The 'widowmaker' isn't human, but it takes lives

BY SUE PALMER
THE WASHINGTON POST

KENNETH K. LAM | BALTIMORE SUN | MCT FILE

Dianne Walters (left) cardiac rehab nurse, talks with Ana Duhon and Carrie O'Connor. Both Duhon and O'Connor had heart attacks in their 30s and were treated at Anne Arundel Medical Center in Annapolis, Maryland, in 2014. They are founding members of the medical center's Young Adult Cardiac Support Group.

In my years as a prosecutor, I saw plenty of violence, including many deaths. Some were accidental, but some were the work of killers, even serial killers. I have always been fascinated by serial killers. How do they choose their victims? How is it that they can take a life so easily? I studied them, tried to understand their behavior. None of that prepared me for the day I met a serial killer of a different sort — a medical one with the ominous name "the widowmaker" — that had come for me.

On Tuesday, Jan. 13, 2015, I suddenly became wide awake at 5 a.m. I lay in bed with my eyes open for maybe a minute, thinking, "Hmm, this is weird," and then, "I feel kind of funny." Within about 30 seconds I rushed to the bathroom and threw up. I felt very cold and climbed back into bed with my husband and snuggled back under the covers. A minute later, though, I knew I was going to be sick again. I figured I was coming down with a virus, but it was strange how suddenly it had come on.

My husband, Tim, was concerned. He sat beside me, felt my cold, clammy forehead and said I just looked so pale. Then he whispered, "Let's go to the emergency room." I laughed. "Why?" I asked. He replied, "You could be having a heart attack."

Tim's father had died of a heart attack at age 64 after feeling the classic stabbing chest pain and heaviness in the chest that you always associate with a heart attack. But that wasn't me. I was 46, I just had a bit of a bug, probably a 24-hour thing. I just needed a little rest. Tim wouldn't have it, though.

And so 30 minutes later we walked into the emergency room at the Vanderbilt University Medical Center, where half-jokingly I said, "My husband thinks I may be having a heart attack."

If you want to get past the first stage at the ER quickly, that is the way to do it. They walked me directly to the back and told me to have a seat. They brought over a portable EKG machine and hooked me up. When the results came back a few minutes later, the ER doctor said, "Hmm. Well, it appears to be a little abnormal, but it's hard to believe you're having a heart attack." "I know," I said, rolling my eyes and feeling embarrassed.

He asked me a bunch of questions. Nope, I don't have chest pain. Nope, I don't smoke. Nope, my cholesterol is normal. Nope, I don't have any history of heart problems in my family. I exercise regularly. I eat well. I have never had a surgery or even been seriously ill. Gee, I have never even had an IV. I'm super healthy. He commented that I look healthy, am not overweight, in good shape. He decided to do another EKG in 10 minutes or so.

A bit later, with the results of that second EKG in her hand, a nurse looked at me and said, "Things are going to start happening really fast. In a couple of minutes there are going to be a lot of people in this room, moving very fast. I don't want you to be scared." I said, "OK." I wasn't scared. I still felt fine and, as far as I knew, all was well. I didn't feel sick anymore, or even funny.

The next thing I know, I was on a gurney with tremendous activity around me. One person was pulling off my clothes, another was sticking a needle into my left arm, another into my right arm. There were at least four other nurses and doctors moving around fast, doing I don't know what. At that point, I started to cry. Suddenly I was scared.

From my right came a gentle voice. I looked over to a man in a white coat, who took my hand. "My name is Dr. Fredi. I am the boss of all these people. We are going to take you upstairs and see what is going on with your heart," he said. "If there is something wrong, I am going to fix it. I'll treat you just like a member of my own family." I said, "OK," Tim gave me a kiss and, in a flash, I was off.

They took me to a big room where everything was white and there were bright lights, a lot of medical equipment and a bunch of people in scrubs. At least that's what I recall. I remember people telling me, "Dr. Fredi is the best, and he will take good care of you." Then I was out.

When I awoke, I was in a different bed in a different room. Tim was there. He told me that I had had a major heart attack, that I was in the process of having it when we went to the hospital, and that Joseph Fredi, an interventional cardiologist, had been able to stop it in its tracks. He literally stopped the heart attack while it was happening by suctioning out a blood clot and putting two stents into my right coronary artery through a tiny hole he pierced in my right wrist.

