A Palliative Approach to Treating a Medically Ill Patient with Terminal Schizoaffective Disorder: Is Less is More the Answer to Suffering?

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BACKGROUND

- A palliative approach for a terminal prognosis is well-understood in medical illnesses.
- There is no agreement as to what qualifies as a terminal psychiatric illness, let alone guidelines for treatment.
- This case explores the concept of a palliative approach to refractory psychiatric illness that emphasizes the patient's quality of life over symptom reduction.[1,2]

CASE

- A 65-year-old male male domiciled in a nursing home, who presented for paranoid delusions, disorganized thought and speech, agitation. Initially admitted to medicine for AKI, then transferred to inpatient psychiatry for ongoing delusions.
- **Past Psychiatric History:** schizoaffective disorder, bipolar type, cannabis use disorder, with multiple long-term hospitalizations, ACT Team, multiple failed medication trials and a history of requiring treatment over objection (TOO)
- **Past Medical History**: Barrett's esophagus, grade D esophageal stricture s/p dilatation, BPH, folate-deficiency anemia
- **Medications :** aripiprazole 20mg daily, Depakote 500mg qAM, 1500mg qhs

HOSPITAL TIMELINE

- Admitted to medicine for AKI, followed by CL psych
- Transferred to inpatient psych, refused meds, needed TOO
- Had coffee ground emesis, transferred to medicine
- Stabilized and transferred to psychiatry
- Found to have anuria, AKI and thrombocytopenia, transferred to medicine then to the MICU for septic shock
- The patient was intubated but failed extubation and needed to be re-intubated.
- Patient required a trach and PEG. Stabilized and transferred to medicine floor, discharged to NH with PEG
- Patient self dislodged PEG at NH, re-admitted to medicine
- PEG replaced for the second time, subsequently dislodged by patient again
- Esophageal dilatation pursued

PALLIATIVE PSYCHIATRY CONSIDERATIONS

Multiple lifetime inpatient psychiatric hospitalization with minimal response to treatment

Extensive medication trials including Lithium, Depakote Haldol, Risperidone, Aripiprazole, Paliperidone, Invega LAI, Olanzapine, Thorazine, Quetiapine, Trazadone, Lorazepam

The patient had several ongoing medical conditions, including gastroesophageal reflux disease (GERD), Barrett's esophagus, esophageal stricture following dilatation, benign prostatic hyperplasia (BPH), folate deficiency anemia, chronic bilateral lower extremity (BLE) issues, and chronic venous insufficiency.

Due to persistent medical concerns, the patient underwent multiple transfers between the medicine and inpatient psychiatry throughout his lengthy hospitalization.

On the inpatient psychiatric unit, the patient required daily use of restraints, seclusion, and as-needed medication for the management of agitation.

The patient persisted in refusing oral medications, and as a result, multiple treatments over objection were pursued.

The patient experienced poor oral intake and significant physical deconditioning throughout his hospitalization.

The patient experienced a significant decline in his medical condition due to pancytopenia resulting from psychotropic medication side effects without improvement in psychotic symptoms.

The patient's family expressed their desire to minimize the use of psychotropic medications to prevent any further medical complications. They were concerned that the patient's current treatment regimen might lead to additional adverse side effects or interactions with other medications, which could worsen the patient's health.

Based on the patient's medical history and clinical evaluation, an inpatient psychiatric admission was deemed unlikely to be of significant benefit at this time. As a result, alternative treatment options, including palliative psychiatry, were considered to address the patient's psychiatric needs while minimizing unnecessary interventions.

The primary medical team encountered difficulties in implementing comfort feeding for the patient as the concept of end-stage psychiatric illness was unfamiliar.

This decision was made while considering the patient's wishes, noting that continued psychiatric intervention would do more harm than good without providing any clinical benefit to the patient, the balance between symptom relief and remission, as well as the importance of respecting patient autonomy.

MEDICAL FLOOR COURSE

- The patient had a prolonged history of declining medication and/or non-adherence
- Due to physical and verbal agitation, the patient was maintained on a low dose of quetiapine via PEG before he removed it himself.
- Patient became severely malnourished d/t TPN refusal and was verbally aggressive with care team.
- A capacity assessment was conducted by CL psychiatry to determine the patient's ability to refuse PEG tube replacement. Patient was deemed incapacitated.
- Despite patient's consistent wishes against PEG, family opted for replacement.
- When the patient removed the PEG for a second time, the focus of care shifted towards a palliative model, and esophageal dilatation was performed to enable comfort feeding.
- Although the patient did not have a terminal medical illness, it was concluded that aggressive treatment of his psychotic symptoms would not result in his participation in medical care.

TAKE AWAYS

- Chronic, refractory mental illness should be viewed as terminal diagnosis when it is treatment-resistant, and significantly impacts a person's overall quality of life, making it difficult to manage and control symptoms despite various interventions
- A palliative approach to severe mental illness focuses on the patient's comfort and autonomy as opposed to symptom cessation.
- In some instances, discontinuing the use of psychotropic medications may be beneficial for enhancing the patient's overall quality of life
- In situations like these, it is crucial to engage the expertise of a psychosomatic physician in the decision-making process concerning end-of-life matters.

References

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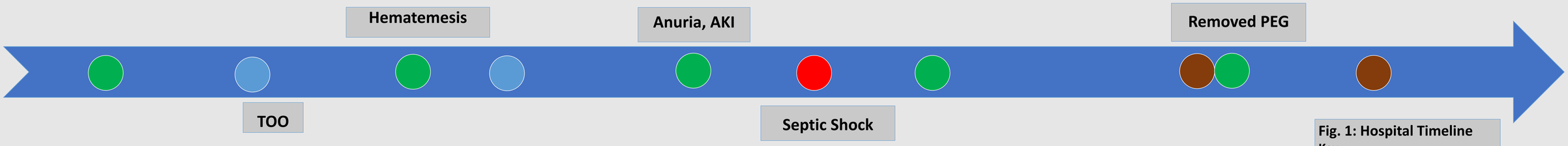

Fig. 1: Hospital Timeline
Key
Medicine Admission/Transfer
Psych Admission/Transfer
MICU
Discharge