

Case History

- 34 year old female. Lives in Europe. Married, four young children.
- Admitted to urology with multiple abdominal masses, including bilateral renal, adrenal and pancreatic masses and intestinal involvement.
- No significant medical or surgical history

Diagnosis

- Biopsy of the pancreatic and renal lesions revealed non-Hodgkin's lymphoma (NHL) – diffuse large B-cell (DLBCL) type
- Clinical stage was IV
- NCI was consulted

Treatment

- The patient was advised to have chemotherapy with a monoclonal antibody (Rituximab)
- The patient opted to enroll in an NCI protocol of dose-adjusted EPOCH with Rituximab.
- The protocol treatment was planned for 18 to 24 weeks (6 to 8 cycles) depending on response.

Admission to ICU

- After one cycle of chemotherapy, the patient developed left shoulder pain.
- Chest x-ray revealed air under the diaphragm, thought consistent with a bowel perforation.
- Although stable clinically, the patient was moved to the ICU for close monitoring.

CT demonstrating extensive bowel involvement by lymphoma



Status in ICU

- Vital signs and other clinical parameters were closely monitored.
- Over 48 hours, the patient remained stable and alert.

Surgery Consultation

- Surgery was consulted and stated standard treatment in such cases was to operate to repair the perforation.
- In view of the surgical team, the medical best interests of the patient required an explorative laparotomy to find and repair the perforation.

Response

- The medical oncologists cited recent that, for small perforations, it may be better to wait and see if they heal on their own.
- In the view of the medical oncology team, the medical best interests of the patient suggested waiting to see if the perforation would seal itself.
- Avoiding or at least postponing surgery seemed especially important for a patient who had recently received chemotherapy.

Questions

- When patients are seen by multiple services that disagree: Who should make the final treatment recommendation to the patient?
- Does the primary team have final say? Should the primary team follow consultants' advice? Should the team with current care responsibility (i.e. ICU) follow instructions of other teams, or make the final recommendation?

More Questions

- Should the default be to follow standard of care?
- Should the options be presented to the patient? Does this further patients' interests or burden patients unnecessarily?
- Are there third parties that disagreeing teams should consult to help resolve disputes (e.g. ombudsman, patient rep, bioethics, hospital administrator, others)?