

An Opinion: Oncological ENT Patient - Decision Making in Medical Treatment



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Abstract

An opinion on decision making in oncologic Ear Nose and Throat (ENT) surgery is given. The aggressive surgical treatment even though life-saving was confronted to the quality of living of an actual person.

Keywords: ENT; Oncology; Surgery; Quality of the Life, Decision Making

Introduction

A physician is due to give a patient medical treatment which is adequate to current medical practice, experience and science [1-4]. However, the uttermost important fact is the equilibrium of everything which has to be provided to that specific individual, considering the patient's actual comfort, quality of present life, his life prognosis, insisting on the quality of living [4-7]. Sometimes, in the urge for practicing more recent, advanced, scientifically based complicated procedures, the human being in that very patient is forgotten [8]. The emphasis is put on "progress", practicing clinical science and usually neglecting the quality of personal life versus testing the usefulness of aggressive and complicated treatment [7,9]. The problem is even more prominent regarding a terminal oncologic patient, which is condemned to spend the rest of his short life completely mutilated [9-11]. It should be emphasized that in half of these cases, such operations heal with no problem and give these patients the life expectancy of five years, which should not be neglected or forgotten [2,7,10].

The main problem is the decision-making process of medical treatment to apply, by indicating a right procedure to the right patient, not forgetting the very best of that very special person. Young interns or recent specialist want to implement the most sophisticated and complicated procedures, to practice and to gain experience. On the other hand, the old specialists are tired, do not involve themselves in the problem, sometimes are not updated and turn to be "quitters". Equilibrium is needed. To be eager, interested, updated, capable, skilled, but most of all, human: comprehensive, prudent, sober-minded, ethical and on the end sincere in clinical attitude and relationship with patient.

Results and Discussion

S.L., male, 47 years old ASA1 never visited a physician. In June, he felt a kind of discomfort while eating. In October, 4 months later, a Squamous Cell Carcinoma was confirmed occupying his vocal fold, right sinus piriformis, base of the tongue with metastasis in his right cervical lymph nodes (T4N1M0).

The surgery (with Informed Written Consent) was performed 6 months (December) after the first symptom: Traqueotomy with Traqueostomy, Right Radical Neck Dissection, Bilateral Suprahyoid Neck Dissection, Functional Neck Dissection on the left side, Resection of the Root of the Tongue and Oropharynx, Total Laryngectomy and Partial Pharyngectomy, which was the correct surgical procedure for the pathology [2,3,7]. The whole content of the neck was evacuated except vital blood supply from the head (carotid artery), vagal and phrenic nerves on right side. The functional evacuation was done on the left side. All soft tissue of the neck, muscles, neural supply of neck, face and shoulder was missing. The skin became very sensitive, easily hurt and damaged.

The hard to move shoulder was "falling" with the imminent pathological fractures. The Traqueostomy itself provided breathing but also lead to appearance of permanent secretion, turning the skin humid, irritated and easily infected. The smell and esthetical disfiguration contributed to the deterioration of self-image of that very person. Deglutition was difficult with frequent aspiration of secretion. The cough, as a protective mechanism, was permanent and disturbing but sometimes not sufficiently effective. Sub nutrition initiated, as expected. The speech, articulation and voices were distorted, in fact the was

incomprehensible. The social and even family exclusion of this person is understandable, but not encouraged.

In order to reconstruct the dissected area, an attempt of reconstruction was made by Pectoralis Maior Myocutaneous Flap on one side of the patient's chest [12,13]. The flap was rejected during immediate post-operative course due to infection [14]. A month later, another attempt of reconstruction was done by Tubular Free Tissue Transfer Flaps on both sides of the chest and the arm [15]. This resulted in more complications: hematoma, pedicle thrombosis, neck abscess [16]. Two months after first surgery S.L., the patient, started to be disoriented, aggressive, incontinent, trying to run away from hospital several times. He was sent to his local Health Unit with diagnosis of Reactive Psychoneurosis, still not talking, weak and underweight.

After a month, in May, eleven months after the first sign of the disease and 5 months after first surgery he died. He died in severe pain, smelling and hardly mutilated. Surgery was performed several times, all of them leaving him in a worse state. The question is, whether it would be better to leave him to spend his life peacefully or to do all this. An alternative medical treatment could be suggested as Intensity-Modulated Radiation Therapy (IMRT) or Molecular Target Therapy, instead of performing surgeries [17-22]. Also, an option of palliative life support could be given, providing an adequate medical, social and family treatment and support [23-26].

The case happened in the nineties, but I think it still continues to be actual, even more because of the emerging new techniques [19]. The procedure applied was contemporary and an up to date medical treatment for the time period it happened [2,3]. The early diagnosis was essential, then and now. In this case time period between diagnosis and beginning of the treatment should be much shorter, but in real life and current practice the medium interval, even nowadays remains the same [27]. Nowadays, the standard Transoral Laser Microsurgery started to be overcome by Transoral Robotic and Flexible Robotic Surgery Image-Directed [28-35]. These "glamorous" procedures could so easily make surgeons "blind" and eager to use them by any chance and in any case. The mutilation should be reduced, the life prognostic rate more confident, the need of the complex reconstructive procedures reduced and the whole procedure simplified, for the surgeon.

But, for a patient the suffering continues. Some studies emphasize that the rate of complications is the same [36,37]. Profound thermal damage of the tissue is extremely painful, there is high incidence of hidden thrombosis, difficulties in monitoring of oncological recurrence, the rate of infection is same, a mutilation continues to be pretty equal, social exclusion is the same, among other problems [37-39]. The emphasis started to be put only on survival rate, forgetting again that these procedures should provide a minimal quality of life for that person [40-42]. The term "quality of life" was very popular in nineties. Patient's Bill of Rights was everywhere [43]. Everything

has been said and a lot written emphasizing the importance of individual's rights to have quality of living despite of being ill [44-47].

Nowadays, all this seems to be forgotten, again. Survival rate is the most important, even though it could be very short and miserable. Despite of the effectiveness of these procedures, the cost of the equipment should not be neglected and it makes it difficult to use in developing countries, where the classical "cold-knife" surgery remains to be unique armature [48-50]. Stem cell engineering could be a future in avoiding mutilation of patient by reconstruction effect, considering that the radical removal of tumor is inevitable and obligatory [51-53].

Conclusion

This is an opinion which was not meant to disapprove contemporary surgical procedures but to make a physician reflect, again, over the problem. Decision making process in medical treatment should also include complete conscious informed consent and emphasis should be put on the quality of life of that very person/patient, and it should not be generalized, which turns it impersonal. The surviving should not be the goal, but living. By emerging techniques which make everything simplified, the process turns to be even more complex and doubtful.

Conflict of Interest

I confirm there is no financial or personal relationship with any people or organization related to this report/opinion that could inappropriately influence this work.

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