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PALLIATIVE CARE ECHO

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Palliative Care role and management of long-term complications in complex case of COVID-19 infection

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Objectives

- Review aspects of a Palliative Medicine approach in a long term acute care hospital setting
- Discuss some of the long term complications that may occur after COVID infection

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Disclosures

- None

Patient Background

- 68 year old woman
- Pmh: COPD, hypertension, depression, morbid obesity
- 2 sisters died this year
  - Complicated bereavement
- 2 other sisters recently positive for COVID-19
- 7/14 – symptoms
- 7/16 – COVID-19 test, positive
- 7/19 – ED for progressive dyspnea and persistently high fever

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Phase I
Hospitalization

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Hospital Course

- 7/19 admission
  - O2 saturation high 80s with ambulation
  - AKI – 1.6
  - Noted to have increased anxiety – mirtazapine, citalopram stopped
  - DNR/DNI – “plan to discuss durable”

- 7/21 – med/surg
  - COVID markers improving, AKI resolved
  - Anxious, frustrated
    - Misses independence and autonomy
  - Notified that sister with COVID admitted to ICU
  - “Agreed to sign durable. Attending to see”

- 7/22 overnight
  - MRT called
    - Tachypneic, hypoxic, can only tolerate prone position
    - “Now states that she wants everything done and does not want to die” – code status changed to full
  - Hypoxia and dyspnea progressively worsen
    - Transfers to ICU

- 7/23-24 – ICU
  - Requires BiPAP, then emergent intubation
    - Facetimes with family prior to intubation
  - Difficulty ventilating, develops shock
    - Starts pressors, paralytics
    - Husband and daughter each updated by team

- 7/29
  - Plasma Exch. discussed, dialysis catheter placed
  - Ongoing difficulty ventilating
    - Requires many different sedatives
- 7/31
  - Desat into 60's while on vent
    - Prognosis discussed with spouse, confirms full code

- 8/3 – vent day 11
  - Completes 5 days of PLEX
  - "The patient continues to be critically ill and unstable. Prognosis is grim. Need to address goals of care with family"
    - ICU team provides updates to family daily
- 8/8
  - Notes continue to address need to discuss goals of care with family

- 8/9 – vent day 17
  - Significantly volume overloaded
  - “failing max vent therapy”
  - Starts dialysis
- 8/10
  - Convalescent plasma ordered
    - Starts 8/14-19

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- 8/16 – vent day 24
  - Sedation stopped
  - Remains unresponsive
  - Ongoing fevers
- 8/17
  - “Prognosis remains poor. Not even stable enough for tracheostomy. Palliative consult”

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Phase II
Palliative Medicine Involved

- 8/18 – Hospital day 31
  - Palliative care contacts family, meeting scheduled
- 8/19 – meeting with palliative care
  - Medical update provided
  - Daughters express frustrations
    - Timely updates
    - “Team more focused on transitioning the patient to DNR”
    - “She is not receiving treatments to prolong her life”
    - Family requests zoom meeting to see patient
    - Requests daily updates
    - No changes to care plan are made

- 8/24 – vent day 31
  - Tracheostomy discussed
  - Can not proceed due to prohibitive vent settings
- 8/25 – palliative followup
  - Has facilitated zoom sessions, family appreciative
  - Understands prognosis, remains hopeful
  - aggressive life-prolonging measures

- 8/26-8/29
  - Critically worsening, unstable, must stop dialysis
- 8/30
  - Resumes dialysis, has seizure, ?anoxic brain injury
  - Team meets with family, no changes
- 8/31 – vent day 36
  - ENT consulted for trach

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- 9/3
  - Trach placed
  - Mental status improving
  - More permanent dialysis line placed
- 9/8 – palliative medicine signs off
  - Patient improving, leaves ICU
  - Goals of patient and family remain clear

- 9/9 – step-down
  - Plan for gradual vent wean
  - Will need PEG tube
  - Will need extensive rehab for critical illness myopathy
- 9/10
  - Not tolerating vent wean
  - Ongoing fevers – Pneumonia? Tracheitis

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- 9/11 – team discusses with family
  - Goals remain clear, aggressive
  - “There is no benefit to reconsultation of palliative care”
- 9/15
  - Pulmonary service feels that pt can now participate in decision making
  - Suggests palliative care re-engagament

- 9/16
  - Spouse reports that patient told him to “stop the vent”
  - Daughters disagree
  - Spouse states priority is that patient not suffer
  - Palliative re-consulted

- 9/17 – 9/22
  - Pt mouthing “I want to die” to family and providers
  - Primary team unsure if she has capacity
  - Palliative care team determines no capacity

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- 9/24 – Palliative Medicine led family meeting
  - Family medicine, LCSW, pulmonary service, family
  - Confirmed stating that she “wants to die”
    - Husband will honor wishes, doesn’t want any suffering
  - Children frustrated, significant mistrust
    - “different stories”
    - “a plot to transition to comfort care since the beginning”
    - “whose side are you on?” to father
  - Multiple attempts to refocus to keep conversation patient focused
  - Decision for family to discuss, no changes made to care plan

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- Subsequent weeks
  - Determined to be at “new baseline”
    - Trach/vent dependent
    - Hemodialysis dependent
    - PEG dependent
  - Frequent contact with palliative LCSW
    - Family eventually on same page
    - Goal remains aggressive life-prolonging therapy
    - Family reluctant about LTAC due to visitation difficulty
  - Eventual discharge to LTAC after 83 day stay

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Phase III
Long Term Care
and Complications

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- First Palliative Visit in LTAC
  - Depressed, anxious
    - Tearful
    - Wants to see family
    - “I want to die”
    - Significant nausea/vomiting with tube feeds

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Goal Setting

- Be able to speak
- Wean vent
  - Remove trach
- Eat by mouth
- See new grandchild
- Go home

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Goal Setting

- Be able to speak
  - Cuff deflated
  - Able to speak over vent
  - Has been able to make phone calls to family

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Goal Setting

- Wean vent
  - Currently in process, tolerating 1 hour off vent

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Goal Setting

- Eat by mouth
  - Noted to have significant N/V with tube feeds
  - Stopped TF and improved
  - Eating safely by mouth but failed calorie counts
    - Can't taste / smell food → no appetite

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Goal Setting

- See new grandchild
  - Born mid November
  - Has had multiple zoom/facetime visits

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Goal Setting

- Go Home
  - Remains a major goal
  - Understands that there is a “long road ahead”
  - “I accept that I am very different now, but I am thankful for where I am”

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Points for discussion

- Ideal time to consult Palliative
  - When volume is very high due to pandemic
- Utilization of telehealth in the setting of COVID-19
  - In hospital, LTAC, other settings
- Management of appetite when taste/smell lost
- Palliative supportive role when care plan remains aggressive in the face of the unknown