

Palliative Care

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DEPARTMENT OF FAMILY
MEDICINE
EFFECT NOVEMBER 2022*



I do **not** have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.

- Ø 12595 Explain the definition of the following terms and their application in palliative care settings and/or advanced care planning: code status, personal care directives, substitute decision-makers, and power of attorney.
- Ø 12596 Propose a management plan for patients receiving palliative care with pain, nausea, constipation and dyspnea.
- Ø 12597 Identify local resources to support palliative patients & their families.
- Ø 12598 Recognize and seek assistance for the following palliative emergencies: opioid neurotoxicity, spinal cord compression, seizures, acute hemorrhage, and acute confusion/delirium.

Palliative is Active, if not Curative, Care

Palliative Care is active care and involves many domains:

- Understanding the Disease and its Trajectory
- Excellent symptom control
- Recognizing and validating the individual
- Care of the whole family
- Recognizing the importance of, and actively addressing, the psychological and spiritual needs of a patient
- Critical reasoning powers to understand the dynamic of patient and family
- The importance of relationship

Adapted from The Pallium Palliative Handbook, 2013

What is your role in diagnosis?



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What the Doctor Said Raymond Carver



He said it doesn't look good
he said it looks bad in fact real bad
he said I counted thirty-two of them on one lung before
I quit counting them
I said I'm glad I wouldn't want to know
about any more being there than that
he said are you a religious man do you kneel down
in forest groves and let yourself ask for help
when you come to a waterfall
mist blowing against your face and arms
do you stop and ask for understanding at those moments
I said not yet but I intend to start today
he said I'm real sorry he said
I wish I had some other kind of news to give you
I said Amen and he said something else
I didn't catch and not knowing what else to do
and not wanting him to have to repeat it
and me to have to fully digest it
I just looked at him
for a minute and he looked back it was then
I jumped up and shook hands with this man who'd just given me
something no one else on earth had ever given me
I may have even thanked him habit being so strong

[Raymond Carver](#), American poet and short story writer (a major force in the revitalization of the short story in the 1980s) died from lung cancer when only 50



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Staying involved with our patients



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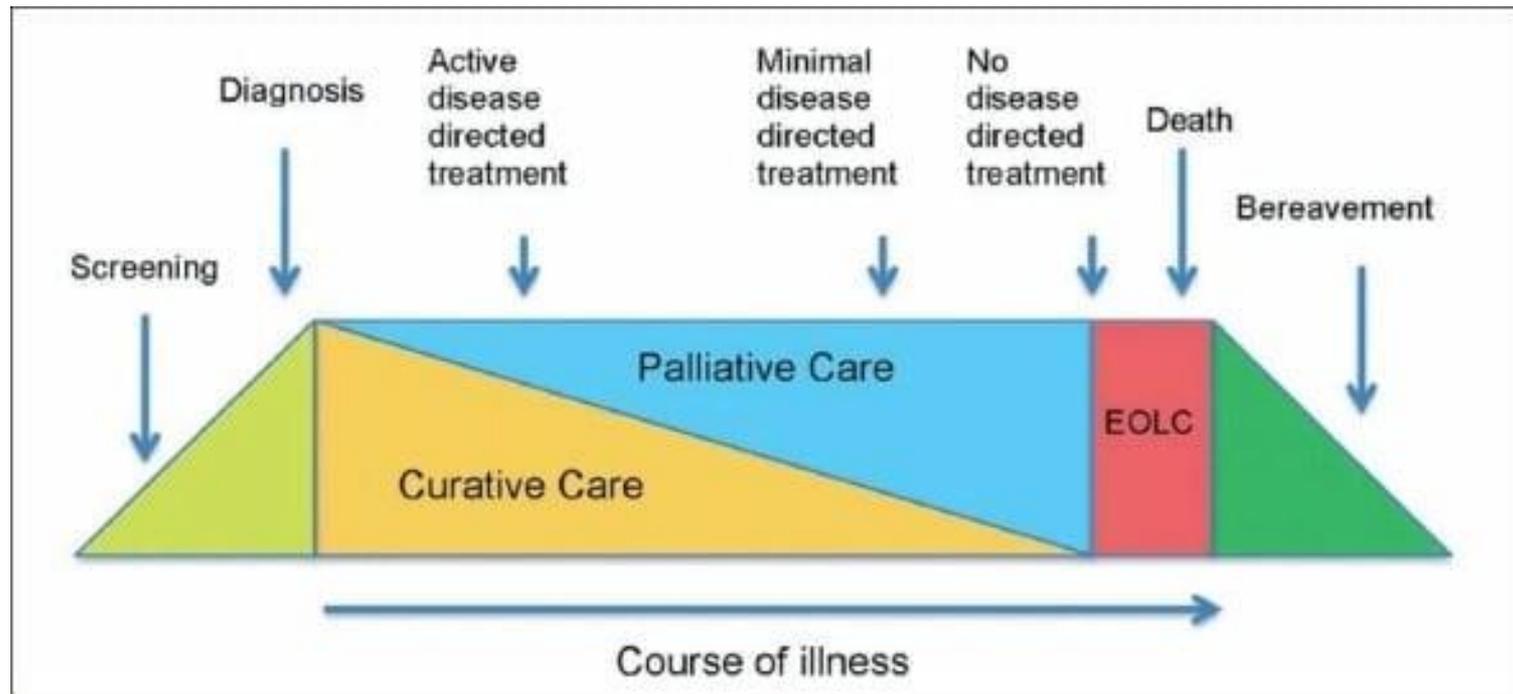
- What happens in the hospital? How is referral made for ongoing care?
- What happens in Cancer Clinic? How is referral made?
- What can/should we do to maintain continuity with our patients?

