

ETHICS AND SYMPTOM MANAGEMENT

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PROGRAM DETAILS

- **Title:** Ethics and Symptom Management
- **Dates/Term of offering:** This activity was released on May 31, 2023 and is valid for one year. Requests for credit must be made no later than May 30, 2024.
- **Joint Providership:** This activity is jointly provided by Global Education Group and Hospice and Palliative Board Review.com.



- **Target Audience:** The educational design of this activity addresses the needs of Physicians, NPs, Nurses, and health care professionals interested in learning more about hospice and palliative medicine and those who want to earn continuing education credits and/or prepare for board certification in hospice and palliative medicine.

PROGRAM DETAILS

- **Program Overview:** Clinicians and health care professionals are unaware of best practices to be utilized regarding appropriate personnel allocation in hospice and palliative care. As such, they do not know how to adequately counsel patients & families on appropriate personnel utilization in the hospice and palliative care setting.
- **Faculty:** Eric Bush, MD, RPh, MBA
- **Physician Accreditation Statement:**

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PROGRAM DETAILS

- **Instructions to Receive Credit:** In order to receive credit for this activity, the participant must score at least a 75% on the post quiz and submit a completed evaluation and credit application form.
 - **Global Contact Information:** For information about the accreditation of this program, please contact Global at 303-395-1782 or cme@globaleducationgroup.com.
 - **Fee Information:** There is a fee for this educational activity.
 - **System Requirements:**
 - **PC:** Microsoft Windows 2000 SE or above, Flash Player Plugin (v7.0.1.9 or greater), Internet Explorer (11.0 or greater), Chrome, Firefox, Adobe Acrobat Reader*
 - **MAC:** MAC OS 10.2.8, Flash Player Plugin (v7.0.1.9 or greater,)), Safari, Chrome, Adobe Acrobat Readers*, Internet Explorer is not supported on the Macintosh.
- *Required to view printable (PDF) version of the lesson.

PROGRAM DETAILS

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PROGRAM DETAILS

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LEARNING OBJECTIVES

- Describe how to perform symptom management in the palliative and hospice setting.
- Describe how to counsel patients and caregivers on interventions in this setting and the applicable risk versus benefit for appropriate interventions.
- Describe how to perform goals of care and advanced care planning discussions with patients and family.
- Describe how to counsel patients and caregivers on appropriate goals of care and advanced care planning given the patient's disease trajectory and wishes.
- Describe how to discuss utilization of appropriate personnel allocation in the hospice and palliative care setting.
- Describe how to counsel patients and families on appropriate personnel allocation in the hospice and palliative care setting and the benefits for patients and families undergoing this type of care.

When to ask about Hospice or
Supportive (Palliative Care)

What People Want

- To die at home
- To be free from pain
- To be in the company of loved ones
- To retain control of the care we receive

The Contrast of Reality

- Less than 25 percent of Americans die at home, although more than **70 percent** say that is their wish
- Only 20 to 30 percent of the population have completed an advanced directive
- Dying is often unnecessarily painful and isolating

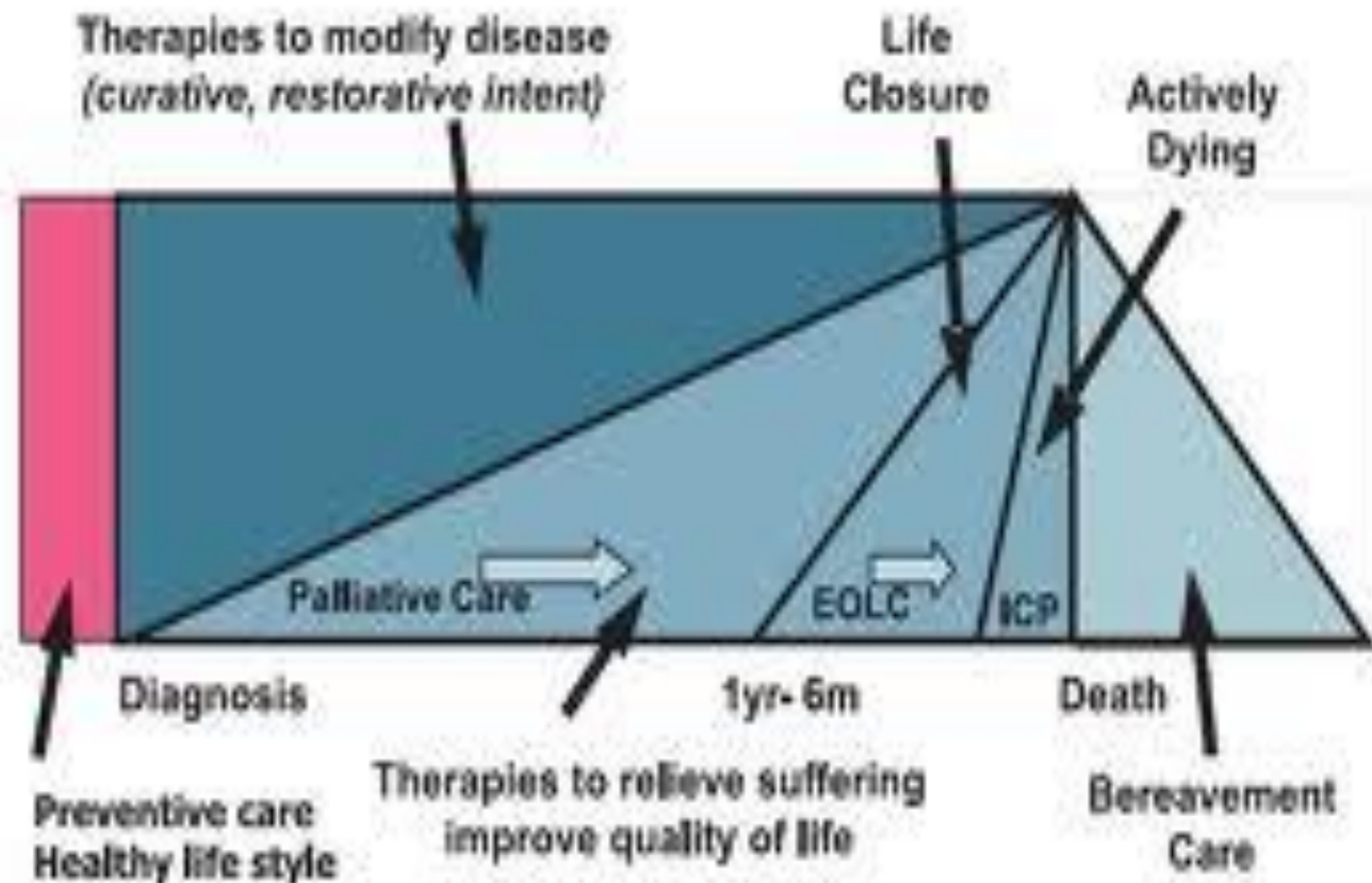
The Reason for this Stark Reality

- Doctors aren't aware of their patients' wishes.
- A major 2007 study found that only 25% of physicians knew that their patients had advance directives on file.
- The end of life is often treated only as a medical moment.

