End of Life Matters in Vascular Surgery

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SAAPM End of Life Matters seminar
25th October 2016

End of Life Matters

The Advance Care Directives Act 2013

empowers adults to make legal arrangements for their future health care, end of life, preferred living arrangements and other personal matters, and/or appoint one or more Substitute Decision Makers to make decisions on their behalf when they are unable to do so themselves. It promotes a rights based patient centred approach to health care and supports the National Safety and Quality Service Standards: 2- Partnering with Consumers and 9- Recognising and Responding to Clinical Deterioration in Acute Health Care.

SA Health Policy and Commissioning Division, Factsheet, June 2014

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Many surgeons feel that the use of Advance Care Directives is

"incompatible with the goals of surgical treatment"

Annals of Surgery:
March 2012 - Volume 255 - Issue 3 - p 418–423
doi: 10.1097/SLA.0b013e31823b6782
Feature

Use of Advance Directives for High-Risk Operations: A National Survey of Surgeons

Redmann, Andrew J. BA, BS; Brasel, Karen J. MD, MPH; Alexander, Caleb G. MD, MS; Schwarze, Margaret L. MD, MPP

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Use of Advance Care Directive in Vascular Surgery

Abdominal Aortic Aneurysm - ruptured
- elective

Other major vascular reconstructions with sudden postop deterioration

Critical Limb Ischaemia in debilitated patient

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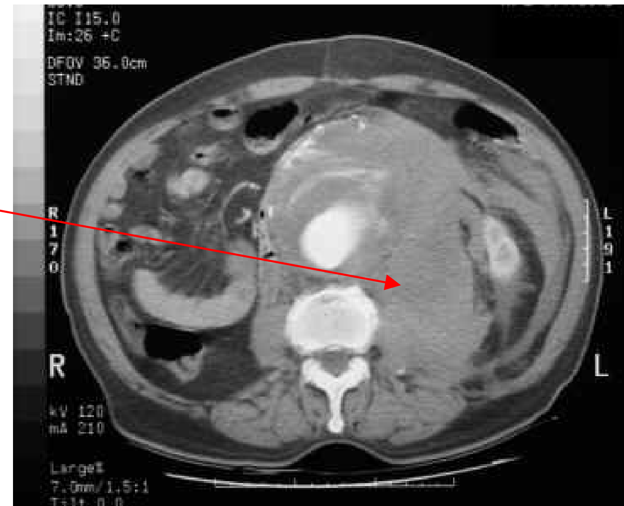
Ruptured AAA

15th cause of death
10th in males >55 years

>95% mortality
May die prior to admission



Operative mortality 35% – 75%
RAH review : zero survival if aged >80 with hypotensive collapse

Loss of independent living is age dependent but significant

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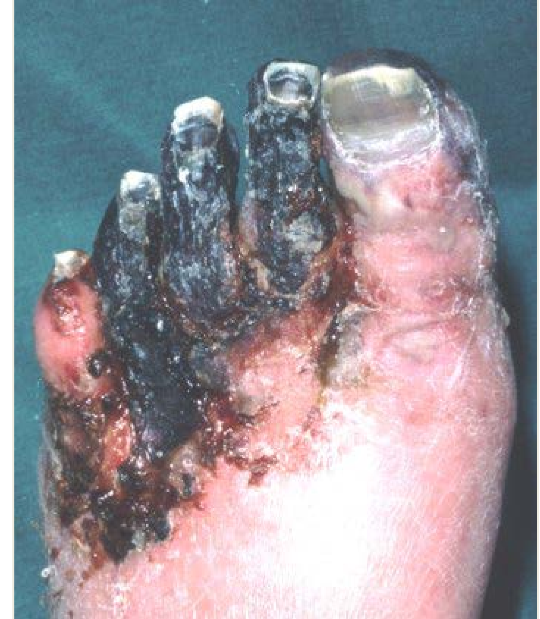
Primary Above Knee Amputation

pain relief
control sepsis
nurses/family reasons

But usually this is an End of Life event



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Use of Advance Care Directive in Vascular Surgery

Abdominal Aortic Aneurysm - ruptured

if known AAA and decided against any repair

Critical Limb Ischaemia in debilitated patient - AKA

if stipulated prior to loss of mental functions that patient would never consider major amputation

THEN PALLIATION IS THE PREFERRED OPTION

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Advance Care Directive practical issues

DATA is instantly available
current
realistic
based on fully informed decision
specific

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What are binding provisions?

A binding provision is a **refusal of health care** (including medical treatment and life-sustaining measures). To be binding the provisions must be relevant and applicable to the current circumstances as set out in the ACD.

Health practitioners must comply with a binding provision unless:

- There is reasonable evidence that the person had changed their mind, but didn't update their ACD.
- It is an emergency and there is no time to consult the ACD/Substitute Decision-Maker or to work out the patient's condition to determine whether the provision applies.
- They have a conscientious objection to complying with an ACD.

