Dr Zaza Lyons
Mr Albie Lyons

Futility And Recovery: A Personal Reflection
Futility and recovery: A personal reflection

Zaza Lyons
Albie Lyons

Futile Care and End of Life Matters

WAASM Symposium

November 15th 2016
Day 1: 20/08/2006 07.56hrs

- Unknown male
- Found unconscious
- ?Assault?
- Intubated and ventilated
- Reactive pupils
- Acute right sided subdural haematoma with midline shift (demonstrated by white line)
28 August 2006

Albert Lyons
14 Belgrave Street
Maylands 6051

Dear Albert

Recognition of Academic Achievement – Semester 1, 2006

The Faculty of Science & Computing is delighted to advise you that you have qualified for this letter of commendation based on your Semester 1, 2006 results. The commendation is awarded in recognition of your high level of academic performance last semester, and we are both pleased and proud of your achievements. This Faculty offers some of the most demanding courses available at Curtin University of Technology, and we recognize that it takes dedication to study, as well as academic excellence, to achieve so well.

The Faculty of Science & Computing seeks to encourage all students to perform to the best of their ability in their chosen course, and to motivate high achieving students to consider further post graduate studies. Celebrating excellent academic achievement, is part of this strategy.

To be eligible to receive a Faculty Commendation, students must have completed a minimum of 75 credits in the previous semester (Semester 1, 2006 for this round) and earned a SWA of 75 or higher. Only course results from the designated semester are considered.

We congratulate you on your performance in Semester 1, 2006, and encourage you to aim to continue at this level in the coming semester(s).

Regards

[Signature]

Prof Geoff West
Acting Dean
Faculty of Science & Computing
Lyons, Albert John

- Intensive care
- Intubated and ventilated
- Reactive pupils
- Unstable intracranial pressure

- Right sided craniectomy
- Evacuation of acute subdural haematoma
- Insertion of right sided ventricular drain
Day 11: 31/08/2006  14.56hrs
Lyons, Albert John

- Bifrontal craniectomy
- Evacuation of acute subdural
- Insertion of left sided ventricular drain
Outcome after surgical decompression of severe traumatic brain injury

I. Timofeev, P.J. Hutchinson

University of Cambridge Academic Neurosurgery Unit, Box 167, Addenbrooke’s Hospital, Cambridge CB2 2QQ, United Kingdom

Accepted 12 July 2006

Summary One of the factors that affects outcome following severe traumatic brain injury is development and progression of cerebral oedema with associated increase in intracranial pressure (ICP).

Uncontrolled elevations of ICP may compromise energy metabolism of the injured brain and lead to secondary injury, affecting neurological outcome of the patient. Decompressive craniectomy has been used for over a century as a treatment of refractory brain swelling in a variety of neurological conditions. However, conclusive evidence of whether it has a beneficial or adverse affect on outcome is lacking.

This article reviews the existing evidence on the role of decompressive craniectomy in management of patients with traumatic brain injury and stresses the need for randomised controlled trials.

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Review

The role of decompressive craniectomy in the management of traumatic brain injury: a critical review

CD Winter¹ FRCS, AA Adamides¹,² BM BS, JV Rosenfeld¹,² MS FRACS

¹Department of Neurosurgery, The Alfred Hospital and ²Department of Surgery, Monash University, Melbourne, Victoria, Australia

Summary Brain swelling and intracranial hypertension following severe head injury are known to contribute to secondary brain damage, and have been shown to adversely affect patient outcome. The use of unilateral craniectomy following the evacuation of a mass lesion, such as acute subdural haematoma or traumatic intracerebral haematoma, is accepted practice. The following review focuses on a bi-fronto-temporal decompressive craniectomy, used as an isolated operation for the control of intracranial hypertension, secondary to diffuse brain swelling refractory to medical management. Though the operation is being increasingly used, current opinion is still divided regarding its overall effects on outcome. This review examines the experimental and clinical evidence for and against the use of decompressive craniectomy, highlights the lack of class I evidence relevant to this topic and emphasises the necessity for well-designed prospective randomised controlled trials.

Keywords: decompressive craniectomy, traumatic brain injury, review
Aspects on Decompressive Craniectomy in Patients with Traumatic Head Injuries