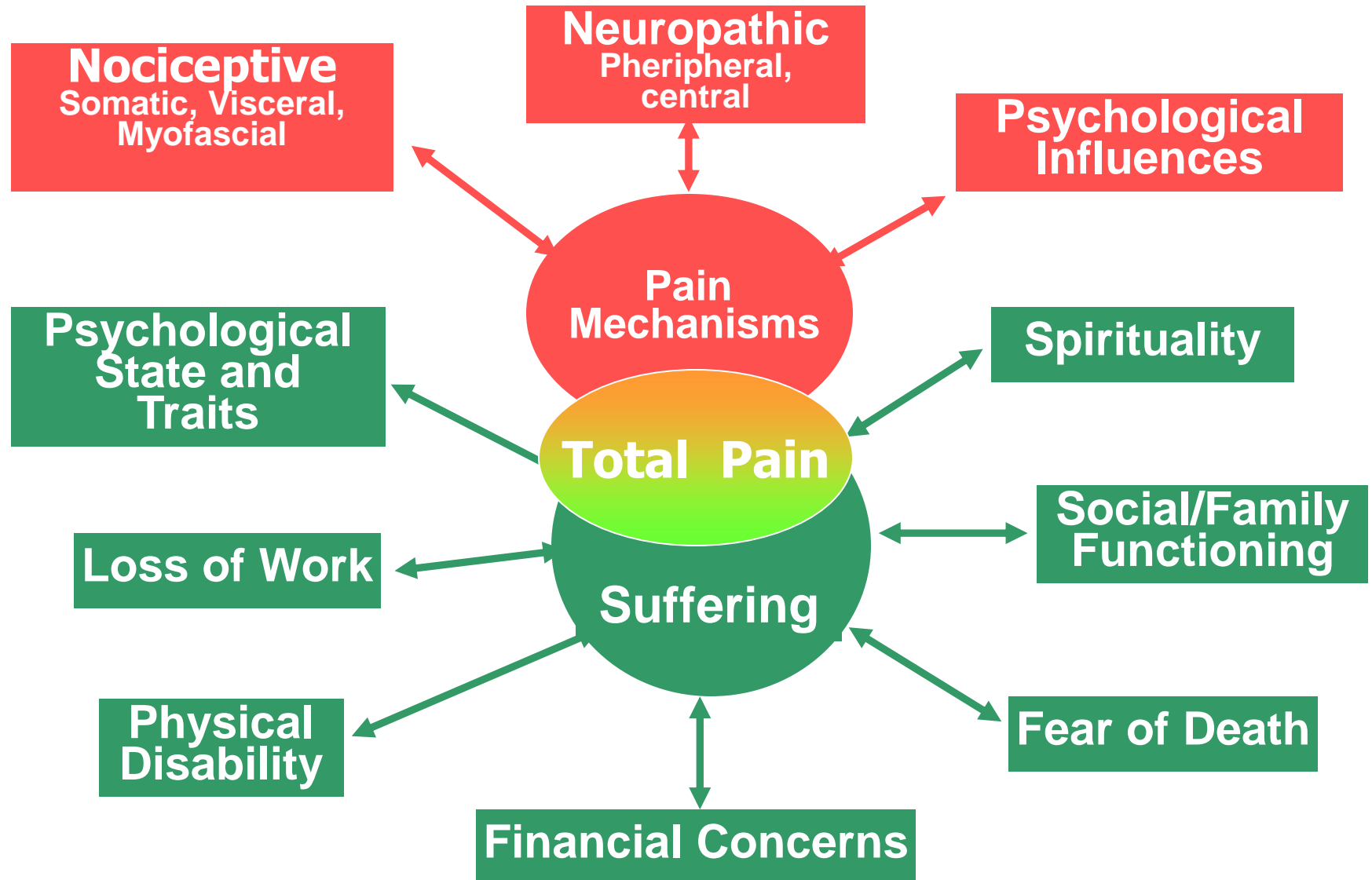
Basic Concepts of Hospice & Supportive (Palliative Care)

Modified from-

<http://depts.washington.edu/pallcare/training/ppt.shtml>



Nature of Pain(or other symptom)



Supportive Care (Palliative Care)

- Supportive Care is given to improve the quality of life of patients who have a serious, chronic or life-threatening disease.
- The goal of Palliative Care is to prevent or treat as early as possible, the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social and spiritual problems related to a disease or its treatment.
- In short, symptom management, regardless of where the patient is in the disease process, is utilizing a biopsychosocial approach.

Supportive Care (Palliative Care)

- Primarily Inpt/office based
- Ongoing eval risk/benefit of interventions
- Chaplain and social work svcs available as outpt
- Helps to improve QOL and shown to improve lifespan in Stage 4 NSCLC
- No mechanism for reimbursement for multidisciplinary home based supportive care
- Pt/families often seen while enrolled in HHC

Hospice

- Provides support and care for those in the last phases of life-limiting illness(prognosis <6months)
- Recognizes dying as part of the normal process of living
- Affirms life and neither hastens nor postpones death
- Focuses on quality of life for individuals and their family caregivers

Differentiation

- Hospice - if the disease follows the expected course, a prognosis of six months or less (patients often referred late, NEJM NSCLC study)
- Supportive (Palliative) - symptom focused care anywhere throughout the disease spectrum, can be delivered in conjunction with curative care

Core Aspects of Hospice

- Patient/family focused
- Interdisciplinary
- Provides a range of services:
 - Interdisciplinary case management
 - Pharmaceuticals
 - Durable medical equipment
 - Supplies
 - Volunteers
 - Grief support

Additional Services

- Hospice offers additional services, including:
 - Hospice residential care (facility)
 - Inpatient hospice care
 - Complementary therapies
 - Specialized pediatric team
 - Caregiver training classes

Hospice Team Members

- The patient's personal physician
- Hospice physician (medical director)
- Nurses
- Home health aides
- Social workers
- Clergy or other counselors
- Trained volunteers
- Speech, physical, and occupational therapists

The Hospice Team

- Develops the plan of care
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for the patient and family
- Provides bereavement care and counseling

Where Hospice is Provided

- Home
- Nursing Facility
- Assisted Living Facility
- Hospital
- Hospice residence or unit
- Prison, homeless shelter – where ever the person is

Who Pays?

- Medicare
- Medicaid
- Insurance
- Private pay
- Sometimes a combination of these...

Admission Criteria

- General
 - Life-limiting illness, prognosis is 6 months or less if disease takes normal course
 - Live in service area
 - Consent to accept services

Physicians *Overestimate* Life Expectancy by What Percent?

- a)10
- b)50
- c)70
- d)90
- e)Google

When to ask about Hospice or Supportive(Palliative) Care

- Poor quality of life
- Uncontrolled symptoms
- Treatment plan discordant with wishes
- Multiple hospitalizations but not getting “better”
- Prognosis 6months or less (based on diagnosis)
- Declining functional status/wt loss/overall decline
- Please d/w your family/physician/clergy/HC team

Summary

- Performance status important trigger for appropriate supportive/pall care/hospice referrals
- Patients/families/physicians often receive/refer patients late for palliative/hospice care
- We are there to support you and our patients/families throughout the spectrum of care
- Effort for true patient centered care must be united to be successful, resulting in better outcomes
- Complete your advanced directives, make your wishes known

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A Community that Cares

The care Saul and his wife received from hospice enabled her to live at home until she died. After her death he joined a coalition that organizes caregiving circles to provide care and support to seriously ill people in his community.

How can you help in your community?
It's about how you LIVE.



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FREE Resources Available from *Caring Connections*

- More information about Hospice and Palliative Care
- State-specific advance directives
- Brochures to download or order:
 - What is Palliative Care?
 - Ask Tough Questions
 - Conversations Before the Crisis
 - Question and Answers: Artificial Nutrition
 - Question and Answers: Cardiopulmonary
 - Question and Answers: Dying at Home

It's About How You LIVE!

- Learn about your options, choices and decisions
- Implement your advance directive plans
- Voice your decisions about hospice and palliative care
- Engage others to learn more about hospice and palliative care

PALLIATIVE CARE AND SYMPTOM MANAGEMENT

PALLIATIVE CARE PERSPECTIVE

- Empathy: The ability to understand the feelings of another

PALLIATIVE CARE

- Care given to improve the quality of life of patients who have a serious, chronic or life-threatening disease.
- The goal of palliative care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.
- In short, symptom management, regardless of where the patient is in the disease process utilizing a biopsychosocial approach