A refusal of health care means that you do not have consent to provide the health care. To provide health care without the person's consent can be grounds for unprofessional conduct or assault and battery.

SA Health Policy and Commissioning Division, Factsheet, June 2014

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Who must follow a binding provision in an ACD?

Health practitioners **must** comply with a binding provision in an ACD if there is no Substitute Decision-Maker (SDM) appointed, or there is no time to contact a SDM if one is appointed.

If the ACD appoints a SDM, the SDM **must** follow the refusal in the ACD if they believe it is what the person would have done in the current circumstances. They **must** therefore refuse the health care on the patient's behalf. The SDM stands in the patient's shoes and their consent/refusal is legally valid as if it was the person making their own decision.

SA Health Policy and Commissioning Division, Factsheet, June 2014

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Part 4: Binding refusals of health care

I make the following binding refusal/s of particular health care: *(If you are indicating health care you do not want, you must state when and in what circumstances it will apply as your refusal(s) must be followed, pursuant to section 19 of the Act, if relevant and applicable).*

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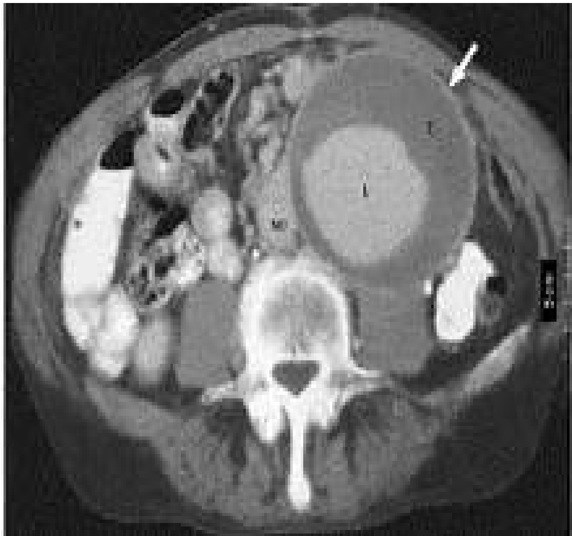
Elective Abdominal Aortic Aneurysms

Clinical presentation

INCIDENTAL FINDING

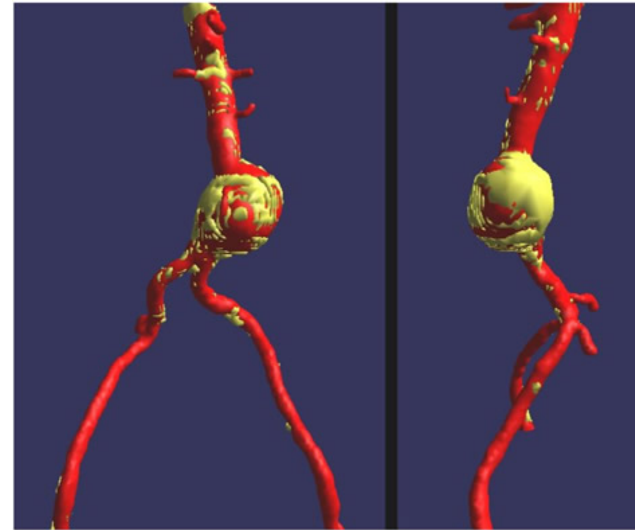


rupture

compression

embolism

thrombosis



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Risk of Rupture

SIZE

Size	Rate
< 4cm	<0.5%
4 - 5cm	0.5-1%
5 - 5.5cm	1-2%

More recent papers suggest lower rupture rates

Size	Rate
5.5 – 6cm	3.5%
6 – 7 cm	4.1%
>7cm	6.3%

Rupture rates of untreated large abdominal aneurysms in patients unfit for elective repair. Parkinson etal J Vasc Surg 2015, 61, 6, 1606-1612

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Risk of Rupture	v	Risk of Intervention	
SIZE		Age	>80
		Life Expectancy	malignancy
		Co-morbidities	cardiac renal respiratory

Mortality Elective open AAA Repair

MORTALITY has reduced over last 20 years

1980	12-15%
2000	3-5%
2015	4.6%
	1% (in selected institutions)

