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RESEARCH

Palliative extubation in emergency units: a case report

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Abstract

Emergency units receive patients of greater severity with acute or worsened chronic conditions, and subject to sequelae or irreversible damages. In these cases, palliative care is prioritized, aiming to provide a better quality of life, with measures that promote physical, emotional, social and spiritual comfort, as essential elements of care for the end of life. One of these forms of comfort is palliative extubation, that is, the removal of the orotracheal tube, which is intended to alleviate suffering and avoid the prolongation of the death process for all those involved. Thus, the purpose of this study was to reflect on these issues from the case report of a patient subject to palliative extubation performed in a reference emergency unit.
Keywords: Emergencies. Palliative care. Airway extubation.

Resumo

Extubação paliativa em unidade de emergência: relato de caso

As unidades de emergência recebem pacientes mais graves, com doenças agudas ou crônicas, e sujeitos a sequelas ou danos irreversíveis. Nesses casos, priorizam-se cuidados paliativos para oferecer mais qualidade de vida, conforto físico, emocional, social e espiritual, elementos essenciais para o término da vida. Uma das formas de proporcionar maior bem-estar é a extubação paliativa, ou seja, a retirada do tubo orotraqueal, que tem o propósito de evitar o prolongamento do processo de morte do enfermo e aliviar o sofrimento de todos os envolvidos. Dessa forma, o objetivo deste trabalho foi refletir sobre essas questões a partir do relato de caso de paciente sujeita a extubação paliativa em unidade de emergência referenciada.
Palavras-chave: Emergências. Cuidados paliativos. Extubação.

Resumen

Extubación paliativa en una unidad de emergencia: relato de caso

Las unidades de emergencia reciben los pacientes más graves, con enfermedades agudas o crónicas, y sujetos a secuelas o daños irreversibles. En estos casos, se priorizan los cuidados paliativos, para ofrecer más calidad de vida, conforto físico, emocional, social y espiritual, elementos esenciales en el fin de la vida. Una de las formas de proporcionar mayor bienestar es la extubación paliativa, es decir, la extracción del tubo endotraqueal, que tiene el propósito de evitar la prolongación del proceso de muerte del enfermo y aliviar el sufrimiento de todos los involucrados. De esta forma, el objetivo de este trabajo fue reflexionar sobre tales cuestiones a partir del relato de caso de una paciente sujeta a extubación paliativa en una unidad de emergencia referenciada.
Palabras clave: Urgencias médicas. Cuidados paliativos. Extubación traqueal.

Declara não haver conflito de interesse.

Emergency Units usually receive patients of higher severity of illness, suffering from acute or chronic conditions, who are subject to sequelae or worsening of chronic diseases [1]. What is currently perceived in these services is that many diseases are difficult to manage or can cause irreversible damage resulting from the evolution process of the disease itself, which requires new measures intended to provide patients with comfort and better quality of life.

In addition, as literature points out, due to the severity of the disease, many families experience the death of the patient right in the emergency unit [2], which exposes the need to prepare both the medical team and patient's family to deal with this type of situation. This preparation happens in advance, when all involved already know the prognosis of the disease and inefficacy of the curative measures, considering the seriousness of the condition. In this case, palliative care comes onto the scene, which may be more beneficial than any deliverance action.

Literature today tends to emphasize "dying with dignity" over extending the suffering of the patient and his/her family with futile treatments [3]. Priority is given to palliative care so patients can be provided with *a better quality of life, with measures that promote physical, emotional, social and spiritual comfort* [4], which reduce the costs of unnecessary treatments [5-9].

People associate palliative care with the immediate dying process; however, the literature makes it clear that this type of care is not limited to the end of life. Palliative care must be offered along with vital therapies for people suffering from severe and chronic illnesses to promote well-being even if it does not prevent the natural course of the disease and unexpected death [1].