DIFFERENTIATION

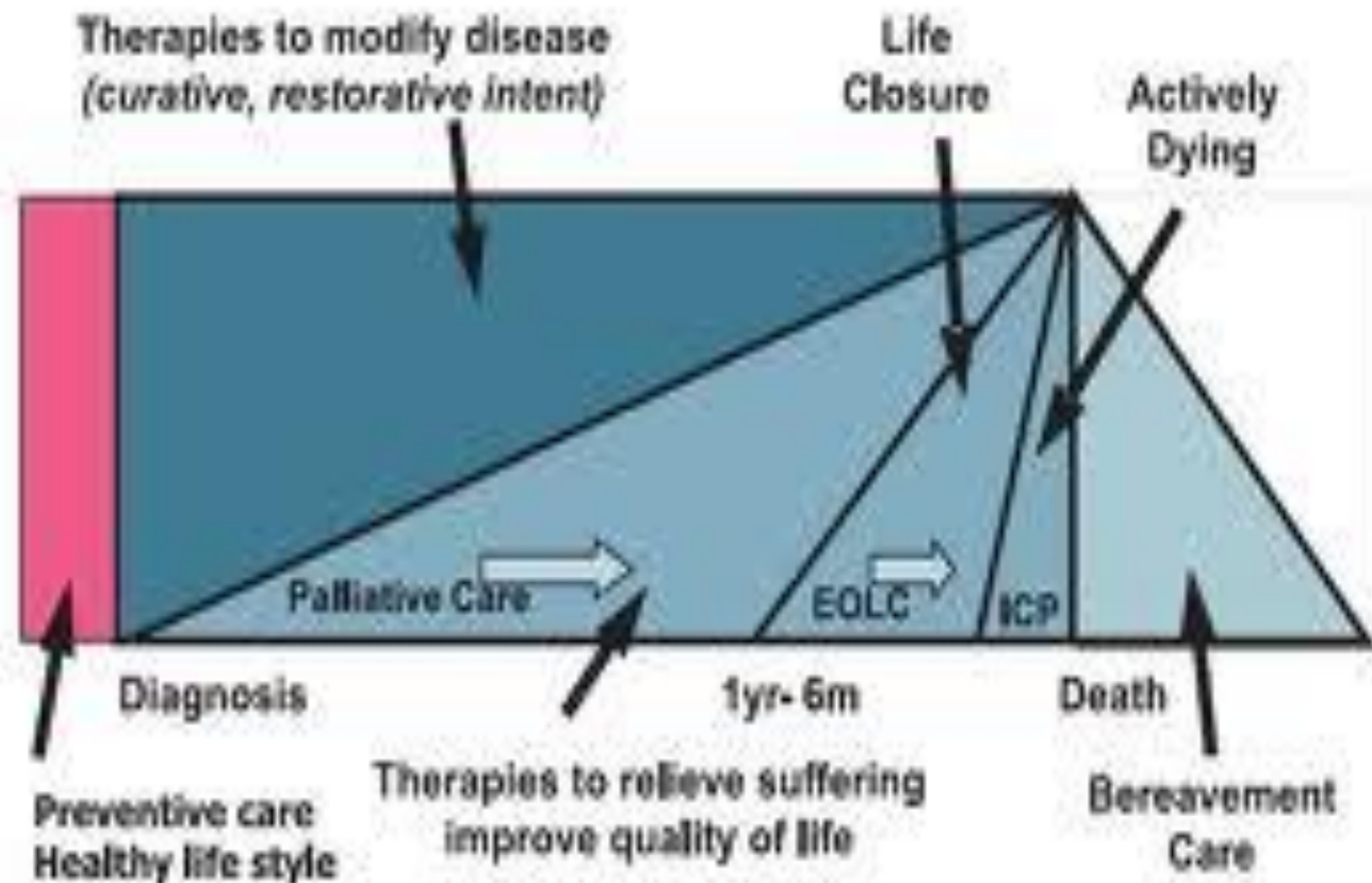
- Hospice: If the disease follows the expected course, a prognosis of six months or less(patients often referred late)
- Palliative: Symptom focused care anywhere throughout the disease spectrum, can be delivered in conjunction with curative care

Why Palliative Care?

- Aggressive measures for control of pain and other distressing symptoms
- Better quality and often longer life, with neither quality or quantity achieved at the other's expense
- More goal centered
- Interdisciplinary team of caregivers, participating in holistic care of patient and family

Modified from-

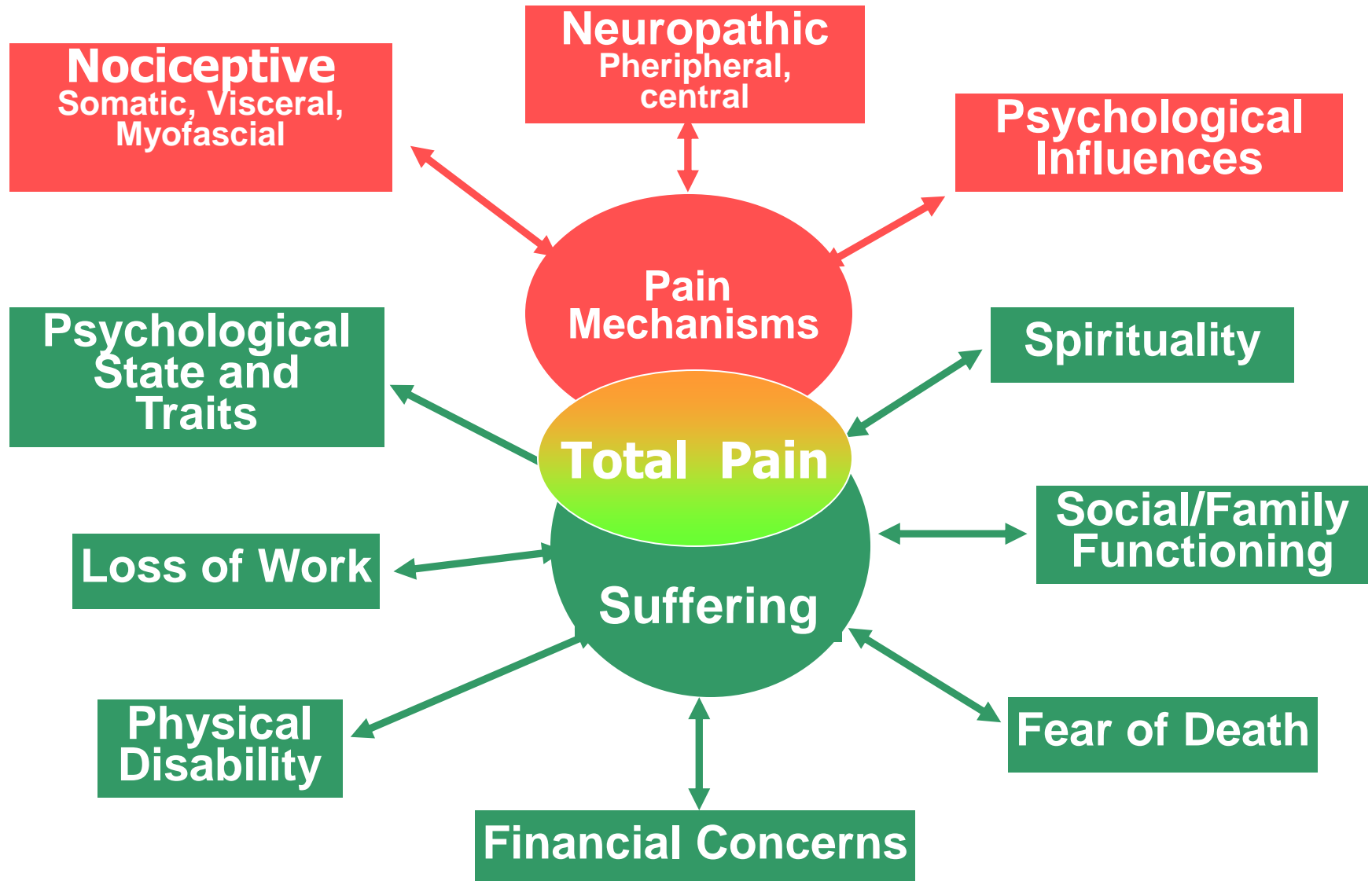
<http://depts.washington.edu/pallcare/training/ppt.shtml>



BASIC CONCEPTS IN PALLIATIVE CARE - PAIN MGMT

- Pain: An unpleasant sensation that can range from mild, localized discomfort to agony. Pain has both physical and emotional components