age

renal failure, cardiac disease

surgeon experience

institution workload

Operative adjuncts

epidural catheter

autologous blood transfusion

blood salvage

intraoperative monitoring

ECG, BP, CVP, left heart pressure, TOE

oxygenation, expired CO_2

urine output

INTENSIVE CARE MANAGEMENT

ventilation

dialysis

inotropes

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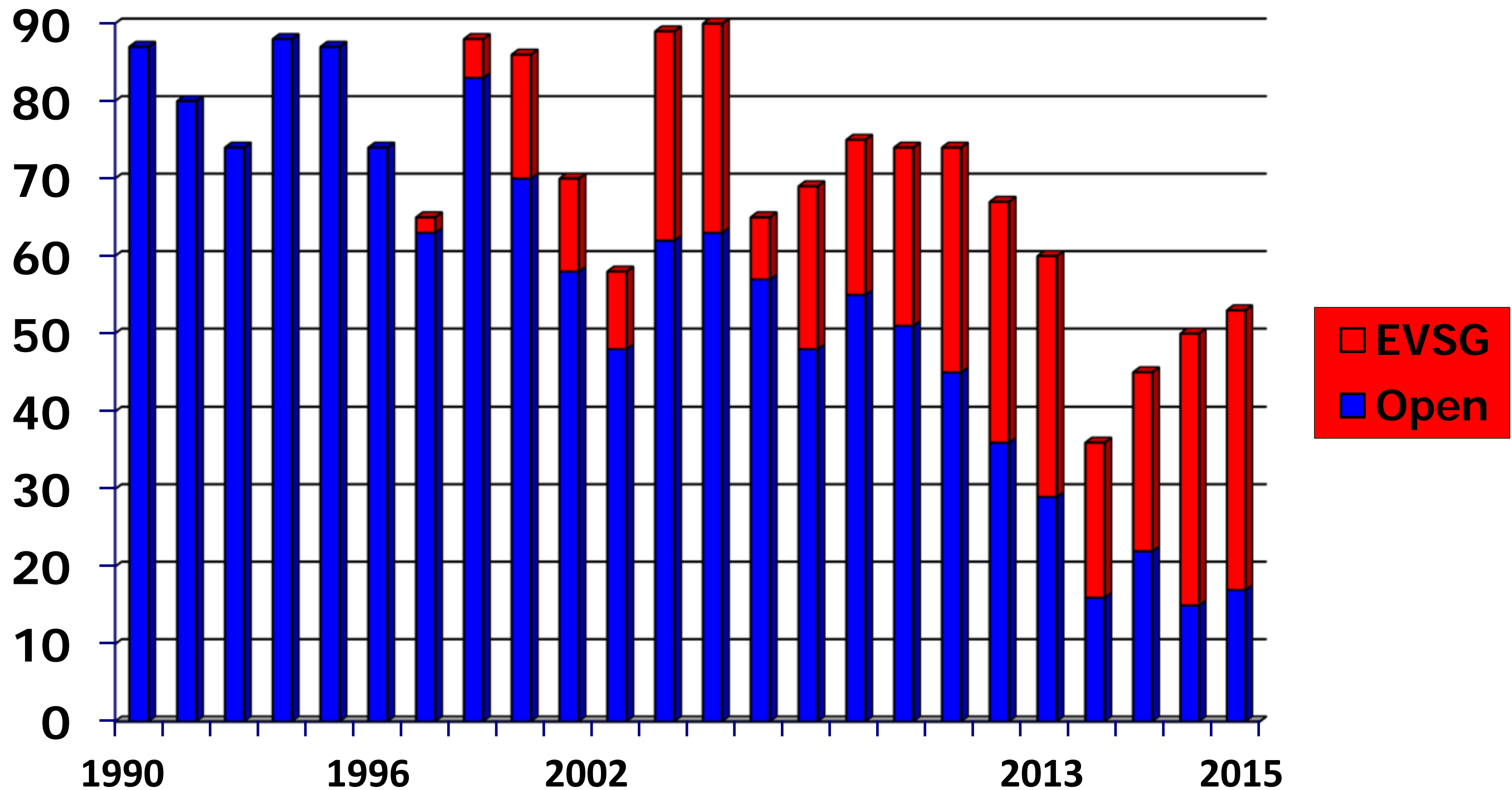

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Vascular Audit will soon be Surgeon specific in Australia

Category	**Total**	**Mortality (%)**
All Aortic procedures	2975	5.2
Open AAA-elective	**542**	**4.6**
Open AAA-ruptured	175	31.4
AAA-EVAR-elective	**1426**	**0.6**
AAA-EVAR-ruptured	66	13.6

Australasian Vascular Audit Report -2015

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EVSG or OPEN REPAIR

EVAR-1 Trial The 15 year results

AAA related deaths	**better**	with OPEN at 15years	p=.006
Survival	**better**	with OPEN at 15years	p=.05
Re-interventions	**more**	with EVSG at 15 years	p=.035

EVSG has given rise to a new set of complications and risks that may further delay the End of life discussion

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What are binding provisions?

A binding provision is a refusal of health care (including medical treatment and life-sustaining measures).

Conclusions

"Many surgeons do not routinely discuss advanced directives preoperatively and more than one half reported they would decline to operate on patients whose directives limit postoperative care. This practice may limit the expression of patient preferences during decision making for high-risk operations"

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Surgeons either opt not to offer open AAA surgery
or negotiate with patient to accept total care postop
IF they decide to proceed