One of the ways of giving some relief to patients admitted to the emergency room is to remove invasive me1asures. Removing mechanical ventilation is the most common action in anticipation of death [10]. Palliative extubation is applied in patients whose death is expected: It is considered as part of the transition to the type of care that generates measures of comfort for the patient, since it was concluded in advance that medical assistance previously offered in an aggressive manner was unable to meet the expected goals, such that the patient could not benefit from the continuity of mechanical ventilation [11,12].

Removal of the endotracheal tube during interventions preceding death should not be considered simply a medical procedure, but care that alleviates suffering and avoids the prolongation of the death process [13]. However, the medical team must address the family in an appropriate manner, allowing the grieving process to start early and providing adequate psychological support and control of the patient's symptoms and well-being, if he/she regains consciousness after extubation.

It is also necessary to provide the documentation that substantiates this care and minimize the possible negative impacts on the medical team [13]. As demonstrated by some studies, adequate palliative extubation is *associated with more family satisfaction* [14] and decreased incidence of depression among family members [3]. However, despite the benefits, this practice still faces some barriers in emergency units [1,2,5].

Very few reports on this practice have been found in the literature available. Thus, the objective of this study is to present the case report of a patient undergoing palliative extubation in an emergency unit.

Method

This is an experience report that presents facts and feelings of those involved in a palliative extubation procedure that took place in June of 2017 at the referral unidade de emergência referenciada – UER (emergency unit) of Hospital de Clínicas da Universidade Estadual de Campinas – Unicamp (Campinas State University Hospital).

Data was collected in July of the same year, about one month after the death of the patient, and gathered based on the procedures described and the patient's medical record. The project was submitted to the ethics committee of the institution; and the term of free and informed consent was judged as dispensable.

Results

The patient, a 80-year old female born in Campinas, was healthy, hypertensive, diabetic and dyslipidemic. She was brought to the pre-hospital care in June 2017, after being found unresponsive by her brother in her bedroom one morning. She arrived at the emergency room with score of 5 on the Glasgow coma scale in a decerebrate State, also showing anisocoria.

Orotracheal intubation was performed upon admission, followed by a skull tomography, which confirmed an ischemic cerebrovascular accident in the brainstem area. Once the patient's condition was stabilized, she was transferred to the intensive care unit of the emergency room where she was kept under mechanical ventilation.

Family members were present during visiting hours, monitoring closely the evolution of the patient's condition. They could see her suffering and how her health was deteriorating by the day, reporting their sight to the medical team. Between the third and eighth day following the patient's admission to the emergency room, the medical team shared with the family and multidisciplinary team the poor prognosis of the disease. They were told that the patient would no longer be able to perform her daily activities, including talking to or understanding people, and would become completely dependent on basic care, such as eating and bathing. Therefore, under this irreversible condition, she would experience a prolonged death process, with more suffering and pain.

The family understood the scenario and realized that leaving her in this situation would only cause more suffering and affect her social circle. After this conversation, the medical team addressed issues related to palliative care, the comfort provided by the multiprofessional team, and the importance of visiting and/or staying with her family, even outside of the normal visiting hours. In addition, they were told that the permanence of the orotracheal tube and the administration of vasoactive drugs would not reverse the patient's condition, which could cause further damage. After a consensus was reached among the medical team and family members, comfort measures were applied, including palliative extubation.

The patient was extubated after nine days of hospitalization. Nevertheless, she continued with a score of 5 on the Glasgow coma index, showing ocular response to calls, eupnea in ambient air, comfortable physiognomy, and no pain. She also continued to receive intensive and basic care like bathing, change of decubitus, and feeding through nasoenteric tube. She was monitored by the medical team and family members 24 hours a day, and passed away five days following extubation.