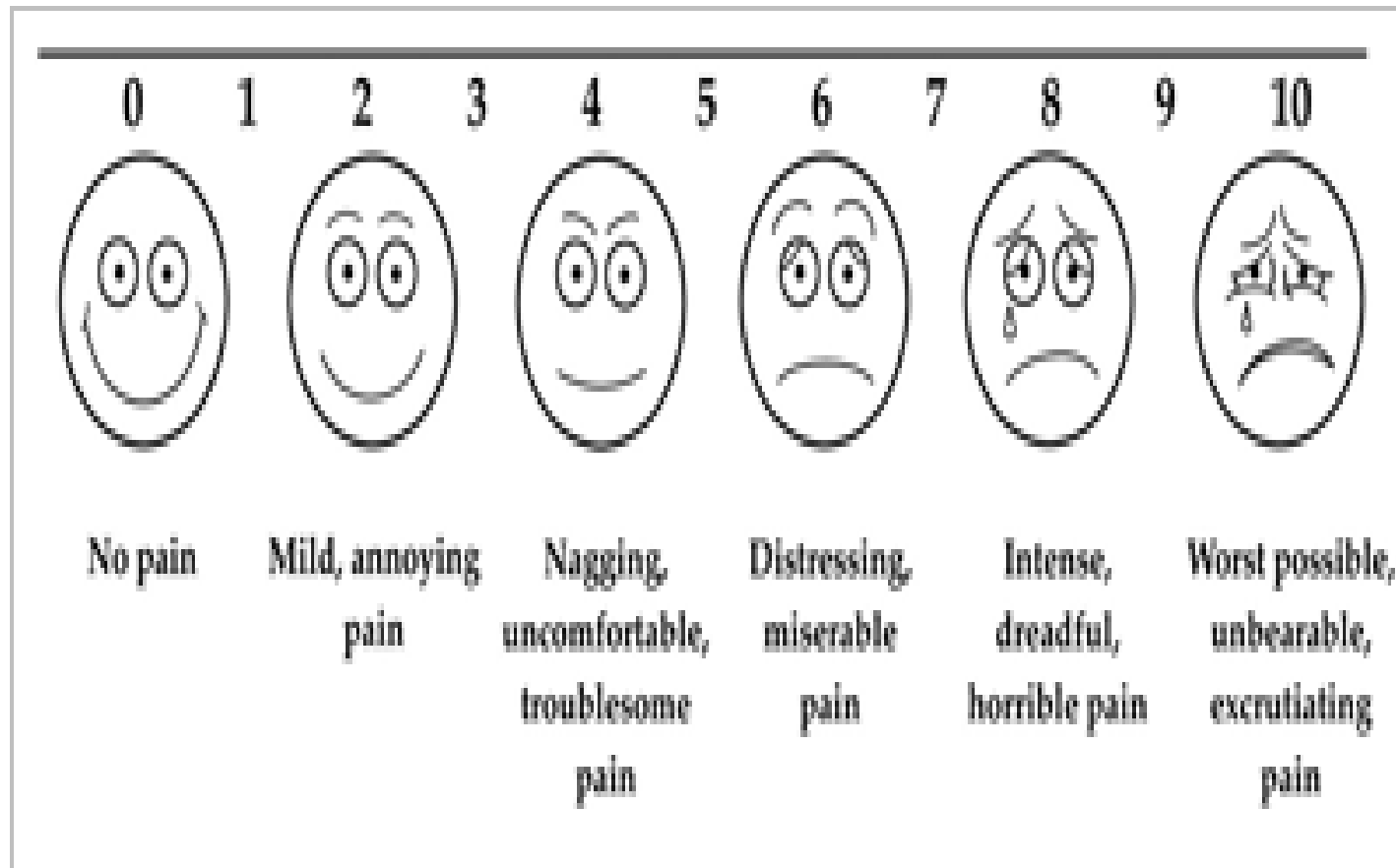
Nature of Pain



ASSESSMENT

- Vital role of nursing in pain and symptom management
- Under appreciated resource
- Goal of assessment and appropriate pain management is to restore functionality

VAS w/WONG-BAKER



PAIN ASSESSMENT (NON-VERBAL)

- CNVI/CNPI Pain Scale w/Move At rest
- Nonverbal vocalizations: * :*
- Facial grimaces/winces :* :*
- Bracing :* :*
- Restlessness :* :*
- Rubbing :* :*
- Vocal complaints :* :*
- Pain score (0-12)=

FUNCTIONAL PAIN SCALE

- Functional Pain Scale-adapted from Gloth et al
- 0 No Pain
- 2 Tolerable (Doesn't interfere with activities)
- 4 Tolerable (Interferes with some activities)
- 6 Intolerable (Able to use phone, TV, or read)
- 8 Intolerable (Unable to use phone, TV, or read)
- 10 Intolerable (Unable to verbally communicate)

**Edmonton Symptom Assessment System:
(revised version) (ESAS-R)**

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression <i>(Depression = feeling sad)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety <i>(Anxiety = feeling nervous)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing <i>(Wellbeing = how you feel overall)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem <i>(for example constipation)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):

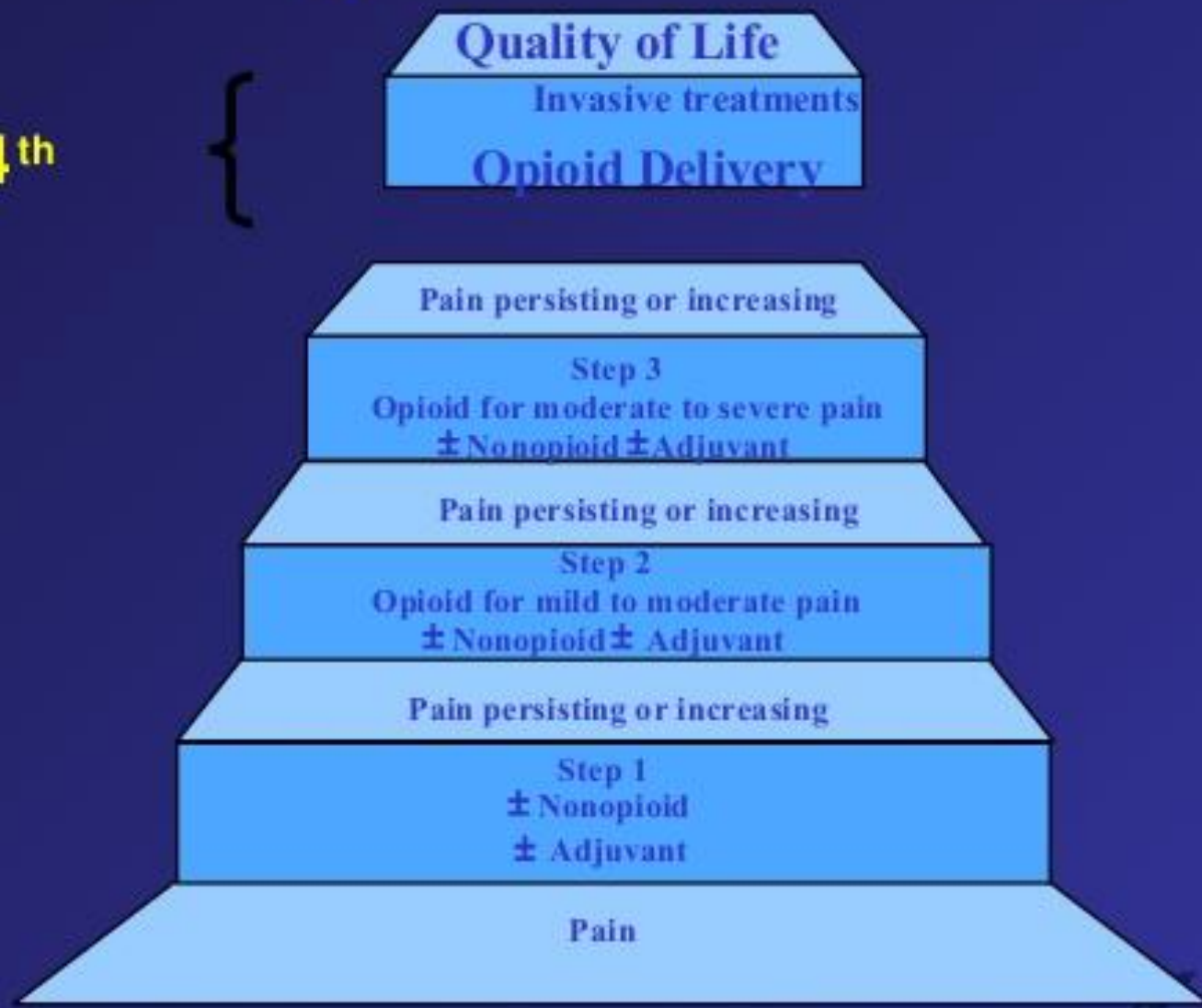
- ☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

Modified WHO Analgesic Ladder

**Proposed 4th
Step**

**The WHO
Ladder**



POLYPHARMACY NIGHTMARE

Avoid the 31 Flavors of Baskin Robbins approach ***for all symptoms:***

- *Stick to the basics.* The basic principle is to titrate one agent to effectiveness or side effect, before introducing a second agent. Use 1 long acting and 1 short acting opiate.
- *Explore the possibilities:* Investigate etiology of pain. Consider complementary approaches. Use opioid sparing adjuvants.