THOMAS S. SKOGLUND,1 CATHERINE ERIKSSON-RITZÉN,2 CHRISTER JENSEN,3 and BERTIL RYDENHAG1

ABSTRACT

In patients with traumatic brain injury (TBI), intracranial hypertension secondary to cerebral edema is a major problem. A last-tier treatment in these cases is decompressive craniectomy. The aim of the present retrospective investigation was to (1) study the long-time outcome in patients with traumatic head injuries with intracranial hypertension treated with decompressive craniectomy; (2) examine the effects on intracranial pressure (ICP) by the craniectomy; and (3) investigate the possible relationship between the size of the removed bone-flap and the effects on ICP. Among the about 150 patients with severe TBI treated at our neurointensive care unit during 1997–2002, 19 patients were treated with decompressive craniectomy. All patients were young (mean 22 ± 11 years, range 7–46 years), and 68% were male. The mean ICP was reduced from 29.2 ± 3.5 before to 11.1 ± 6.0 mm Hg immediately after the craniectomy; at 24 h after the craniectomy, the mean ICP was 13.9 ± 9.7 mm Hg. Paired-samples t-test revealed a statistically significant decrease, both when comparing the preoperative values to the values immediately postoperative as well as to the values after 24 h (p < 0.01). A significant correlation between the size of the craniectomy and the decrease in ICP was found using Pearson regression analysis. The outcome of all patients could be assessed. The survival rate was 89%. Two patients died (both day 4 after the trauma); 68% of the patients had a favorable outcome (Glasgow Outcome Scale [GOS] score of 4 or 5); 16% were severely disabled (GOS score of 3); and one patient (5%) was left in a vegetative state.

Key words: brain edema; decompressive craniectomy; intracranial pressure; outcome; traumatic brain injury
Outcome following decompressive craniectomy for malignant swelling due to severe head injury

BIZHAN AARABI, M.D., F.R.C.S.(C), DALE C. HESDORFFER, PH.D., M.P.H., EDWARD S. AHN, M.D., CARLA ARESCO, C.R.N.P., THOMAS M. SCALEA, M.D., AND HOWARD M. EISENBERG, M.D.

Department of Neurosurgery and R Adams Cowley Shock Trauma Center, University of Maryland School of Medicine, Baltimore, Maryland; and Mailman School of Public Health, Columbia University, New York, New York

Object. The aim of this study was to assess outcome following decompressive craniectomy for malignant brain swelling due to closed traumatic brain injury (TBI).

Methods. During a 48-month period (March 2000–March 2004), 50 of 967 consecutive patients with closed TBI experienced diffuse brain swelling and underwent decompressive craniectomy, without removal of clots or contusion, to control intracranial pressure (ICP) or to reverse dangerous brain shifts. Diffuse injury was demonstrated in 44 patients, an evacuated mass lesion in four in whom decompressive craniectomy had been performed as a separate procedure, and a nonevacuated mass lesion in two. Decompressive craniectomy was performed urgently in 10 patients before ICP monitoring; in 40 patients the procedure was performed after ICP had become unresponsive to conventional medical management as outlined in the American Association of Neurological Surgeons guidelines. Survivors were followed up for at least 3 months posttreatment to determine their Glasgow Outcome Scale (GOS) score.

Decompressive craniectomy lowered ICP to less than 20 mm Hg in 85% of patients. In the 40 patients who had undergone ICP monitoring before decompression, ICP decreased from a mean of 23.9 to 14.4 mm Hg (p < 0.001). Fourteen of 50 patients died, and 16 either remained in a vegetative state (seven patients) or were severely disabled (nine patients). Twenty patients had a good outcome (GOS Score 4–5). Among 30-day survivors, good outcome occurred in 17, 67, and 67% of patients with postresuscitation Glasgow Coma Scale scores of 3 to 5, 6 to 8, and 9 to 15, respectively (p < 0.05). Outcome was unaffected by abnormal pupillary response to light, timing of decompressive craniectomy, brain shift as demonstrated on computerized tomography scanning, and patient age, possibly because of the small number of patients in each of the subsets. Complications included hydrocephalus (five patients), hemorrhagic swelling ipsilateral to the craniectomy site (eight patients), and subdural hygroma (25 patients).

Conclusions. Decompressive craniectomy was associated with a better-than-expected functional outcome in patients with medically uncontrollable ICP and/or brain herniation, compared with outcomes in other control cohorts reported on in the literature.

key words • severe head injury • traumatic brain injury • decompressive craniectomy • intracranial pressure • cerebral perfusion pressure • outcome
2008 21st Birthday

2013 Graduation
BSc Nanotechnology
1st class honours

2014 Backpacking
around the world
# Futile Care and End of Life Matters

A Symposium by the Western Australian Audit of Surgical Mortality

Tuesday, 15 November 2016

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Title</th>
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<tbody>
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<td>James Atken</td>
<td>Chairman</td>
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</tbody>
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## Preparing for the Inevitable

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hon Jim McGinty AM</td>
<td>Parliament’s role in End of Life matters</td>
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<tr>
<td>Dr Penny Flatt AO</td>
<td>The aged care sector’s role in preparing for the End of Life</td>
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<tr>
<td>Dr Matthew Anstey</td>
<td>End of Life care - a national policy perspective</td>
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</tbody>
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## Managing Dying in the Acute Patient

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Title</th>
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<tbody>
<tr>
<td>Dr Tim Paterson</td>
<td>Proceeding in borderline cases</td>
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<tr>
<td>Mr Stephen Honeybul</td>
<td>Futile care or no treatment</td>
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<tr>
<td>Dr Zaza Lyons</td>
<td>Futility and recovery: a personal reflection</td>
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<tr>
<td>Mr Albie Lyons</td>
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<tr>
<td>James Atken</td>
<td>Discussion (to conclude at 8.30pm followed by refreshments)</td>
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This activity qualifies for 3 RACS CPD points in *Maintenance of Knowledge and Skill*.