Discussion

The presentation of this case is due to the low applicability of extubation in our field. Given the context in which increasingly aggressive medical interventions do not reverse the serious evolution of certain diseases, the continuous presence of the orotracheal tube has been shown to contribute to an agonizing death process. Palliative extubation is performed precisely to avoid this dramatic situation. Emergency unit professionals must learn to implement procedures that aim not only to treat and cure diseases but also to reduce patient suffering in situations that are often unavoidable and increasingly frequent [13].

The literature on the subject shows that critical care specialists can identify which patients are undergoing life-prolonging treatments, which generate, at the same time, more suffering prior to imminent death [11,13]. Therefore, physicians must evaluate and confirm the diagnosis of these patients subject to palliative extubation and also check that the unit responsible for their hospitalization can provide support to their relatives and offer appropriate palliative care.

In the case of the patient aforementioned, the referral emergency unit had an intensive care room available with five beds and infra-structure similar to that of a conventional intensive care unit (ICU), which is intended to provide patients in critical condition with intensive care until their relocation to a hospitalization unit that is more appropriate. In addition to hemodynamic support, the intensive care room has more space so that the medical team can better serve patients and families. There is less rotation as compared to to the emergency unit with two visiting schedules available. These factors helped patients, family members and the medical staff to establish a closer contact, since the latter cared for patients 24 hours a day, ensuring full care.

All these aspects follow what is recommended in the literature, since it was possible to integrate several issues in the emergency unit. Prior to extubation, the team that cared for the patient was gathered to receive explanations about the situation and to better understand the concept of palliative extubation, precisely so that any doubt could be clarified and the team could fell more confident about the procedure. This was paramount in this case, since the fear about this issue has already been pointed out by some studies, especially considering that health professionals generally face other barriers such as overwork, overcrowding, workplace disorganization, lack of knowledge on the subject, in addition to emotional stress [1,2,5].

It is essential to call upon the family, clarify doubts, explain the current situation of the patient,

and the appropriate measures that can ensure what is best for him/her. The relatives mentioned in the present case report chose not to witness the moment when the tube was withdrawn, which emphasizes the importance of respecting all the people involved, including their period of denial and acceptance of the facts.

The professionals who were part of the multiprofessional team, such as doctors, social workers and nurses, were particularly understanding about the anxiety of the relatives and the stress experienced by the team responsible for the extubation [13]. As recommended by the literature available, it is necessary to register every step of the process in medical records, so that they serve as documentation and basis for all professionals to evaluate the preparation, competence and performance of the medical team [13], in addition to demonstrating that palliative extubation can have a measurable outcome.

It is also emphasized that the real purpose of palliative extubation is to avoid the prolongation of the death process; the discomfort generated by orotracheal intubation; and to provide therapeutic care for the control of signs and symptoms, such as pain, until the onset of death. As for family members, care before and after grief is necessary, in addition to psychosocial support, especially after palliative extubation, since death can occur days later, as in the case of the patient object of this study, who died five days following the procedure [13].

Final considerations

As in hospitalization units, palliative care must also be available in emergency units, improving the well-being of patients, providing relief, and comforting the families and professionals involved. Palliative extubation, or the withdrawal of mechanical ventilation from the patient whose death is expected, was presented by discussing this case report and mentioning other studies, as an example of palliative care that may prevent agonizing death. It becomes evident that, once the medical team and family members reach a consensus, that it is possible to carry out this practice and reduce the suffering of the patient, improving his/her well-being, social cycle, and that of all the professionals involved.

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Participation of the Authors

Julieth Santana Silva Lage was responsible for the bibliographic review, writing part of the introduction, method and discussion, and reviewing the introduction, method, clinical case (results), discussion and final considerations. Agatha de Souza Melo Pincelli also participated in the bibliographic review and final considerations. Jussara Aparecida Silva Furlan reviewed the bibliographic references and clinical case. Diego Lima Ribeiro wrote part of the abstract, introduction and discussion, being a reviewer and supervisor for the work. Rafael Silva Marconato was the idealizer of the article, in addition to one of the reviewers and supervisors for the work.

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