CONCEPT

- DOME
- Daily Oral Morphine Equivalence
- Codeine and meperidine should be avoided

Opioid Prescribing and Equianalgesic Dose

Generic (Brand)	Onset (O) and Duration (D)		Approximate Equianalgesic Dose	
	Oral	IV	Oral	IV
Morphine (MSIR®) [CII]	O: 30-60 min D: 3-6 h	O: 5-10 min D: 3-6 h	30 mg	10 mg
Morphine extended release (MS Contin®) [CII]	O: 30-90 min D: 8-12 h	—	30 mg	10 mg
Hydromorphone (Dilaudid®) [CII]	O: 15-30 min D: 4-6 h	O: 15 min D: 4-6 h	7.5 mg	1.5 mg
Hydrocodone/APAP 325 mg (Norco 5, 7.5, 10®) [CII] Hycet (7.5 mg/325 mg per 15 mL)	O: 30-60 min D: 4-6 h	—	30 mg	—
Fentanyl [CII] (Sublimaze® Duragesic®) <i>Patch for opioid tolerant patients ONLY</i>	Transdermal O: 12-24 h D: 72 h per patch	O: immediate D: 30-60 min	—	100 mcg (0.1 mg)
Methadone (Dolophine®) [CII] <i>Opioid tolerant patients ONLY</i>	O: 30-60 min D: >8 h (chronic use)	—	Variable	Variable
Oxycodone 5, 15, 30 mg (Roxicodone®), Oxycodone 5, 7.5, 10 mg/ APAP 325 mg (Percocet®), ER=Oxycontin® [CII]	O: 10-15 min D: 4-6 h	—	20-30 mg	—
Tramadol (Ultram®) [CIV] ^	O: 1 h D: 3-6 h	—	300 mg	—

^ Not recommended in nursing mothers.

Equianalgesic Opioid Dosing

Drug	Equianalgesic Doses (mg)	
	Parenteral	Oral
Morphine	10	30
Buprenorphine	0.3	0.4 (sl)
Codeine	100	200
Fentanyl	0.1	NA
Hydrocodone	NA	30
Hydromorphone	1.5	7.5
Meperidine	100	300
Oxycodone	10*	20
Oxymorphone	1	10

ONSET OF ACTION

- IV opioids: 5-15 minutes
- Oral opioids: 45-60 minutes
- Transmucosal (fentanyl): 20-30 minutes

METHADONE-BENEFITS

Mu agonist, synthetic opioid:

- Has two non-opiate analgesic receptor activities:
 - Prevents MAO reuptake in periaqueductal gray
 - Prevents N-methyl-d-aspartate (NMDA) receptors
- Lacks neuroactive metabolites
- High bioavailability (79 +/-11 hours)
- Long half life (30 +/- 16 hours)
- Highly lipophilic
- Fecal excretion-safe in ESRD
- Very inexpensive

METHADONE

When converting to Methadone:

- Assess the appropriateness of converting in the home
- Educate to side effects and responses
- Process takes 3-5 days to reach full therapeutic effect
- Breakthrough dosing with another opioid is imperative for transition
- Know the assessment findings that indicate overdose or under dosing

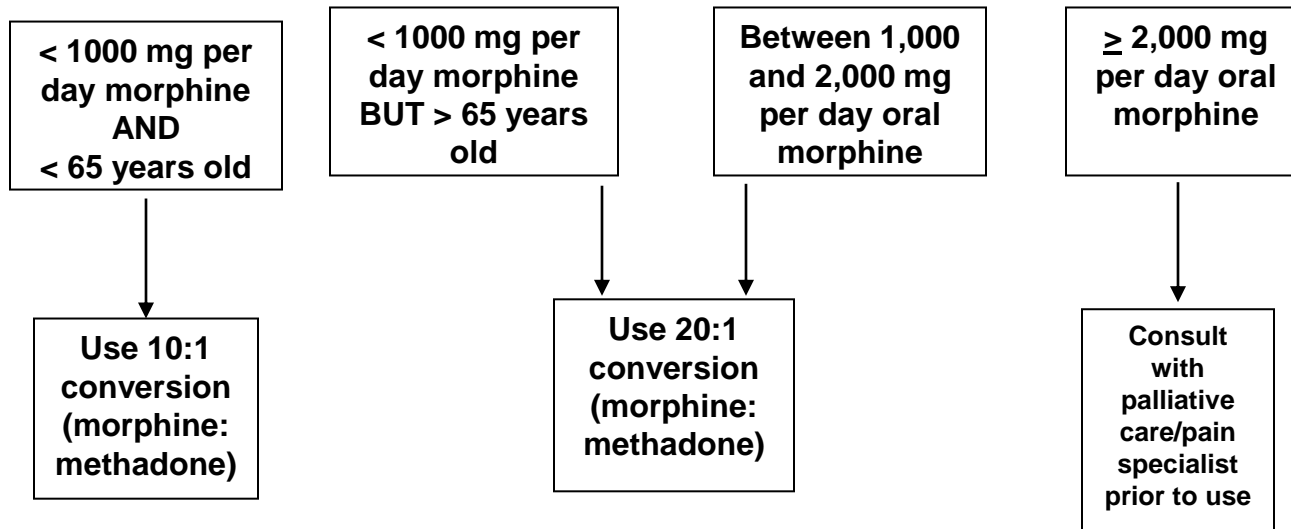
METHADONE PRECAUTIONS

- Lack of caregiver(s) to monitor the patient
- Very limited prognosis
- Increased risk of QT prolongation in patients with known bradycardia or heart failure, patients with hypokalemia or those taking drugs which potentiate QT prolongation.
- Patients with OSA, hypercarbia.

METHADONE DOSES

- Initial dose for opioid naïve patients: 1-2.5mg at bedtime or twice a day
- Use their previous opioid or morphine for breakthrough pain
- With careful oversight, can use methadone for breakthrough(rare) in case of allergies etc..
- IV Methadone is twice as potent as oral

CONVERSION FROM MORPHINE TO METHADONE



FENTANYL PATCH

It isn't for everyone:

- Generally not for beginners. Patient must be opioid tolerant to the minimum equivalent of Morphine 50-65 mg/day, to be able to tolerate 25 mcg of Transdermal Fentanyl . No they can't be cut in half or use prn.
- Need a little fat for the patch. It's a lipophilic agent requiring adequate adipose tissue to facilitate absorption into fatty subcutaneous molecules.
- Not good for a quickie. It takes 12-24 hours for onset of action, not appropriate for acute or emergent pain management.
- Keep it cool. Fever/External heat (102-104°) can increase absorption
- Generally, doubling the strength of the patch will give you the DOME(Daily Oral Morphine Equivalents). For example, a 25 mcg patch will provide approximately 50**mg** of oral morphine equivalents per day(please see fentanyl patch manufacturing info/package insert for exact dosing prior to prescribing).

OPIOIDS ARE INCREASED BUT NO PAIN RELIEF IS IN SITE.....

What type of pain is the patient experiencing?

- Somatic, Myofascial, Neuropathic
- Has the pain changed in quality-important in differentiating acute on chronic
- Total body pain
- Emotional suffering/depression-pay attention to pt affect
- Anxiety

PCA PITFALLS

Your patient is getting sleepier and sleepier:

- Is the patient opioid naïve and receiving basal and bolus dosing at the start?
- Is someone other than the patient using the bolus button?
- Is the prescriber increasing the basal rate in response to the patient's persistent complaints of pain?
- PCA to oral
- Does the patient need a long-acting opioid?
- Will prn dosing only provide adequate coverage?
- The pump is off-when should the new regimen start?
- The bolus button becomes a Xbox(Nintendo etc)
game(anxiety)Attempts verses Doses received
- Continuous opioid infusions even at end of life should only be started once patient has “failed” appropriate titration of ATC parenteral opiates

IMPORTANT DEFINITIONS

- Addiction-characterized by aberrant behaviors
- Physical Dependence-need for a substance to function
- Tolerance-requiring increased dose of substance to experience expected effects
- Opioid Naïve-<30mg DOME
- High Dose Opiates->90mg DOME

SABOTAGING SIDE EFFECTS

CNS: drowsiness, confusion, hallucination

- The dose of opioid is excessive
- The pain is not opioid responsive
- Conversion from one opioid to another was done incorrectly
- Other concomitant sedatives being prescribed (most commonly benzos)

Respiratory Depression

- Excessive opioid dose in naïve patient
- Can occur if dosing persists in face of sedation

CASE 1

- 43 YO M WITH 1 YR C/O “DYSPPNEA”(2012-2013)
- NON-SMOKER
- FORMER MILITARY
- LEFT CW PAIN
- MARRIED, 1 ADULT SON W/SPECIAL NEEDS
- ER CT SHOWED LT LUNG MASS
- VATS COMPLETED PATH C/W STAGE 4 NSCLC
- PAIN 8/10 “SHARP,STABBING”
- WHERE DO WE GO FROM HERE

CASE 1 (CONTINUED)

- Gabapentin+IV Ketorolac+IV Hydromorphone Immediate Post-op
- Chemo/RT
- Convert to po dilaudid prn btp prior to d/c, continue and titrate gabapentin, venlafaxine added for depression
- Patient continues to f/u oupt pall care(5yrs later), remains on gabapentin, venlafaxine, “medical marijuana” & crizotinib with good qol

