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Many older trauma patients would benefit from palliative care

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Half of older adults who sustain injuries severe enough that they could die in the hospital or become unable to function independently are not asked in the intensive care unit (ICU) if they wish to speak with palliative care specialists about their preferences for end-of-life care, a new study finds. The study results suggest that many older trauma patients have unrecognized needs for palliative care, the authors said at the 2014 American College of Surgeons Clinical Congress.

"Palliative care is not just for someone likely to die after trauma but for anyone who is seriously injured, who is frail or has other life-limiting illness" said senior investigator Anne C. Mosenthal, MD, FACS, chair of Surgery at Rutgers New Jersey Medical School, and a trauma surgeon and palliative medicine physician at University Hospital in Newark, N.J.

Also called supportive care, palliative care tends to the whole patient, including physical, emotional, social, and spiritual needs, and aims to improve the person's quality of life.

"Elderly trauma patients have many needs beyond their injuries," Dr. Mosenthal said.

Research shows that compared with younger people who have sustained trauma, individuals older than 55 years are more likely to experience multiple organ failure after trauma,[1] and even mildly injured patients above age 60 have a five times greater risk of dying.[2]

People nearing the end of their lives who receive palliative care have better well-being and quality of life as well as improved relief of pain and other symptoms compared with those who do not receive this supportive care according to a new report from the Institute of Medicine (IOM).[3]

"A conversation about what older trauma patients desire in end-of-life care should occur sooner than later," Dr. Mosenthal observed.

"Yet many physicians are not trained to have this conversation with their patients," she continued. "Or, often the family wants "everything done" even if it is not what the patient has requested in an advance directive such as a living will."

Many hospitals, including University Hospital, have a multidisciplinary team of palliative care specialists. However, it is unclear which patient characteristics should trigger the need to offer a trauma patient and his or her family a meeting with this team, Dr. Mosenthal stated.

Therefore, she and her colleagues conducted a study to investigate whether older trauma patients, who could benefit from a palliative care consultation, were being identified on admission to the hospital and which factors could be used to identify such patients in the future. They reviewed the medical records of 92 trauma patients age 55 or older who were admitted to University Hospital's surgical ICU from June to December 2012.

The researchers determined that patients who would benefit from a palliative care evaluation included those who later died in the hospital; were discharged to a care facility such as inpatient rehabilitation, skilled nursing, or long-term care; or had a poor functional outcome at discharge (as found by a Glasgow Outcome Score of less than or equal to 3, indicating dependence on others to perform activities of daily living).

Nineteen of the 92 trauma patients died in the hospital, the investigators reported. Of the 73 survivors, 46 patients were discharged to a facility (including 11 who went to a long-term-care facility and two who went to a hospice facility), and 27 went directly home. Only 32 (49 percent) of 65 patients found to warrant a palliative care consultation actually received one. Although 17 (90 percent) of the 19 patients who later died did receive a palliative care evaluation, only 15 (33 percent) of the 46 patients discharged to a facility did.

In retrospect, the researchers found certain admission factors that could help identify future patients who would benefit from palliative care, in that they were linked to a significantly increased risk of the patient dying or being discharged to a facility rather than going home. These patient characteristics included age 75 or older and/or having an altered level of consciousness (Glasgow Coma score of 13 or less), high injury severity or multiple injuries (Injury Severity Score of 18 or more), a traumatic brain injury (Abbreviated Injury Scale score for the head of 3 or greater), or a blood transfusion.

Based on the study results, she said the research team wants to develop a standardized care protocol that all trauma patients over age 65 admitted to the hospital will be offered early palliative care interventions and asked about advance directives.

Dr. Mosenthal recommended that trauma centers and hospitals perform a multidisciplinary palliative care assessment of elderly patients with severe trauma within 24 hours of admission.

More information: 1 Sauaia A, Moore FA, Moore EE, et al. Early predictors of postinjury multiple organ failure. Arch Surg. 1994;129:39-45. Available at archsurg.jamanetwork.com/artic … spx?articleid=595844. Accessed September 26, 2014.

2Shifflette VK, Lorenzo M, Mangram AJ, Truitt MS, Amos JD, Dunn EL. Should age be a factor to change from a level II to a level I trauma activation? J Trauma. 2010;69:88-92.

3 Institute of Medicine. Dying in America: improving quality and honoring individual preferences near the end of life. September 17, 2014. Available at www.iom.edu/Reports/2014/Dying … the-End-of-Life.aspx. Accessed September 23, 2014.