Palliative and Curative Care Exist Simultaneously



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Category 1: Full Treatment

Category 2: Full treatment excluding CPR, intubation, ventilation, defibrillation but ICU for monitoring

Category 3: Full treatment excluding ICU

Category 4: Comfort Care

Alleviation of Suffering:

- Physical pain, nausea, shortness of breath
- Emotional (fear, depression, anxiety, loss of autonomy)
- Social (loss of identity, saying good-bye)
- Spiritual (eternity, belief in a god, meaning of one's life, legacy)

Maximizing function and quality of life

Mountain, 1990, Robert Pope



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What Physical Symptoms Will You Need to Treat?



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- Pain
- Nausea and Vomiting
- Constipation
- Anorexia
- Anxiety/Restlessness/Fatigue
- Shortness of Breath
- Delirium
- Seizures

Ms. P.W. diagnosed with pancreatic cancer.
Her husband called at midnight that she was having extreme abdominal pain and had insufficient analgesia at home.

Communication tool so that all providers as well as the patient and family are “in the loop”.

Role of Home and Community Care Support Services

What drugs do you want to have in the home?



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- Hydromorphone 2 mgs/ml
- Dimenhydrinate 250 mgs/5 mls
- Midazolam 5 mgs/ml x 10 mls
- Scopolamine 0.4-0.6 mg ampoules

Drugs must be ordered precisely in terms of concentration and amounts.

Designation as Palliative Physician Facilitated Access



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- What are the criteria to receive designation as a PCFA physician?
All physicians who wish to join PCFA may do so, under the following criteria:
 - Provide more than 20 palliative care consults in a year; or
 - Provide more than 50 palliative care visits in a year; or
 - Have been identified as a provider of palliative care by a regional director for Cancer Care Ontario (CCO); or
 - Have been identified as a provider of palliative care by the executive of the section of palliative medicine at the OMA; or
 - Have been identified as a provider of palliative care by an End of Life Network or Community Care Access Centre; or
 - Are a member of a Palliative Alternate Funding Plan (AFP); or
 - Work in collaboration with a Palliative Care Physician.

- https://www.health.gov.on.ca/en/pro/programs/drugs/formulary42/edition_42.pdf

Pain Management:

Hydromorphone prn then straight

prn dose = 10% of 24 hour dose q1-2 hrs

- Know equivalent doses between narcotics. Eg: morphine:hydromorphone = 4:1.
- When rotating opioids, decrease dose by 50% (75% for methadone)
- Remember oral: parenteral for hydromorphone is 3-5:1 (i.e. parenteral is 3-5x more potent)

- Often use Gravol (dimenhydrinate) S/C as initial choice: 25-50 mgs S/C Q4h prn.
- The choice of anti-emetic depends on the cause of vomiting; the other properties of chosen drug might have clinical benefit:
- Metoclopramide (Maxeran) (PARTIAL bowel obstruction), methotrimeprazine (Nozinan) (concurrent anxiety), haloperidol, ondansetron (Zofran) (chemotherapy, central nausea)

“The hand that prescribes narcotics also prescribes laxatives”:

- PEG, lactulose, suppositories-glycerine and Dulcolax (bisacodyl)
- Generally speaking, use osmotic rather than stimulant laxatives.

