ANZASM Case of the Month
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This case has been selected by the ANZASM Committee for your information.

Poor communication in a patient presenting with right buccal squamous cell carcinoma

Oral/Maxillofacial Surgery

Case summary

An 89-year-old woman was admitted for an elective surgical resection and reconstruction of the cT2N0M0 right buccal space. She had relevant medical history of hypertension, hypercholesterolaemia, gastroesophageal reflux disease and years of passive smoking exposure.

The procedure appeared to proceed without incident. However, concerns were noted that evening regarding ventilation, and an anaesthetist was called. A working diagnosis of incomplete reversal of muscle relaxant was determined, and the patient was transferred to the intensive care unit then successfully discharged to the ward 2 days later.

On review on the third day of admission, the Otolaryngology, Head and Neck (ENT) team observed fluid overload and instituted a strict fluid balance chart. Overnight, the night cover noted fluid from the tracheal stoma, and on the fourth day of admission, Plastic and Reconstructive Surgery assessed aspiration, resulting in ENT advancing her nasogastric tube and reiterating the need for strict fluid balance. Intravenous antibiotics (piperacillin/tazobactam) were also commenced. On the sixth day of admission, the patient was noted to be drowsy (as fluid was overloaded) prompting review by the medical registrar upon which the goals of care were noted to be inappropriate. These issues were not discussed further in the progress notes. One week into admission, a salivary fistula was identified and managed surgically. Intravenous antibiotics were changed to meropenem (given tracheostomy aspirate grew *Morganella morganii* and multidrug-resistant *Escherichia coli*).

By the 10th day of admission, the patient was noted to have decreasing blood pressure and oxygen saturation with infection thought to be the likely cause. On the 16th day of admission, she had 3 large vomits, decreased oxygen saturation and low blood pressure, as well as rigors and fevers. A consultant discussion was noted to continue active medical management (despite earlier concerns) and ceftriaxone was added to the antibiotic regimen. Abdominal pain and deranged liver function tests were noted, and by the 18th day of admission her abdomen was distended. Review by General Surgery recommended no change to management. However, when the symptoms continued to worsen, a computed tomography scan was requested the following day (which showed omental fat stranding and extraluminal gas, concerning for small bowel infarction and perforation). The risks of

surgical intervention were deemed to be too high and further treatment was considered futile. The patient was palliated, eventually passing away one month into admission.

Discussion

Communication issues were evident in the management of this case.

The goals of care for this patient were poorly documented, with the level of consultant involvement being unclear. Three versions of the goals of care were documented during the course of this patient's admission, with only the initial documented goals of care indicating clear discussion with a consultant.

Three different units appeared to be managing this patient, each conducting their own ward rounds. Discussion between teams did not appear to be occurring (or was not documented) with the level of consultant input again being uncertain.

Clinical lessons

Lack of communication, absence of clear treatment goals, multiple teams independently managing the patient, and insufficient consultant input resulted in surgical issues not being acted upon in a timely fashion.