Geriatric Simulation Case: Respiratory Distress

A 75 year old man with a history of lung cancer and COPD arrives by EMS in moderate distress. (EMS run sheet)

Bp 150/90 HR 125 irreg (MAT) RR 45

A thin man appears on an EMS stretcher in moderate distress able to respond to question in several word sentences.

PMHx: lung Ca on chemo and RT, COPD, HTN
Meds: albuterol and atrovent MDIs, diltiazem, furosemide, aspirin 81 mg
NKDA

Emaciated man in significant respiratory distress
Bp 158/94, HR 134 irreg, RR 42, T 99.6 O2 sat 88% on NRB
HEENT- airway patent
Pulm- costal retractions, diffuse wheezing, rhonchi scattered
Cv- tachycardic, irregular
Abd- soft, NT
Ext- trace B pretibial edema
Neuro- Awake and alert, appropriate to situation

EKG MAT at 130

CXR hyperinflated lungs, multiple nodules c/w mets, cephalization?

Labs

WBC 14K
H&H 16/ 48
Plts 550

Na 129
K 4.2
Cl 92
HCO3 32
BUN 30
Cr 1.1
Glucose 110

BNP 500
CPK 100
Troponin negative
Case Progression

A 75 year old man with a history of lung cancer and COPD arrives by EMS. He is a thin man in moderate respiratory distress only able to respond to questions with short sentences. He is very hypoxic and tachypneic.

If the patient is not asked his wishes he will be inappropriately intubated. His daughter will reveal that he had a DNR. She is his proxy and is available by phone. He does not wish to be intubated, have pressors or CPR. He would like supportive care with BIPAP, fluids, antibiotics, and pain medications only. He knows that he is dying and has a previously established DNR order. Ultimately, the trainee should not resuscitate the patient as it would be a violation of his wishes; the patient should be kept comfortable and die comfortably with dignity.

Learning Objectives

APPROPRIATE CARE of the terminal patient.

Which investigations and therapies should be performed? Which should be withheld?

Assess for living will and end of life wishes.

Critical Actions

1) Evaluate and stabilize A, B, C’s-
   A- patent
   B- labored- oxygen, consider noninvasive ventilatory techniques (BIPAP)
   C- monitor

2) Assess for and treat potentially reversible etiologies of respiratory distress

3) Discuss treatment options with the patient and family, especially airway management and ETI. The patient has a DNR order and is receiving hospice care. This may not be apparent unless the physician includes the patient and his family in a discussion of specific treatments. The patient has specified what care he would like to receive at the end of his life. He has a living will, a DNR order and a health care proxy. He would like nebulized therapy, steroids, antibiotics, IVFs, pain medication and noninvasive ventilation, but does not wish to be intubated, undergo CPR, receive pressor therapy or artificial nutrition. His daughter is his proxy and is available by telephone.

Important Actions
1) Complete the PE
2) Consider a full differential diagnosis and potential treatment options
   a) COPD exacerbation
      a. Bronchodilators (albuterol)
      b. Anticholinergic agent (ipratropium)
      c. steroids
      d. BIPAP
   b) CHF
      a. Nitroglycerin (if bp tolerates)
      b. ACE inhibitor
      c. Loop diuretic
      d. BIPAP
   c) Pneumonia
      a) antibiotics
   d) Dehydration
      a) consider fluids
   e) Cardiac
      a) aspirin
      b) nitroglycerin

B) Treat symptoms (respiratory distress, pain, nausea, vomiting, anxiety.)
   a) oxygen
   b) analgesia
   c) antiemetics
   d) anxiolytics

3) Discuss patient management with primary MDs

**Handout**

Every year more than two million people die in the US. Approximately ten percent die suddenly, unexpectedly, of an MI or an accident. The vast majority experience an illness with a predictable course, either a terminal illness with a period of decline (like cancer) or a chronic condition punctuated by periodic crises (COPD, CHF, Alzheimer’s dementia.)

Many of these conditions will result in multiple symptoms including pain, nausea, vomiting, and shortness of breath. It is our job in the ED to treat these symptoms as well as to manage the basic A, B, C’s.
How do people wish to die? A 1996 Gallup poll found that 90% of Americans state that they wish to die at home. In fact, only 25% of people die at home while 75% die in institutions (50% in hospitals, 25% in nursing homes). Why is there such a dramatic discrepancy between how people wish to die and how they actually die? How can people ensure that their wishes are known and followed?

