

Short Communication

Administering Cardiopulmonary Resuscitation (CPR) to Cancer Patients in the Palliative Phase

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Summary

The paper discusses when it is suitable to administer Cardiopulmonary Resuscitation (CPR) to cancer patients in the palliative phase.

There are international guidelines that deal with the issue of CPR in the event of serious illness. These say that at least one of three conditions must be met in order to refrain from any type of possibly life-prolonging treatment for a patient in the palliative phase.

1. The patient, or family if the patient is not able to give informed consent, must have stated that he/she does not want it.
2. The personnel in charge consider, if possible in consultation with the patient/family, that the treatment, if successful, will prolong or worsen the suffering.
3. The personnel in charge consider such treatment to be futile.

CPR is not recommended for patients who have terminated tumour-directed treatment and those with a reduced general condition and reduced function status measured in the form of KI < 50 alt. WHO, ECOG > 2.

Abstract

It is every person's right to decide over their own life. Care and treatment must at all times be planned in consultation with the patient and be based on the evidence to hand. A precondition for the patient having the opportunity to make independent decisions is that they understand the implications of any decision.

The patient has the right to refuse treatment and palliative patients have the right to refrain from all forms of treatment.

All therapeutic decisions should be made in consultation with the patient and, when dealing with palliative treatment, the patient's own wishes are of paramount importance to therapy decisions. When no further evidence-based treatments remain to turn to, it is important to inform the patient of this fact and, in consultation, terminate the tumour-directed treatment, instead focusing on palliative treatment to relieve pain and symptoms.

CPR is not recommended for patients who have terminated tumour-directed treatment and those with a reduced general condition and reduced function status measured in the form of KI < 50 alt. WHO, ECOG > 2.

Case Description

An oncologist colleague describes an actual case. Mother, also a

doctor and a high-ranking academic, was diagnosed with cancer of the colon. The disease relapsed and she lived for three years with wide spread cancer, undergoing treatment with palliative chemotherapy. From the day the disease recurred she was aware that it was incurable and would inevitably lead to death. However, thanks to the various treatments she received a little extra time and for the greater part she enjoyed a good quality of life. For the majority of the time she was treated as an outpatient. When, in her final months, she was hospitalised due to pain problems, she was asked whether she wished to be revived in the event that her heart failed. This question increased her anxiety as she felt it was inappropriate and had been asked at completely the wrong time.

Information Regarding CPR During Life's Final Stages Should be Given at the Appropriate Time and Adapted to Each Individual Patient's Needs

Today, cancer is a public health issue and with improved methods of treatment more than half of patients are cured of the disease. However, this is not the group of patients we are discussing in this article. For patients in the palliative phase of the disease, the question of cardiopulmonary resuscitation is an everyday clinical problem. Somewhere in the region of 25% of all patients who die belong to this group [1].

CPR is a generally established and potentially life-saving method of treatment in the event of heart failure. The survival rate, defined as a percentage of patients discharged from hospital, is generally around 15% [2]. For chronically sick cancer patients the data is flawed, but that which is available points to corresponding figure of only a few percent [2].

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When is CPR an Option for a Chronically Sick Cancer Patient?

When is it Appropriate to Ask a Chronically Sick Cancer Patient if they Wish to Undergo CPR in the Event of Heart or Breathing Failure?

There are international guidelines that deal with the issue of CPR in the event of serious illness. These say that at least one of three conditions must be met in order to refrain from any type of possibly life-prolonging treatment for a patient in the palliative phase [2].

1. The patient, or family if the patient is not able to give informed consent, must have stated that he/she does not want it.
2. The personnel in charge consider, if possible in consultation with the patient/family, that the treatment, if successful, will prolong or worsen the suffering.
3. The personnel in charge consider such treatment to be futile.

What Does the Evidence Suggest?

An article by [3] studied what had been written in the literature in the years 1989-2010. They found 18 studies, four meta-analyses, eight clinical studies and six literature studies or review articles. Ten of the articles considered CPR administered to all patient categories (unselected patient material) and eight considered CPR administered to cancer patients only.

The studies showed consistently negative results.

Cancer patients display extremely low survival rates after CPR, and lowest of all are those patients with metastasised cancers. The factors with the highest prognostic value are reduced function status, measured by the Karnofsky Index (KI), WHO or ECOG. WHO/ECOG >2 or KI <50 in principle leads to zero survival, and this is the unequivocal result from a number of studies. They suggest that a reduced function level, serious illness and reduced general condition are in themselves the strongest prognostic factors [4].

CPR is not recommended for patients who have terminated tumour-directed treatment and those with a reduced general condition and reduced function status measured in the form of KI < 50 alt. WHO, ECOG > 2 [5,6].

The factors described above are indirect indications of serious disease and poor prognoses. The termination of tumour-directed treatment is often a sign of an advanced malignancy and in conjunction with the decision to terminate any such treatment, it is necessary and unavoidable that the patient be informed that the disease is no longer curable, that the course of the disease cannot be stopped and that the patient will die of this illness. This conversation begins a process culminating in death and the patient requires time to deal with the crisis that such a discussion entails, as well as time to reorientate themselves in the final phase of life. To actively broach the subject of CPR to a patient in the midst of this process may be both inappropriate and unethical.