Fredi had taken me into the catheterization lab and determined that my right coronary artery was 100 percent blocked, and the center artery, called the LAD, was 70 percent blocked. LAD blockage is the problem they call "the widowmaker," because it is the most frequent source of sudden death. It kills a lot of people, including "Sopranos" star James Gandolfini and newsman Tim Russert. (Comedian Rosie O'Donnell survived hers.) Doctors say it's a true serial killer.

Plaque had ruptured in the wall of my right coronary artery, which caused the clot to form and can produce the sort of nausea that made me throw up. That was my only warning sign. If I had gone back to sleep that morning, as I had wanted to, I may not have awakened, and if I did, there probably would have been devastating damage to my heart. As it was, I had no damage.

When I sat down to write this story, I wondered where it should end. I guess the most important thing I can tell you is how it didn't end. Heart disease is the No. 1 killer of women in the United States — with nearly 300,000 deaths a year — but I survived this serial killer. I just passed the one-year anniversary of my heart attack. I took a nuclear stress test the other day. My heart, Fredi says, looks perfectly healthy. There is no sign of scar tissue, and I'm able to lead an active life doing anything I want.

My good health is due to one thing: early intervention. Because my husband got me to the hospital so fast, Fredi was able to save me and save my heart. So my lesson is this: Don't think it can't happen to you. Just because you're young and healthy, because you don't smoke or drink, because you work out and you're thin and you eat well and you've never had any medical problems and you have no family history, don't think that you can't have a heart attack. You can.

They are still not sure what caused mine.

I would tell you to trust your instincts — except in this case my instinct was to chalk up my symptoms to something else and to worry about whether the doctors and nurses would think I was crazy. So I'll say don't trust your instincts, if your instincts are to wait and see what happens. When you just don't feel right, don't ignore it. Fredi says that nine out of 10 women with my symptoms would not have gone to the hospital. I wouldn't have gone either, if it weren't for Tim.

Many women have no chest pain, no tightness, no pain in the arm or jaw until it is much too late. Many women suffering a heart attack simply "don't feel right," just as I did. So if that happens, don't ignore the feeling and don't worry about someone thinking you're crazy. Get yourself checked out. The worst thing that happens is they send you home and tell you you're fine. You can live with that.

We all want to die with dignity — but not yet

BY TAMMY WORTH
THE WASHINGTON POST

HEIDI DE MARCO | TNS

Jeremy Wilson, 40, cleans his father John Wilson's mouth during his weekly visit in February at St. John's Pleasant Valley Hospital in Camarillo, California.

A woman with ovarian cancer who came to see internist Leslie Blackhall was very upset. The woman's oncologist had told her it was time to discontinue treatment — that it was doing more harm than good.

Blackhall knew that the effects of more chemotherapy would be intense and would compromise this patient's immune system while buying her only a bit more time. So she asked the woman, who was in her 60s, what she would do with more time. The response: Have more chemo, on the chance it might let her live longer.

Medical advances bring the promise of extending life, but some of the treatments used in a person's last months, weeks or days — such as CPR for failing hearts, dialysis for failing kidneys and feeding tubes for those unable to nourish themselves — often do not provide more time and can worsen quality of life.

Yet saying no to more treatment is tremendously hard to do, whether that decision is made by patients or by relatives for patients who are too infirm to express themselves.

"People don't have a good way to think about end of life," said Blackhall, an associate professor of internal medicine at the University of Virginia Health System in Charlottesville. "If we tell people, 'Chemo isn't going to help you,' they still want it. We [all] want a peaceful, comfortable, dignified death ... but not yet," she said.

So what has research found about commonly used end-of-life interventions? Which ones can be useful and which are not, and when should they be administered?

Resuscitation

CPR is just one of the treatments offered in hospitals and other medical settings with the purpose of keeping people alive so an underlying health condition can be treated. For instance, a young and healthy person who has a major allergic reaction to a drug can be given CPR to bring them back and treat the reaction.

But CPR is frequently used even when there is no intervention that can prolong life. For a person with metastatic cancer or late-stage dementia whose heart stops beating, the odds are quite low that resuscitation will be lifesaving, said Blackhall, who began studying this issue in the late 1980s.

Numerous studies have borne this out, one of the most recent being a 2009 analysis in the New England Journal of Medicine that looked at more than 400,000 people older than 65 who received in-hospital CPR. Researchers found that only 18 percent survived long enough to be discharged. The survival rate dropped at higher ages, with only 12 percent of those 90 and older recovering enough to leave the hospital.

"It is less likely to work when the cause of heart stopping is something you can't fix to begin with," such as terminal cancer, Blackhall said. "They are dying, and if they survive that 15 minutes, [the process of CPR] often breaks their ribs. They will end up in the ICU with a catheter, a tube down their throat and another one to feed them."