Living Wills, Health Care Proxies, and DNR Orders:

A **Living Will** is a document that addresses a patient’s specific requests about medical interventions to prolong life (ETI, CPR, artificial nutrition, etc.) A Living Will is a document that allows a person to explain, in writing, which medical treatments he or she does or does not want during a terminal illness. A Living Will takes effect only once a person is incapacitated and can no longer express his or her wishes. The Will specifies which treatments may be used and which treatments may not be used to prolong life. The purpose of a Living Will is to allow a person to make decisions about end of life care when he or she is no longer able to express his or her own wishes. Living wills may be changed or revoked as long as a person has the capacity to make medical decisions. A Living Will becomes operative once it is provided to a physician and a patient no longer has the ability to make or communicate health care decisions for his or herself.

A **Health Care Proxy** is a person appointed by a patient to make health care decisions if the patient loses the ability to make decisions for him or herself. A Health Care Proxy can also decide how a patient’s wishes apply as his or her medical condition changes. Hospitals, doctors and other health care providers must follow a Health Care Proxy’s decisions. The patient may give the person selected as Proxy as little or as much authority as he or she wants. The patient may allow their Proxy to make all health care decisions or only certain ones.

A **Do Not Resuscitate (DNR)** order authorizes the withholding of cardiopulmonary resuscitation (CPR) at the moment of cardiopulmonary arrest. In NYS, endotracheal intubation is not included in a DNR order. DNR does not equal DNI. That does not mean that a physician must intubate every DNR patient in NYS. It means that a DNR patient is not necessarily DNI and that each case must be addressed individually. There may be situations when a DNR patient would choose to be intubated, or when a physician attending to a DNR patient may choose to intubate (perhaps in the instance of a reversible process like pneumonia.) In the absence of a DNR Order, the legal presumption is that the person would want resuscitation.

A Hospital DNR order may be issued if a person is in an in-patient acute care or long term care setting. It is to be reviewed for continued appropriateness every 7 days. However, it remains effective even if it is not reviewed weekly. There is no standard form for Hospital DNRS.

A Nonhospital DNR may be issued by a doctor in an institutional setting to take effect for the person after discharge to the community or issued by a doctor in the community for the outpatient setting. It remains effective when a person transfers to an institutional
setting until reviewed by the attending physician and either continued or cancelled. A Nonhospital DNR should be reviewed by a community doctor every 90 days for continued appropriateness; however, it remains effective even if it has not been reviewed within the 90 day period. A Nonhospital DNR order must be on a Department of Health (DOH) approved form. This form is intended for patients not originating from a hospital or nursing home. The form (DOH-3474) is available on the NYS DOH's web site (www.health.state.ny.us) Another option, the standard DOH approved metal bracelet includes a caduceus and the words "Do Not Resuscitate". EMT's should assume that a DNR order is in place authorizing the bracelet. It is not necessary to locate a written DNR order if a patient is wearing a DOH DNR bracelet.

A DNR Order does not withhold or withdraw medical treatment other than CPR. (www.omr.state.ny.us/hp_dnr_guidelines.jsp) A DNR Order does not apply to choking or respiratory distress in the absence of arrest. If the person is not in cardiac or respiratory arrest, appropriate medical treatment for all injuries, pain, difficult or insufficient breathing, and/or other medical conditions (especially reversible conditions like hypoglycemia, hypothermia, hyperkalemia, sepsis) must be provided. A DNR order is not a directive to disregard a person’s needs for basic care and comfort.

The Medical Orders for Life Sustaining Treatment (MOLST) Program is designed to improve the quality of care that people receive at the end of life by translating patient goals and preferences into medical orders. MOLST is based on communication between a patient or their Health Care Proxy or other legally designated decision maker and health care professionals to ensure informed medical decision making. The MOLST Program assists health care providers in discussing and developing treatment plans that reflect patient wishes. The MOLST Program also helps providers honor patient wishes regarding life sustaining treatments. (Compassionandsupport.org)

In summary, Emergency Physician's are in a unique position to provide care and support at critical moments in people's lives, often with a dearth of information. We are taught to perform the A,B,C's and manage critical patient's at all stages of illness. It is important to communicate well at all times, especially difficult moments and to have a thorough knowledge of the ways in which patients may document their end of life wishes so that we may abide by them when that moment arrives.