- midazolam (Versed): short-acting-use S/C q1h.
- Very useful for anxiety, for catastrophic events, for prolonged seizures, for palliative sedation.
- Specify the nature of a catastrophic event.
- Midazolam vs lorazepam
- Also methotrimeprazine (Nozinan)

A patient calls to report that her 85 yo husband with very severe COPD:

- has been confused for 2 days-sometimes his sensorium clears and then he becomes agitated again.
- seems to be talking to his long-deceased parents
- is awake at night but often dozes off during the day
- has a low-grade fever of 37.8

- COPD, predominantly emphysema, x years, gradually worsening.
- hx. of prostate cancer
- hx of CVA affecting left hemisphere of the brain
- on 8 litres/min. O₂ at home
- has morphine for dyspnea, MDIs, aerochamber at home.

Delirium

- How would you address this patient's illness?
- What are the possible causes of an agitated delirium?
- What actions would you take and what decisions would you make? Think of setting and goals of care.

Category 1: Includes CPR and intubation

Category 2: ICU care but no CPR

Category 3: Medically appropriate treatment
but

no admission to ICU

Category 4: Comfort Care

- Autonomy – respect for the patient's right to self-determination.
- Beneficence – the duty to 'do good'.
- Non-Maleficence – the duty to 'not do bad'.
- Justice – to treat all people equally and equitably.

Approach to delirium



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- *Look for reversible causes*
- History
- Physical exam
- Laboratory investigations

History

- When did it begin?
- Can you tell what caused it?
- Any new meds? Any recently stopped meds? Any complementary treatments?
- Any falls?
- Bowel movements?
- Urine output?
- Other concomitant symptoms: fever (infection), vomiting, etc.
- Consider hypercalcemia
- Consider metastatic disease

- CBC
- Blood chemistry including kidney function, liver function, electrolytes, albumin, calcium
- Urine culture, chemistry and microscopy
- Brain imaging??

Delirium: Factors to Consider

- What are the goals of care?
- What is the setting: home, hospice or hospital?
- What is the patient's quality of life and what are they hoping for?
- Can the delirium be easily corrected; e.g. infection vs medication side effects vs brain metastases?

Sparrow

Robert Pope



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What's your opinion?

- I would first of all:
 1. send my patient to the ER for a W/U, blood tests, CXR, CT scan of head;
 2. Do a house call and assess;
 3. Ask the lab to visit to do initial blood work and urine: Based on this I would make a decision.
 4. Ask my patient's wife to monitor BP, respiratory rate and temperature and call tomorrow to communicate her readings.



- Massive GI bleeding
- Acute shortness of breath
- Seizures
- Acute cord compression
- Superior Vena Cava Syndrome
- Total suffering: Role of MAID/palliative sedation

What a dying patient wants >>



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- Achieving adequate pain and physical symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving burden for family members
- Strengthening relationships with family

Completion of Life Tasks >>



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What a dying patient wants >>



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- Clear decision making
- Preparation for death
- Completion of life tasks
- Ability to contribute to others
- Affirmation of the whole person

From: The Pallium Palliative Pocketbook
2013

The Role of Hope

How do we discuss prognosis? What in the relationship allows this discussion?

How do we stop medications? What message are we giving?

■ Regional Palliative Consultation Team

1-800-651-1139

www.bruyere.org/en/regional-palliative-consultation

Nurse practitioners, advanced practice nurses, nurse specialists and physicians

- Home and Community Care Support Services:

613.310.2222

- The importance of communication and interdisciplinary care
- Chart in the Home

- Will it be part of your practice?
- Do you feel prepared with your training?
- Are there barriers?
- ?Office ?House calls ?Hospice
- Skills: Diagnostic/ Drugs/Emotional
- Time commitment/Call/The shape of your practice

Robert Pope 1956-1992



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