CASE 2

- 72 yo F consulted for acute on chronic LBP
- Initial admit for CHF exacerbation, deconditioning
- Pt with long h/o chronic LBP, s/p spinal cord stim placed at JHU ~5yrs ago
- Given gabapentin at hs and po oxycodone/acetaminophen prn
- Little improvement in pain
- Extremely flat affect

CASE 2 (CONTINUED)

- Pt queried wrt depression
- Dgtr died earlier this month from CA
- Son died almost exactly 1 yr previously from AMI
- Pt w/insight into somatization of depressive features/normal grief process
- Declined additional anti-depressant tx
- Opted to embrace current coping skills (religion, denial)
- Dx-Unresolved/complicated grief

CASE 3

- 52 yo m physician w/widely metastatic prostate ca
- Chemo 1 wk PTA
- Severe pain,dyspnea
- Seen on bipap in ICU,teenage son at bedside
- Taking Oxycontin 80mg po q6h atc with Oxy IR 30mg po q4h prn for BTP

CASE 3 (CONTINUED)

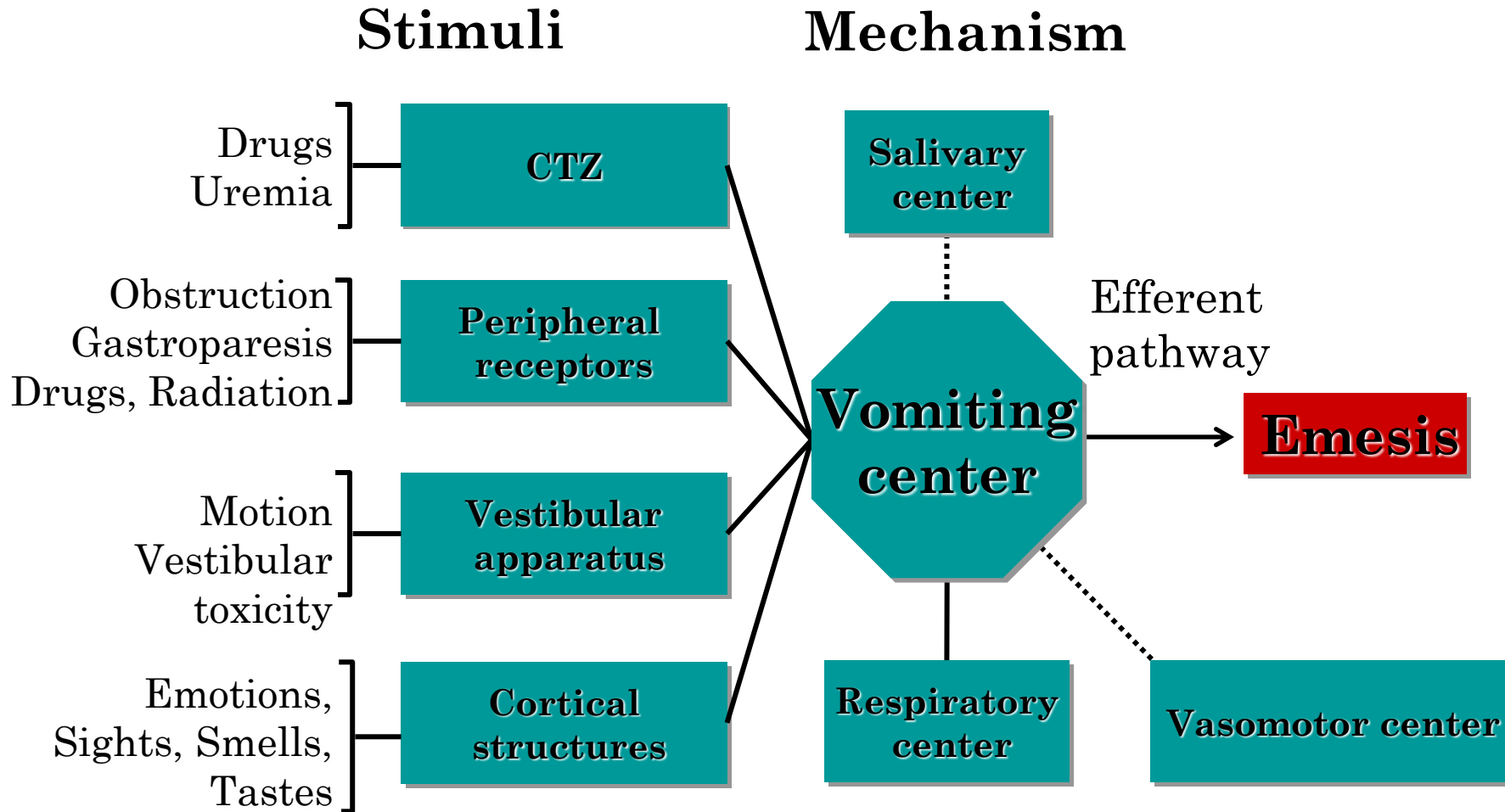
“Physician know thy self”

- Establish goals of care(“break the ice if needed”)
- Do not take hope away but be realistic
- Discuss risks and benefits(we ALL have them)
- Establish a clear plan and objectives
- Calculate DOME as a starting point(convert to hydromorphone PCA Basal 1mg/hr,bolus 0.5mg q6min)
- Use adjuvants(Dexamethasone 8mg IV BID)
- Know the therapeutic index prior to making changes
- Use adjuvants aggressively when possible

NAUSEA

- Definition-stomach distress with a distaste for food and an urge to vomit

NAUSEA & VOMITING



Tortorice and O'Connell. *Pharmacotherapy*. 1990;10(2):129-145; Andrews. *Br J Anaesth*. 1992;69 (suppl 1):2S-19S; Grahame-Smith. In: *Nausea and Vomiting: Mechanisms and Treatment*. Berlin, Germany: Springer-Verlag; 1986:1-8.

ANTI-EMETIC THERAPY

- CTZ
 - Serotonin antagonists *5-HT3*
 - (Ondansteron, granisetron)
- Peripheral and Cortical
 - Corticosteroid
- Benzodiazepine
 - Lorazepam
 - *S/E sedation*
- Butyrophenone
 - Haloperidol
 - *S/E tardive dyskinesia, arrhythmias, hypotension*
- Dopamine antagonist
 - *D2*
 - Metoclopramide
 - *S/E seizures, tardive dyskinesia*
- Cannabinoid
 - *Blocks VC*
 - Dronabinol /Nabilone
 - *S/E alt sensorium, anxiety, mood disturbance*
- Anti-convulsant
 - *Taste related nausea*
 - Clonazepam
 - *S/E drowsiness, ataxia*
- Anti-histamine
 - Meclizine,scopolamine
 - *S/E tachycardia, dry mouth*

COMPLEMENTARY THERAPIES

- Acupressure bands(“Sea Bands”)
- Acupuncture
- Avoid triggers
- Environment
- Music toning
- Relaxation, imagery, diversion therapy
- Meditation
- Hypnosis
- Psychosocial support

CASE 4

- 38 yo M with Stage III Laryngeal CA
- Recent completion of cisplatin
- Undergoing RT
- Persistent N/V
- Has PEG tube
- No recent BM's
- Where do we go from here?

