthy 35-year-old woman with viral myocarditis who was transferred to our hospital in cardiogenic shock requiring emergent implantation of a biventricular cardiac assist device (BiVAD). The palliative care service was consulted 6 weeks post-operatively because the primary service was concerned that she was withdrawn, depressed and anxious. We found that CK did indeed have a depressed mood and anxiety, but also had complaints of discomfort from a rectal tube placed for unremitting diarrhea, insomnia only partially responsive to recently prescribed citalopram and alprazolam, and intermittent nausea and vomiting with eating, necessitating a nasogastric tube for nutritional support. CK also reported frustration over a recent pulmonary setback requiring thoracotomy, readmission to the intensive care unit and a short period of mechanical ventilation. Her husband was supportive and visited her frequently, but she was reluctant to have their 3 school-aged children visit because she did not want them to see her looking so ill.

The initial visit focused on giving support to both CK and her husband. Alprazolam was increased to TID from BID and haldol 0.5 mg BID was added for nausea which was thought to be secondary to mechanical irritation of her stomach and pancreas from the BiVAD. The case was also reviewed with the GI nutrition attending who suggested adding fiber and probiotic replacement to her tube feedings. She was started on scheduled doses of loperamide.

On follow up several days later, CK reported resolution of her nausea and diarrhea. The rectal tube was removed and loperamide was decreased to PRN. Her anxiety was improved and she agreed to speak to the palliative care psychologist for assistance in coping with her illness and for behavioral modification therapy for her post-prandial emesis. Her depression was treated with an increase in her citalopram from 20mg to 40 mg. Music therapy was requested.

CK was transferred out of the intensive care unit and her chest tubes were removed. She was able to eat without nausea and vomiting and eventually her feeding tube was removed. She responded well to psychotherapy and looked forward to visits from the music therapist. She became more cooperative with physical therapy and less withdrawn from the staff. She allowed her children to visit more frequently, looked forward to visits by the palliative care team and sincerely thanked them for their help and support. A repeat echocardiogram was performed which showed partial recovery of her cardiac function. She was discharged home 3 months after admission with a plan to have the BiVAD removed in several months if she regained normal cardiac function, or otherwise be listed for cardiac transplantation.

Discussion: In this case, the palliative care team was initially called to evaluate a patient for depression and anxiety. However, the team also was able to address a myriad of other issues for the patient which, when looked at individually seemed minor in the context of her very critical illness, but whose combined effects had a large impact on her quality of life. These problems were also hampering her recovery through her inability to eat, which compromised her nutritional status, and her rectal tube, which limited her mobility and her participation in physical therapy. Furthermore these issues led her to be withdrawn and uncooperative with staff.

Many members of the multidisciplinary palliative care team worked together to address CK's physical and psychological symptoms, help her cope with her illness and improve her quality of life while in the hospital. The palliative care team's ability to address these problems allowed the primary service to focus on her serious medical problems, including managing her BiVAD, improving her pulmonary function, titrating her cardiac medications and ultimately getting her well enough to leave the hospital. This case is an illustration of how the palliative care approach of assessing the patient's entire experience of illness and then systematically addressing each of a patient's symptoms and concerns enhances the patient's well-being and improves patient outcomes.

References:

Morrison RS. Meier DE. **Clinical practice. Palliative care.** *New England Journal of Medicine. 350(25):2582-90, 2004 Jun 17*

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