Dialysis

When dialysis, which removes waste from the blood, was introduced in the 1940s, its purpose was to keep young people with acute renal failure alive until their kidneys began to properly function again.

Today, an estimated 650,000 people have end-stage renal disease, more than 70 percent of whom are on dialysis. The typical patient on dialysis is 65 years old, and the fastest-growing group is individuals who are older than 75. The treatment is used in approximately 90 percent of elderly people with end-stage renal disease, according to 2013 research in the journal Aging Health. Acute failure, particularly in young people, can be reversed, allowing them to live long, healthy lives. Dialysis, however, doesn't cure end-stage renal disease.

Sharon Kaufman, author of "Ordinary Medicine: Extraordinary Treatments, Longer Lives, and Where to Draw the Line," said this is another area where the default treatment may not be the best option for older patients.

"People aren't 'choosing' dialysis — they are being directed toward what is available, and what is available is more," said Kaufman, who chairs the department of anthropology, history and social medicine at the University of California at San Francisco. "Patients are not getting better; they are just hoping not to get worse."

In many cases, dialysis does not lengthen the lives of older, frail patients. And even when it does, that extra time can be problematic. Researchers from the Johns Hopkins University School of Medicine found that frail, elderly dialysis patients had a 40 percent mortality rate after three years compared with a 16 percent rate for healthier patients receiving the treatment. This is, in part, due to the toll dialysis can take on the body.

A New England Journal of Medicine article from 2009 looked at more than 3,500 patients with end-stage renal disease starting dialysis in U.S. nursing homes. Researchers found that 39 percent retained kidney function three months after initiating treatment; but at 12 months, only 13 percent maintained it and more than half had died. The study authors concluded that dialysis in this patient population is associated with a "substantial and sustained decline in functional status."

Patients do have a choice about undertaking dialysis, but Kaufman contends that the medical system makes it extremely hard to say no.

People are directed toward dialysis because of health care's love of technology, its fee-for-service system and the specter of litigation hanging over hospitals that do not use all their resources to extend life, Kaufman said. Also, terminally ill patients often have a strong will to live, and they feel as though they are "choosing death" if they opt out.

Kaufman recounted the case of a physician friend with end-stage renal disease who opted out of dialysis, concluding that the hours attached to a machine and the treatment's side effects — including fatigue, low blood pressure, blood poisoning and muscle pain — were not worth it.

"Because he was a physician, he knew," Kaufman said. "Doctors don't want for themselves what they do for their patients, and that's what patients need to know."

Feeding tubes

As dementia advances, people tend to be less interested in food. They become more likely to fight someone trying to feed them, choke when swallowing food or keep it balled up in their cheek instead of swallowing.

Feeding tubes are often used to bypass these issues. The idea is that the tubes provide nourishment to prolong life while avoiding aspiration pneumonia (where food goes into the lungs rather than the stomach) and decreasing the risk of pressure ulcers, a breakdown of the skin from something rubbing against it.

Nearly a third of the people in U.S. nursing homes with cognitive impairment at some point are given feeding tubes, according to a 2010 article in JAMA. But a recent study in the Archives of Internal Medicine found that feeding tubes didn't reduce the chances of pressure ulcers among nursing home residents, and doctors say aspiration pneumonia still occurs when stomach contents back up into the esophagus and then into the lungs.

"It turns out that, at the point in time when people develop problems with chewing and swallowing and eating, their dementia is quite advanced and they don't have a lot of time left anyway," said Muriel Gillick, director of the program in aging at the Harvard Pilgrim Health Care Institute.

But, she said, "it is hard to say to a family, 'Your mom has trouble swallowing, so we are just not going to give her anything to eat anymore.' Families want it because feeding someone we love is our way of nurturing and showing we care."

Feeding tubes, like dialysis and CPR, are often provided in many health care settings because patients and families aren't offered alternatives that seem acceptable as the end approaches.

"What matters most is a person is comfortable ... and I think generally we have ways to achieve this that don't involve sticking tubes in people," Gillick said. Ice chips can be offered to assuage thirst, and reading to people, holding their hands, keeping them warm and dry are all sustaining activities that improve quality of life. These things shouldn't be thought of as "trivial or fluff," she said.

"All of us are going to die," Blackhall said. "The question should be how do we want to live — what do we actually want to do with that time? Let's make sure that whatever time you have, you can do those things."