CASE 4 (CONTINUED)

- Metoclopramide 5mg IV q6h ATC with titration upward to 10mg IV q6h ATC
- Nausea improved, now w/emesis without preceding nausea, scopolamine patch added
- MRI brain ordered-negative for CNS/cerebellar mets
- 2nd scopolamine patch added, & reglan titrated up to 10mg IV q4h ATC with adequate symptom control-subsequent med conversion to liquid via PEG and d/c home

CONSTIPATION

- Constipation is defined as having a bowel movement fewer than three times per week

BACK-UP ON THE GI BELTWAY: CONSTIPATION

- Opioids, anticholinergics, antispasmodics, antidepressants, antipsychotics, antiemetics, aluminum antacids, diuretics, iron, vinca alkaloids
- Hypercalcemia, hypokalemia
- Dehydration, polyuria, fever, vomiting
- Inadequate fluid & fiber intake
- Immobility
- Lack of privacy & bowel training
- Autonomic neuropathy/failure
- Bowel ileus or obstruction
- Spinal cord involvement
- Hemorrhoids, anal fissure, perianal abscess
- Radiation fibrosis
- Intracolonic or pelvic tumor mass

TREATMENT

Step 1: Preventative/Maintenance Regime

Stool softner & stimulant

Docusate Sodium/casanthranol

Docusate Sodium/Sennosides

****** *abdominal cramping, colic, diarrhea, nausea, vomiting*

Step 2: If no bowel movement in 48 hrs

Hyperosmotic Agents or Laxatives

Lactulose, Poly-ethylene-glycol, Sorbitol

Milk of magnesia, Bisacodyl

****** *abdominal distention, pain, flatulence, electrolyte disorders*

TREATMENT

Step 3A: If no bowel movement in 3-4 days

- *Rapid-acting Laxative*

Note: *Administer only in the presence of active bowel sounds & in the absence of rectal fecal impaction, vomiting, severe abdominal cramping*

- Magnesium citrate, Mineral oil 30-60 ml
- ** *malabsorption of fat soluble vitamins, electrolyte disturbance*

Step 3B: if no bowel movement in 3-4 days *Fecal Impaction*

- Pre-treat with analgesia or mild sedative
- Soften stool with glycerin suppository or oil retention enema
- Manually disimpact stool, while encouraging relaxation deep breathing techniques
- Follow with SSE or tap water enemas until clear
- Offer sitz bath, or apply warm compresses, Tucks pads or local anesthetic ointment

PHARMACOLOGIC TREATMENT

- Prokinetic agent:
 - Metoclopramide 5-10 mg QID
 - Erythromycin 250mg IV BID
- Opioid Antagonist
 - Naloxegol
 - Methylnaltrexone
 - Naloxone
- Opioid rotation to lipophilic agent
 - Fentanyl or Methadone

CASE 5

- 46 yo F with Stage 4 Cervical CA
- Cachexia, declining fxnal status
- On opiates as outpt
- Scant BM x 5 wks PTA
- Abd distention and pain
- How do we proceed?

CASE 5 (CONTINUED)

- D/C prn IV hydromorphone with change to Fentanyl PCA
- Initiate adjuvants for pain(gabapentin)
- Metoclopramide 5mg IV q6h ATC with upward titration to 10mg IV q4h ATC
- GI involved mult enemas given, mult scopes performed to try and resolve impaction
- Surgery on board in case of perforation
- Methylnaltrexone given subcut mult times with some results

DYSPNEA

- The subjective sense of breathlessness or smothering.

BACKGROUND

- Dyspnea is the primary complaint of patients with advanced lung or heart disease.
- 94% of patients with chronic lung disease experience dyspnea in the last year of life.
- In SUPPORT (Study to Understand Patient Preferences and Outcomes of Treatment), “serious dyspnea” was far more common (66%) than “serious pain” (25%).
- These investigators reported that patients with COPD were more likely to die with poor control of dyspnea than patients who had lung cancer.

PRINCIPLES

- The experience of dyspnea includes sensory (how severe is it?) and affective (how unpleasant is it?) components.
- Based on a neurophysiological model, breathlessness is thought to be similar to the perception of pain.
- ACCP Statements based on dyspnea that persists at rest or with minimal activity and is distressful despite optimal therapy of advanced lung or heart disease.

ACCP POSITION

- Patients with advanced lung or heart disease should be asked about the intensity and distress of their breathlessness.
- Pursed-lips breathing, relaxation, oxygen for those with hypoxemia, noninvasive positive pressure ventilation, and oral/parental opioids can provide relief of dyspnea.
- Therapies should be started with the understanding that the patient and clinician will reassess whether the specific treatments are relieving dyspnea without causing adverse effects.
- It is important to communicate about palliative and end-of-life care.

PT PRESENTATION

- Shortness of breath
- Breathlessness
- Smothering feeling
- Suffocation
- Present at rest
- Worsened by activity

DIAGNOSIS

- Self-report is the key to detecting dyspnea & appreciating the severity of dyspnea.
- Blood gas, oxygen saturation, and respiratory rate do not substitute for patient's self assessment and report of dyspnea.

GOAL OF TREATMENT

- Should be to improve the patient's subjective sensation rather than trying to modify any abnormality in blood gases or pulmonary function
- *Primum non nocere* - avoid suctioning and other traumatic interventions when possible, start low doses of medications in naïve individuals and titrate appropriately

PATIENT CASE 6

- 86 yo F with CHF
- UTI subsequent hypotension
- Dyspneic and “anxious”

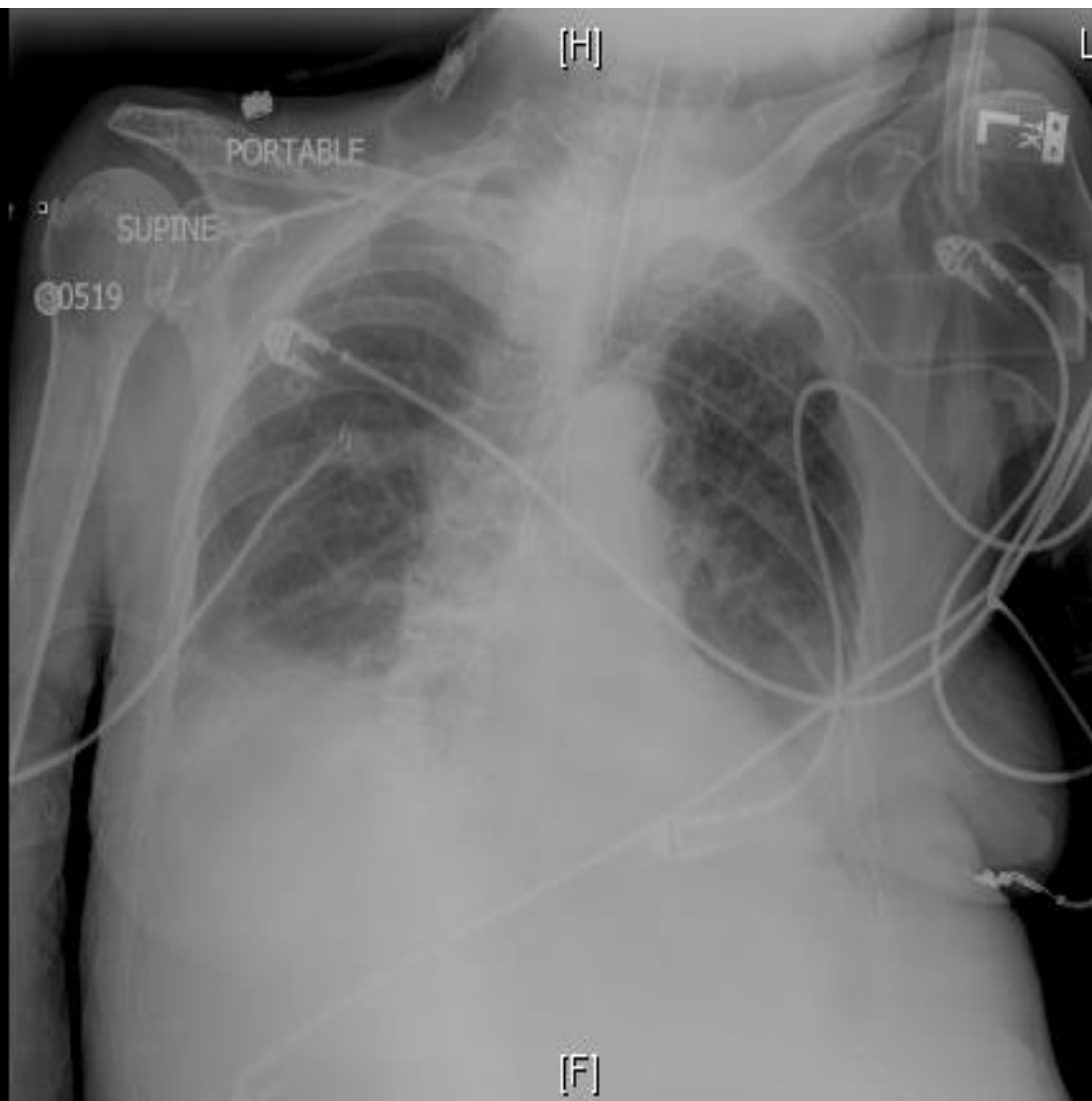
PATIENT CASE 6 (CONTINUED)

- Pt on NRB
- Agitated, dyspneic ,tachypneic, pooling oropharyngeal secretions
- On TPN, with inc wt and dec albumin
- B/L Crackles, poor aeration
- Pt AMS, poor historian, non-verbal cues

Se:1
Im:1

[R]

