Case Study

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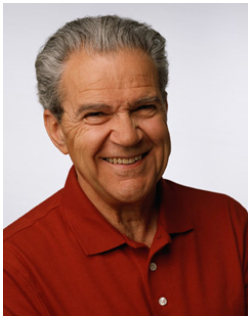

Case history:

Mr. Russell Halbert was a 58-year-old male with a one hundred pack year history of smoking, Chronic Obstructive Pulmonary Disease (COPD). About two years ago patient noted a silvery patch on his tongue but did not immediately seek medical attention. He continued to smoke and use chewing tobacco.

Presenting symptoms:

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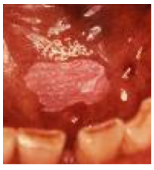
Translate »

About six months ago the patient sought medical help after he developed the following symptoms:

- A feeling that something is caught in the throat.
- Difficulty chewing or swallowing.
- Difficulty moving the tongue.
- Difficulty articulating
- Numbness of the tongue.



A work up revealed a oral squamous carcinoma of the anterior two thirds of the tongue and floor of the mouth which had unfortunately metastased to the cervical lymph nodes. He was treated with surgical resection of the tongue extensive resection of bone and soft tissue.

Malignancy grows:

The malignancy progressed rapidly despite treatment and resulted in extensive tissue necrosis resulting in the following distressing symptoms:

- hypernasality and loss of tongue made speech completely unintelligible.
- Extensive loss of teeth coupled with loss of tongue making it very difficult to swallow
- Severe facial disfigurement
- Necrotic non healing oral ulcer causing severe mal-odor.
- Facial pain.

At first, Russ Halbert's symptoms were relatively well controlled with:

- Methadone (50 mg thrice daily),
- immediate-release morphine sulfate (50 mg every four hours,) for breakthrough pain and, on an "as needed" basis,
- haloperidol (0.5 mg every six hours) for nausea and vomiting,
- lorazepam (0.5 mg every four hours) for anxiety, and

Mr. Halbert did quite well on this regimen for several weeks, but as the disease progressed, his pain worsened secondary to extensive local tissue necrosis culminating in admission to the hospital for symptom control.

Upon admission, numerous interventions were attempted in an effort to assuage Mr. Halbert's pain , including:

- conversion from oral methadone to a continuous subcutaneous infusion of morphine (6 mg/h)
- patient controlled anesthesia (PCA) of morphine sulfate infusion 2 mg every 15 minutes as needed
- lorazepam (0.5mg every 4 hours);
- metronidazole gel applied to the ulcerated tissue on the face (to control local infection and thereby the bad odor)
- oxygen via a nasal cannula; and
- a fan gently blowing on his face.

Unfortunately, none of the treatments alleviated or attenuated his sense of severe pain.

Goals of care family conference:

At this point, a family meeting was held to elicit goals of care and it determined the following:

- patient adamantly refused further surgery, chemotherapy and radiation therapy and received complete support from his wife and adult children
- heroic life prolonging measures (endotracheal intubation with mechanical ventilation etc) was discussed with Mr. Halbert and his family; however, they elected to forgo artificial respiratory support and chose to continue with symptomatic treatment, invoking the Russell's do-not-resuscitate election in light of the futility of intubation and assisted ventilation.
- Patient and family refused a feeding tube.
- They elected for comfort care.

Symptoms worsen:

Over the next week, the patient's pain worsened despite aggressive pain management. He was clearly suffering greatly and this caused severe distress to his dear wife and loving children who could not bear to see him suffer in this manner.

- Since his pain was unendurable and refractory to all palliative measures, palliative sedation was proposed as a humane and compassionate approach to allay his suffering.
- After explanation of the procedure, both he and his family readily agreed to deep and continuous palliative sedation. An informed consent document was signed and a note describing the indications

and plans for palliative sedation was recorded in the patient's chart.

- A 4-mg subcutaneous bolus of midazolam was then administered, followed by a continuous subcutaneous infusion of 1.5 mg of midazolam per hour. The Ramsay Sedation Scale was utilized to monitor depth of sedation, and the dosage of midazolam was titrated upward to maintain a deep level of sedation (a 4-mg bolus every 30-60 minutes, as needed, was utilized, with the continuous infusion increased by 0.5 mg/h after each bolus).
- He was sedated within 10 minutes, but after 30 minutes he was still arousable with verbal stimulation and complained of pain. So a second bolus of midazolam was administered and his infusion increased to 2 mg/h.
- Titration continued over the next few hours until he was deeply sedated, with an eventual dose of 5 mg/h required to maintain deep and continuous sedation.
- He died 4 days later, sedated, peaceful, and with his family at his bedside.
- **Choice of sedative:**
    - **Midazolam,** a benzodiazepine, was chosen to provide Mr. Habbert's' sedation because of its short half-life. There is extensive clinical experience with its use as sedative pharmacotherapy at the end of life.
    - **Phenobarbital** is also a cost effective and efficacious agent that can be used as a first- or second-line medication and would have been added to Mr. Halbert's regimen had a high-dose (i.e., 120-200mg/d) of midazolam failed to provide adequate sedation.

- **Propofol** has also been touted as a valuable agent for palliative sedation; however, its cost and intravenous route of administration limit its use outside of an intensive care unit.

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