

Short of Breath

At 7 am, as I walked swiftly to the oncology ward for morning rounds, I got a hospital call. A new patient has been shifted from the emergency ward to the inpatient ward on O₂ support. Somehow, I too felt short of breath.

It was 6 weeks back when a young doctor came sick to the outpatient department in a trolley sitting as she was unable to lie down. She was dyspneic and frankly panting for breath. She had gross right pleural effusion on chest X-ray. She was urgently admitted and an intercostal drain was put in. Soon, she became stable and better. This lady was diagnosed with vulval squamous cell carcinoma nearly 2 years back and had got treated with surgery and postoperative radiotherapy then. After 6 months, she had local skin and pelvic nodal recurrence and by now she had received three lines of chemotherapy/targeted therapy, the last dose of which got completed just 4 months back.

Now, with pleural fluid positive for malignant cells, she had clearly progressed and she also had residual ulcerative disease in the lower abdominal wall and inguinal area. She was still dyspneic and had extreme local pain, for which morphine was started with some relief. However, she remained hopeful and filled with confidence (how could she be so in spite of knowing everything?). Two years back, she was an energetic young girl in her final year of her medical internship who had own dreams of medical practice when this unfortunate course of events unfolded.

My professor was very concerned sensing proximity of the terminal event. With three lines of chemotherapy, best response has never been more than stable disease, essentially pointing toward inherent chemotherapy resistance. Nothing can be expected to induce a miracle. My mind however echoed the feelings of the young girl. How can we decide best supportive care alone for her when she is so young? After much debate, he agreed for her next line albeit reluctantly. Explaining that it is optional and might not really work and with her informed consent, she was given fourth line of chemotherapy at a reduced dose in view of performance status and low albumin levels. Palliative care team was already observing the patient. She was optimistic and so was her family. I tried to be so.

In spite of the reduced dose and antiemetic prophylaxis, she started to have nausea and gastritis. Her oral intake reduced and total parenteral nutrition had to be started. There was no respite for her dyspnea and she continued to have significant intercostal drain output for many days. Things were getting clear to her family and to me. Oh my God, it is not working. She however continued to remain positive. The daily rounds for me got tougher as I was at loss of words to her repeated queries on the next

dose of chemotherapy and timing of response expected. Meanwhile, her shortness of breath increased and palliative care team offered her morphine drip. She blankly refused it. She wanted to be awake and alive at any cost. I wondered whether having a medical background was the cause of her denial. Or is it her young age?

She had her last breath 4 weeks back, unwilling for any sedation for her distressing dyspnea in the midst of her unfortunate but understanding family. In the oncology residency, we have to pass through such moments multiple times when all we can do is to be a mere spectator.

Then a week later, a middle-aged lady with advanced ovarian cancer got admitted to my ward with dyspnea. She was treated with surgery and chemotherapy 3 years back and had relapsed multiple times afterward. This time, she was on her third line of chemotherapy when she developed significant dyspnea. She had a brief febrile illness 2 weeks back and now came to emergency ward very sick and drowsy. On evaluation, X-ray chest showed nearly white-out lung. She was neutropenic due to chemotherapy but was afebrile. With high CA-125, clinically she appeared progressive. Her family also appeared to have reconciled to the fact that she will not survive further.

And this time, I was not keen on being aggressive, and after sending cultures, I started her on empirical antibiotics and bronchodilators with O₂ support in her inpatient room. The onus of my discussion with family was that the intent is palliation and she might not be a candidate for Intensive Care Unit (ICU) admission. This time, my professor however had very different thoughts. He suspected it to be a postchemotherapy infective complication and wanted to give a trial of intensive critical care support. This was discussed with the family and the ICU team. Neither of them were willing for any ICU admission or procedures in view of her advanced cancer which had likely progressed and also due to her very poor general condition.

After much counseling of both parties and with consent for only noninvasive ventilation support, the patient was shifted to the ICU. In the next few days, her blood cultures grew methicillin-resistant *Staphylococcus aureus* and promptly sensitive antibiotics were started. Over the next 1 week, she showed tremendous improvement and got discharged with no dyspnea and in much better general condition. She had by now come by walk for follow-up twice in the last 2 weeks and was asymptomatic. Her face was beaming with so much energy and I could not believe that she was the same lady for whom I had nearly assumed end of the path.

I remained perplexed for the next week. Why had the outcomes been so different for the two ladies? The young doctor had gynecological cancer with poor biology and inherent chemotherapy resistance though her age and general condition were better. On the other side, the middle-aged lady with ovarian cancer had become sick while on chemotherapy, had low counts and a history of short febrile illness. This had alerted us to a possible reversible cause although she was very sick at the admission. So how should I approach the next patient who comes to me in such condition again?

I believe that each such individual patient with “terminal” dyspnea is different and I must not have *a priori* conclusion about his/her final outcomes. The biology of cancer, the lines of chemotherapy, family and patient expectations, age and general health of the patients, and any new or old guideline may help me but I must not make any assumption whatsoever. After proper discussion with the family and the patient, all measures have to be taken to find out any correctable cause of dyspnea and treat accordingly. The art of oncology is best taught by each of our patients, always.

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