

Infections in Advanced Cancer and Palliative Care—To treat or not to treat?

Case 1. Mrs. A, 64 years of age, has a non small cell lung cancer with bone metastases. Her treatment regime has included palliative radiotherapy to a number of painful bony sites. She is presently at home and her Palliative Performance Scale score is 70% (1). She has developed a low grade temperature, and has urinary frequency and dysuria. You suspect she has urinary tract infection possibly with a bacteremia.

Case 2. Mrs. B, 58 years of age, has breast cancer with liver and lung metastases. She has developed a Stage 3 sacral pressure ulcer that is draining purulent exudate. Her Palliative Performance Scale score is 50%. She becomes febrile. She is uncertain as to whether she wants treatment (oral or IV) for her infected pressure ulcer.

Case 3. Mr. C, 70 years of age, has colonic carcinoma with intraabdominal metastases. He is presently in hospital. He is in a mixed delirium, is febrile with a temperature of 39.5 degrees Celsius, has a congested cough, and is hypoxic on 10 lpm of oxygen (pulse oximetry-76%). His Palliative Performance Scores is 20%. You suspect he aspirated last night. Based on his clinical status, you anticipate that he will die shortly. His family are insistent they he receive IV antibiotics.

Of the three cases, who would you treat with antibiotics? How did you arrive at your decision?

Discussion: In some situations, ‘if’ to treat an advanced cancer patient’s infection with antibiotics becomes a clinical challenge. Health care workers may consider the following at the time: Is treatment compatible with the palliative philosophy, in other words, will it improve symptoms and/or quality of life? Is it clearly futile? i.e. does the patient’s clinical status and co-morbidities suggest that the patient will die soon despite treatment?

What evidence is available that may aid in you in your decision making?

Although the studies are few in number, several indicate a symptomatic improvement in infection related symptoms, particularly for dysuria associated with a urinary tract infection (2-4). However, the effect of antibiotic administration on mortality, notably increasing length of life, is variable—many patients who received antibiotics died while receiving them or shortly following (2, 4, 5, 6).

A paper by Ford et al, (7) outlines a number of ethical issues to consider when contemplating antibiotic treatment. These include consideration, at times of increased life extension, that treatment could lead to increased risks of distress as the chronic disease progresses, concern for increased intrusiveness of an anti-infective treatment such as daily parenteral medication or maintenance of intravenous lines, the risk of increasing resistant pathogens, and increased costs to hospice systems. These issues need to be

weighed against opposing issues of the potential for symptom improvement and response (Case 1-increased for an uncomplicated urinary tract infection (5)), patient wishes following full disclosure of potential benefits and risks (Case 2- the patient may develop a life threatening septicemia if untreated. The patient fully understands this, but still does not wish treatment), and family wishes (Case 3-the patient will very likely die soon even if he were to be treated, but families may be left with the guilt of ‘not trying everything’ in the event of a response).

While future research may produce guidelines on ‘what’ antibiotic to use and ‘how’ to administer the antibiotic, ‘if’ to treat an advanced cancer patient’s infection will remain a challenge. It is anticipated that personal and ethical decision making principles will continue to be paramount.

References:

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