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EDITORIAL

Palliative Surgical Outcomes: Are We Looking Through a Keyhole?

Geoffrey P. Dunn, MD, FACS

Department of Surgery and Palliative Care Consultation Service, UPMC Hamot Medical Center, Erie, PA

The study by Badgwell et al. represents a necessary step in bringing the worlds of palliative surgical care and palliative medicine, both ably represented by the authors, closer together.[1] Although they rightly conclude a larger sample size might give us more information about the best choice of tactics in the overall strategic goal of maintaining quality of life in the face of progressive physical decline, the high attrition rate from death in this study highlights more fundamental problems in the current conceptualization of the role of surgery and its outcome measurement in the palliative care setting. For a substantial number of the patients enrolled in this study the question may have been more about the quality of death than the quality of life. The question of "What would 'success' look like?" for those studied would have different answers depending on which of these two perspectives is taken.

The high number of patients who had expired by 30 days in this study is sobering, but does not necessarily negate the value of operative intervention. However, the answer to the question of "Was it worth it?" is so personal and subjective and tempered by the experiences of multiple individuals (family members and providers), often without the testimony of the patient, that it is hard to imagine a validated tool that could generate data for future decision-making. The wide variety of surgical interventions and the rarity of some of them (pancreaticoduodenectomy) for relief of symptoms will make it difficult to categorically endorse surgical palliation over procedural and nonoperative palliation. The desire to maintain hope, so crucial an incentive for selecting treatment, has such profound spiritual implications that one wonders if an outcome measure such as FACT-G, which does not measure spiritual well-being, is missing a significant positive outcome. Miner observed high patient satisfaction toward surgeons after palliative operations, even in those who had no demonstrable benefit from surgery or in those experiencing serious complications.[2] He attributed this phenomenon to the dynamics of the patient-family-surgeon guiding decisions about palliative care, which he describes as the "palliative triangle." There is a spiritual, almost mystical quality to this dynamic that highlights the complexities for outcomes measurement. The high level of satisfaction families that can occur following palliative surgery despite marginal benefits does not excuse surgeons from considering the risk of potentially shortening remaining time due to surgical complications or reducing quality of remaining time. The cost of these interventions will be justifiably scrutinized in an era of increasing resource use discipline.

This study offers several valuable suggestions for the conduct of future quality of life studies for palliative surgical intervention—patient self-ranking of relevant factors for outcomes measures and the use of the multidisciplinary team. Expertise in palliative medicine is now much more widely available than at the time surgical palliative care began to organize itself as a discrete discipline a decade ago. Surgeons have good reason to seek out palliative medicine expertise in designing studies and staffing interdisciplinary teams—surgeons have been found to be poor predictors of survival of patients with incurable abdominal malignancy, and the rate of surgery for all indications in the last year of life varies substantially with age and region.[3,4] Not too long ago, there would have been only one consideration for managing malignant bowel obstruction from advanced disease—exploratory laparotomy, even with the foreknowledge that the likely result would be significant morbidity if not mortality. Baines et al.'s work

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G. P. Dunn, MD, FACS
e-mail: gpdunn1@earthlink.net

in the mid-1980s challenged this with the successful medical management for this dilemma, but it was 2 decades before this information appeared in the surgical literature.[5,6] Recent innovations in surgery are equally unlikely to appear in the palliative medicine literature. Dr. Betty Ferrell, one of the authors of the Badgwell et al. study, is one of the few palliative medicine professionals who have been actively engaged in surgical palliative care research.

The "palliative triangle" could be further fleshed out with the addition of the palliative care team to the surgeon component. If in-depth knowledge of nonsurgical palliative treatments is not available, surgery may be inappropriately seen as the only effective treatment. The extended palliative care team can also support the surgeon who may be pressured to offer surgery of doubtful value to meet the emotional and existential needs of patients so they will not feel abandoned or lose hope.

The spiritual impact of surgical treatment choices should be evaluated prospectively through the lens of the palliative care team because the recognition of spiritual need is already built into the palliative care team *weltanschauung* (world view). Because the spiritual impact may be the most positive outcome of surgical intervention, it should be assessed and, if desired, measured. Four decades ago, John Gaisford, a plastic surgeon, emphasized the importance of collegiality with individuals entrusted with spiritual care for the successful outcome of palliative surgery.[7]

I agree with the authors that more data is needed to assess the impact of palliative surgical intervention, yet they have already achieved one valuable and overdue step integrating surgeons and surgery into the larger continuum of palliative care by their inclusion of a nonoperative treatment arm in their prospective trial of surgical palliation.

REFERENCES

1. Badgwell B, Krouse R, Cormier J, Guevara C, Klimberg VS, Ferrell B. Frequent and early death limits quality of life assessment in patients with advanced malignancies evaluated for palliative surgical intervention, *Ann Surg Oncol.* 2012. doi:10.1245/s10434-012-2420-5.
2. Miner TJ. Communication skills in palliative surgery: skill and effort are key. *Surg Clin N Am.* 2011;91:355–66.
3. Hølmebakk T, Solbakken A, Mala T, Nesbakken A. Clinical prediction of survival by surgeons for patients with incurable abdominal malignancy. *Eur J Surg Oncol.* 2011;37:571–5.
4. Kwok AC, Semel ME, Lipsitz SR, Bader A, Barnato AE, Gawande AA, et al. The intensity and variation of surgical care at the end of life: a retrospective cohort study. *Lancet.* 2011;378:1408–13.
5. Baines M, Oliver DJ, Carter RI. Medical management of intestinal obstruction with advanced malignant disease: a clinical and pathological study. *Lancet.* 1985:990–3.
6. Krouse RS, McCahill LE, Easson AM, Dunn GP. When the sun can set on an unoperated bowel obstruction: management of malignant bowel obstruction. *J Am Coll Surg.* 2002;195:117–28.
7. Gaisford JC. Palliative surgery. *JAMA.* 1972;221:83–4.