

PALLIATIVE CARE ECHO

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

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

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

Phase I Hospitalization

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

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

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

- 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

- 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-engagement

□ 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

- 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

- 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

Phase III

Long Term Care and Complications

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

Goal Setting

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

Goal Setting

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

Goal Setting

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

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

Goal Setting

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

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”

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