AP Chest Landscape



TREATMENT

- Address goals of care
- Continue O2 (but remove mask when possible)
- Diurese
- Decrease fluid burden (d/c TPN and IVF)
- Start low dose opiates (ie; Morphine 2mg IV q4h ATC with titration for dyspnea - when goal is comfort, do not hold for parameters such as BP etc)
- Scopolamine patch 1.5 mg top q72 for secretions

AGITATION/ANXIETY IN DEMENTIA

- Agitation/anxiety - a moving back and forth or with an irregular, rapid, or violent action; a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome
- Prevalence 60 to 90 percent of patients
- Both typical and atypical antipsychotics carry **negative mortality benefit (ie increase risk for earlier death)**
- Interventions - remove/treat exacerbating cause if possible (UTI, PNA etc), provide supportive, caring environment, avoid physical restraints, use pharmacologic interventions selectively; if antipsychotics absolutely necessary use low dose preferably via SL route (ie Haloperidol 1mg sl q4h prn)

CASE 7

- 90 yo m with ES dementia (FAST 7A) well cared for at home, acute/chronic
- UTI-TX w/ceftriaxone
- Agitation persists in spite of TX environment
- 24 Hr sitter
- Start Valproic Acid Sprinkles 125mg PO Q6H, ATC w/ improvement in behavior

TAKE HOME POINTS

- *Primum non-nocere (First do no harm)*
- Risk/benefit ratio changes as patients goals of care change
- Palliative care can lengthen lifespan and enhance QOL
- Evaluate the whole patient (look for congruent vs discordant non-verbal cues).
- Maintain your own well-being and appropriate boundaries

KNOWLEDGE CHECK

- Palliative care is the same as Hospice Care T/F
- Morphine is the strongest opiate T/F
- Hydromorphone, Methadone & Buprenorphine are strong opiates T/F
- Dyspnea is defined by Pulse Ox T/F
- Agitation in dementia is best treated with non-pharmacologic interventions T/F

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APPENDIX

What People Want – Page 11: Notes

Citations:

- Item 1:
- Institutes of Medicine Report *Dying in America*, 2014:
<http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>
- As reported by PBS Frontline, *Facing Death* (sourcing a Time/CNN Poll from 2000: <http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/>)
- Items 3 and 4:
- Institute of Medicine (IOM) Report *Dying in America*, 2014:
<http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>
- The Journal of the American Medical Association, *SUPPORT Study*, 1995:
<http://jama.jamanetwork.com/article.aspx?articleid=391724>

The Contrast of Reality – Pg 12: Notes

- People often don't receive the care they want – almost everyone has a “horror story” of a loved one dying in pain or isolation that could have been avoided.
- Citations in Order
- 1.a Reported by PBS Frontline, sourcing the Centers for Disease Control, 2005: <http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/>
- 1.b Harvard Business Review *Tackling Social Problems*, 2012: <https://hbr.org/2012/01/tackling-social-problems/>
- 2. IOM, *Dying in America*, 2014
- 3. Reported by PBS Frontline, sourcing The Associated Press, 2010: <http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/>
- 3. Reported by National Health Care Decisions Day (NHDD) sourcing The Pew Research Center, *More Americans Discussing – and Planning – End-of-Life Treatment*, 2006: <http://www.people-press.org/files/legacy-pdf/266.pdf>

The Reason for this Stark Reality – Pg 13: Notes

- Reported by PBS Frontline sourcing Critical Case Journal, 2007:
<http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/>
- Reported by National Health Care Decisions Day (NHDD):
<http://www.nhdd.org/facts/>

Core Aspects of Hospice – Pg 21: Notes

- As defined by HMB

Additional Services – Pg 22: Notes

Not all programs offer these – based on needs in community, mission, resources, skills

Hospice Team Members – Pg 23: Notes

Also from the HMB – palliative care programs don't need to include all these disciplines

The Hospice Team – Pg 24: Notes

- These are primary services offered by hospice. Not all patients/families avail themselves of these services.
- Develops the plan of care with the family
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for care needs of patient and family
- Provides bereavement care and counseling to surviving family and friends

Where Hospice is Provided – Pg 25: Notes

- Delivered across care setting
- Man on the porch

www.caringinfo.org 800.658.8898 – Pg 31: Notes

- www.caringinfo.org is a national consumer website, sponsored by NHPKO, with specific information on:
 - Advance care planning
 - Caregiving
 - Pain
 - Financial Planning
 - Hospice and palliative care
 - Grief
- Plus a consumer helpline number is available to answer your questions. Will mail advance directives for FREE

FREE Resources Available from *Caring Connections* – Pg 32: Notes

- The FREE resources available from Caring Connections are:
- State-specific advance directives
- Advance Care Planning information
- Some of the brochure topics available to download or order:
 - *Advance Directives and End-of-Life Decisions*
 - *Health Care Agents: Appointing One & Being One*
 - *Conversations Before the Crisis*
 - *You Have Filled Out Your Advance Directive...Now What?*
 - *Ask Tough Questions*

It's About How You LIVE! Pg 33: Notes

- Overall – IT'S ABOUT HOW YOU LIVE!
- Think about how you want it to be for yourself, your loved ones and your community and decide what actions you need and want to take when you walk out the door
- You can **Learn** more about your options and choices about hospice and palliative care
- You can **Implement** a plan to ensure your wishes are honored by completing your advance directives and other plans for future health care. FREE advance directive forms are available at www.caringinfo.org
- You can **Voice** your decisions about hospice and palliative care by talking to your loved ones and doctor
- You can **Engage** in personal or community efforts to improve end-of-life care by helping others to learn more about hospice and palliative care
- We are here to help you take that next step with whatever you decide. To contact us.....
- Thank you for your time.

ONSET OF ACTION - PG 52: NOTES

- The 1992 Agency for Health Care Policy and Research CPG states that pain should be reassessed:
 1. Within 30 minutes of parenteral drug administration
 2. Within one hour of oral drug administration
 3. With each report of new or changed pain
- However, these recommendations pertain to the reassessment of acute pain in an acute care setting.
- Multiple factors determine the appropriate frequency of pain reassessment, including characteristics of the pain (eg duration, severity), patient factors and needs, the clinical setting, and pain management plan (ie type of drug or intervention).
- In the outpatient setting, patients should be instructed to report any changes in pain characteristics, side effects of treatment, and treatment outcomes. Periodic reassessment is recommended in patients with chronic pain to evaluate improvement, deterioration, or treatment-related complications.

NAUSEA & VOMITING – PG 70: NOTES

- The vomiting center coordinates emesis. It is located in the lateral reticular formation of the medulla, adjacent to the structures involved in the coordination of vomiting (cranial nerves VIII and X and the vasomotor, respiratory, and salivary centers).
- Vomiting results from the stimulation of a multistep reflex pathway controlled by the brain. It occurs when efferent impulses are sent from the vomiting center to the salivation center, abdominal muscles, respiratory center, and cranial nerves.
- There are many stimuli that can contribute to poorly controlled emesis in patients receiving complex, multiday chemotherapy.
- Some of these stimuli, such as motion, uremia, smells, or tastes, act centrally in the brain to stimulate the vomiting center.
- Others, such as gastroparesis and radiation, primarily interact peripherally by stimulating afferent impulses from the gut to the vomiting center.
- Chemotherapy drugs stimulate emesis both centrally and peripherally.

ANTI-EMETIC THERAPY – PG 71: NOTES

- Corticosteroids are widely used to control CINV; their antiemetic mechanism of action is unknown, but it may be mediated through inhibition of prostaglandin synthesis.
- At equivalent doses, corticosteroids have equivalent safety and efficacy and can be used interchangeably. The corticosteroids most commonly studied for use as antiemetics have been dexamethasone and methylprednisolone. Dexamethasone has the advantage of being available in many dosage formulations.
- For acute CINV, corticosteroids (eg, dexamethasone, methylprednisolone) add approximately 20% to 25% to the emetic response rates of cancer patients when given with a serotonin antagonist, compared with using the serotonin antagonist alone. For delayed CINV, dexamethasone and serotonin antagonists appear to have equivalent antiemetic activity.
- Use of corticosteroids in hematologic malignancy patients may be prohibited by treatment protocols either because of theoretical concerns about drug interactions or infection concerns in high-risk patients.
- Often the cancer treatment regimen already includes a corticosteroid, the administration of which should be scheduled close to chemotherapy administration to take advantage of the synergy with serotonin antagonists.

POSTTEST/QUIZ

Please click on the link below to be taken to this activity's quiz. After successful completion, you can then fill out an evaluation and application for CME credit.

[Ethics and Symptom Management](#)