Cancer in the elderly — a case for informed pessimism?

Five of my patients died recently. I wonder how well the NHS served them.

Mr A died at the age of 77 years. He had diabetes, peripheral vascular disease and had had carcinoma prostate treated with radiotherapy. Although not formally assessed he was showing signs of early dementia. In January 2003 he developed a cough, which failed to resolve. He had a positive bronchoscopy, followed by a prompt lobectomy. He did not do well. He rapidly became chair bound and oedematous, developed a chest infection, was admitted to hospital and died of a massive haemoptysis less than 2 months after operation (July 2003).

Mr B was 80 years old when he died. A one-legged bachelor (old war wound) who lived alone, he had his bowel cancer diagnosed in August 2000. His only other past medical history was of a cholecystectomy in 1989. He refused operation, but remained active. In January 2003 he was getting discomfort in his left iliac fossa — which interfered with his artificial limb. He requested referral for operation. CT scan showed locally extensive tumour. In March he had a Hartman's procedure and was home by early May. Unusually he requested several visits over the coming few months for mucorrhoea. He was admitted to hospital in mid July due to continued rectal stump bleeding and pallor. He did not return home. He died at the end of September (6 months after the operation).

Mrs C was a widow aged 87 years when she died. She had glaucoma, diabetes, had had a post-operative pulmonary embolus in 1985 and mild cardiac failure. She was obese. She developed vaginal bleeding in October 2002. A stage 2 adenocarcinoma was diagnosed and she had a hysterectomy in January. She developed a deep vein thrombosis and pulmonary embolus in April 2003. Following this there was increasing heart failure. She developed large abdominal masses, diagnosed as metastatic carcinoma. These started to fungate. She died 2 weeks after being admitted to hospital for terminal care in December 2003.

Mr D was 71 when he died. His Duke's stage C bowel cancer was resected in 1998. In 2002 his CEA was noted to be rising. He did not attend six Barium enema appointments over the following months. It became apparent that he was declining, but he steadfastly refused anything to do with hospital. His CEA was 1872 in June 2003 with deranged liver function tests. He stayed at home with a few ups and downs managed by slow release morphine and dexamethasone. A sudden deterioration in December 2003 meant a precipitate admission to hospital, where he died within a couple of hours.

Mr E was 85 years old when he died. He was a widower with no children. He had ischemic heart disease. He had a knee replacement in December 2002, with recurrent anaemia following this. He developed cardiac failure in July 2003. Finally investigations showed an asymptomatic extensive carcinoma stomach in December 2003. When discussing his prognosis I commented that he might have a few months, or that he might be, 'called tonight.' 'How glorious!' was his reply. He stayed at home until a further haematemesis. He died after a short hospital admission in January 2004.

The first three cases left me with serious concerns; the later two seemed to have a better quality of life, without further intervention. As a GP I may be over pessimistic about the benefits of surgery and over optimistic about how well terminal care can be managed at home. I am left wondering whether I should have strongly advised patients A, B and C not to have surgery (only Mrs B asked my opinion, and we deferred to the experts). The surgery was 'successful' in all three cases. It was the course of events following that was the problem. Doctors only ever help patients defer death. The question is, for patients in the last decade of life, often with considerable other pathology, do we need a more informed pessimism about the benefits of active intervention?

With the increasing pressure of litigation felt by doctors plus societal desire to 'fight' cancer, I fear that futile surgery (and chemotherapy) could become more of a 'norm' — to the real detriment of our patients wellbeing.

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