Case Review Learning #2, June 1, 2010

Case: A patient with metastatic nasopharyngeal CA with local invasion into the brain, complicated by trismus, epistaxis, and known difficult airway, was transferred from OHNS to Medicine for continued oncologic management. Over a period of many hours, the bleeding from her tumor escalated, eventually resulting in uncontrollable bleeding, hypoxic respiratory arrest and PEA arrest. She was subsequently cooled, but had no residual neurologic function, and family withdrew care.

The Problem: The issues raised in this case were ones of inter-service communication and the transition of care.

The Relevance of the Problem:
Patients often transfer to medicine while they still have problems necessitating subspecialist care. Some consultants, such as OHNS, are not in house for call, and communication is based on telephone conversations. In addition, appropriate involvement of the consulting service requires the primary team’s recognition of change in status and acuity, as well as coordination to get the needed support. These can be difficult when a problem is outside of the primary team’s scope.

Efforts to date related to this topic:
● An inter-service meeting was held between the medicine, OHNS and ICU teams involved in this case to discuss the breakdown in communication.
● Feedback was given to involved team members.
● Guidelines were written based on discussion at this meeting and are being disseminated to the respective clinical services (see below).

Guidelines For the Shared Management of Deteriorating Difficult Airway Patients
OHNS/Medicine/ICU

Findings
I. Handoffs between general medicine and subspecialty services warrant clear communication about high risk clinical situations, i.e. a difficult airway, during the transition of care. Important information to communicate includes:
   1. A clear description of status at time of transfer.
   2. Red flags to look for.
   3. Clear management plan for anticipated problems (how to get help quickly, from whom, after hours considerations, etc).
   4. Anticipatory steps which may be helpful in some circumstances, for example an anesthesia consultation ahead of time in a patient with a known difficult airway.

Both the transferring and accepting teams are responsible for giving and asking for this information at the time of transfer.

II. It is important to recognize and communicate a change in status of the patient to the appropriate people.
   1. When patients are deteriorating, or when management is unclear, senior residents and attendings should be involved early, when possible.
   2. Deteriorating patients should be considered for ICU transfer. ICU team involvement can assist with this decision when management is unclear.

III. Telephone communication is often limited by the inability to see the patient. Tips to improve this include:
   1. On the part of the calling physician, an assessment of acuity, supported by clear description when possible. I.e. The patient is choking on her blood, which is pouring out of her mouth as...
though she’s vomiting blood. The sister and the patient are both in distress due to the situation, which appears to be clearly different than that described prior to our assuming care.

2. Physicians should clearly state their own level of discomfort with the situation, when present, and specifically ask for the patient to be seen physically by someone with more expertise if felt to be needed.

3. Teams receiving information should be attuned to escalating frequency of calls, frequency of events (such as stuttering bleeding in this case), concern on the part of the calling team, the limited scope of knowledge of the calling team regarding any specialty issues (difficult airway in this case). When these are present, it is best to offer more help (ie. Recommend evaluation by critical care medicine or to come in to see the patient, continued contact with the team by phone, and remaining easily accessible).

4. For various reasons, communication sometimes breaks down, ie. pages may be dropped, people may be dealing with other emergencies, or may incorrectly assess situations. When a team feels they are calling for help and need more, it is important to recognize and utilize resources available which include:
   a. Their own senior resident and attending.
   b. The other team’s senior resident and attending.
   c. The Rapid Response Team.
   d. The ICU team.

More communication is better, and no one should be offended if further help is sought when a patient’s safety is felt to be at risk.

IV. For OHNS specific management of nasopharyngeal tumors with bleeding and difficult airway:

1. Once bleeding is copious, it can then be very difficult to place a non-surgical airway (such as awake fiberoptic intubation).

2. After hours, the ICU fellow/attending are most capable people in house to assess an acutely deteriorating airway situation, though OHNS on call also comes in, and General Surgery is in house and able to provide cricothyrotomy. In this situation, calling a code will get the right people to the bedside quickly.

3. There is an emergency airway pager: 415 443 4990, though calling a code/or calling ICU is probably the best way to get this kind of help immediately.

4. Afrin, local pressure and acute management of hypertension are important first steps to control epistaxis when time allows. When nasopharyngeal tumors bleed heavily, it can be devastating. Anticipatory planning is most important, including escalating level of monitoring and getting the right people involved while time allows.

V. Objective documentation of what was done/communicated is important, and can be entered in a timely manner after acute management of the patient.