The final stage of an advanced cancer is when the heart stops beating. A low level of physical function is in itself a hinder in dealing with new and stressful situations, there being no reserves of strength to fall back on.

Failure in the duty to provide information

As a healthcare worker, there is no obligation to inform patients that it is not planned to begin futile treatment (for example, to refrain from CPR in cases of advanced cancer). If the patient or their family actively enquire whether or not CPR is to be administered, adequate information should of course be provided detailing the planned action and the medical reasons behind the decision. This procedure avoids the routine imparting of unsolicited or unwanted information regarding CPR to chronically sick patients and their families.

Any such unwanted information can lead to anxiety and it is important that the process of dying should be as calm, peaceful and dignified as possible.

In summation, based on the existing evidence there are clear criteria for refraining from administering CPR to patients in the palliative phase. The strongest prognostic factors are the termination of tumour-directed treatment, low function status and advanced malignant cancer. From a quality-of-life perspective it should be considered wholly inappropriate to discuss CPR with a patient who is in the process of dying. The focus of the patient's care should be on conversation, contemplation, reflection and closure as well as the easing of pain, anxiety and depression.

A patient approaching the final phase of life often experiences mood swings that may vary many times during the day. Morning anxiety linked to the longing for death may be replaced later in the day by a sense of calm or even happiness. In a patient who has lived with terminal cancer for many years while displaying insight, wisdom and realism, one may suddenly be confronted by questions that suggest that the patient is wholly unaware of their illness. It is however not difficult to readjust the patient to the reality of their situation. It is enough to say "yes, but we spoke about that yesterday, it's your illness that is causing the discomfort," and the patient replies "but of course." You are then back on track. If one has a previous relationship to the patient, these are simple mechanisms to manage.

Where the patient-doctor relationship is new, there may sometimes be unfortunate misunderstandings, such as when a terminal cancer patient suffers an undercurrent complication such as breakthrough pain or other symptoms that require transfer to a different unit, for example hospitalisation with completely new healthcare staff. The worsening of the patient's condition leads to a flare up of unrest and anxiety, "am I about to die?" This, together with the unfamiliar care situation and staff may result in denial and projections. It is important to bear this in mind when, as a care provider, you deal with a terminally ill patient for whom the end is inevitable, a fact that both patient and carer are all too aware of and which creates anxiety with every change/deterioration.

A close relationship between the various care providers, as well as frequent feedback to the doctor who has medical responsibility for the patient, can reduce this type of misunderstanding. Interdisciplinary rounds are another way of optimising medical care in each individual case.

A medical decision to refrain from CPR must be documented in the patient's medical record. The record should contain details of the date and reason for the decision and who participated in reaching the decision. A note should be made of whether or not the patient/family was informed of the decision. On reaching a decision to refrain from CPR, the term DNACPR (Do Not Attempt CPR) should be inserted in the specified line and place, followed by the date and the responsible doctor's signature.

Decision-Making Procedures on Limiting Life-Prolonging Treatments.

When should limitations on life-prolonging Treatment be Evaluated?

When the patient so requests.

When the treatment prolongs suffering during the dying process. Treatment may perhaps postpone the moment of death for a few hours, days or weeks but reduces the options in relieving pain and symptoms. Active treatment may prevent a peaceful and dignified end.

Treatment will lead to such serious complications of a psychological or physical nature as to in all probability rob the patient of any quality of life.

Ethical Aspects

Patient Autonomy

It is every person's right to decide over their own life. Care and treatment must at all times be planned in consultation with the patient and be based on the evidence to hand. A precondition for the patient having the opportunity to make independent decisions is that they understand the implications of any decision.

The patient has the right to refuse treatment and palliative patients have the right to refrain from all forms of treatment.

All therapeutic decisions should be made in consultation with the patient and, when dealing with palliative treatment, the patient's own wishes are of paramount importance to therapy decisions. When no further evidence-based treatments remain to turn to, it is important to inform the patient of this fact and, in consultation, terminate the tumour-directed treatment, instead focusing on palliative treatment to relieve pain and symptoms.

The Principles of Beneficence and Non-Maleficance

For patients with advanced cancer, the benefits of any chosen treatment must be weighed against the undesirable side-effects of any such treatment.

The Principle of Justice

Respect for the equal worth of all human life is a cornerstone of healthcare. Healthcare should be provided on the same terms for the entire population. No patient may be discriminated against on the grounds of gender, age, disability, type of illness or its causes.

Quality of Life

Quality of life is a subjective experience which is defined in terms of psychological and emotional well-being. The term also encompasses the individual's ability to do the things he or she wishes, to enjoy good physical and psychological health and to be able to participate in social activities. During care in the final stage of life, a patient's physical well-being is one of the most important factors related to quality of life.

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