

Palliative Care



*LEONARD BLOOM :
DEPARTMENT OF FAMILY
MEDICINE*



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

- 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.
- 12596 Propose a management plan for patients receiving palliative care with pain, nausea, constipation and dyspnea.
- 12597 Identify local resources to support palliative patients & their families.
- 12598 Recognize and seek assistance for the following palliative emergencies: opioid neurotoxicity, spinal cord compression, seizures, acute hemorrhage, and acute confusion/delirium.

Sparrow

Robert Pope



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

Mountain, 1990, Robert Pope



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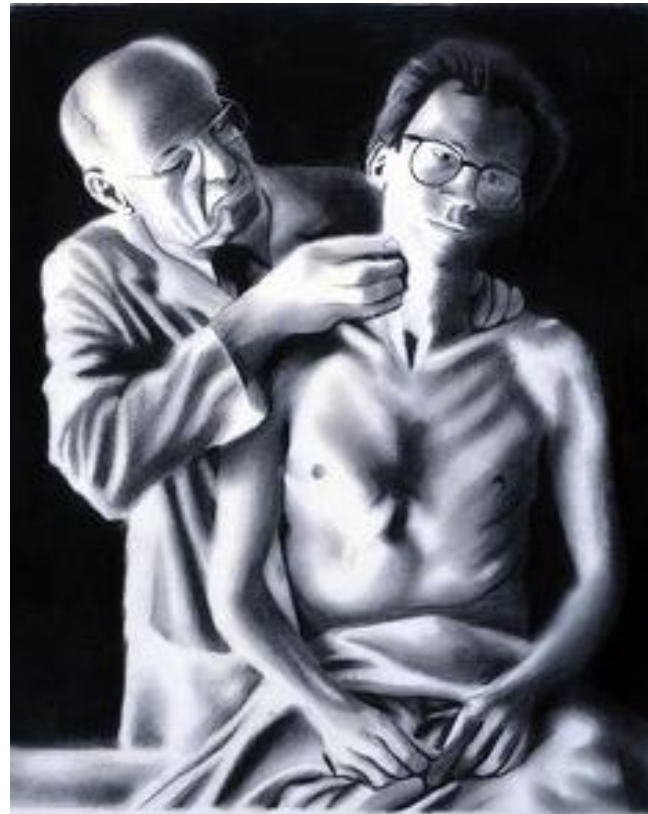


How do you communicate the **diagnosis**?



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- **S**etting
- **P**erception of condition/gravity
- **I**nvitation to explain situation
- **K**nowledge-ensure clarity
- **E**xplore **E**motions/**E**mpathy
- **S**trategy/**S**ummary

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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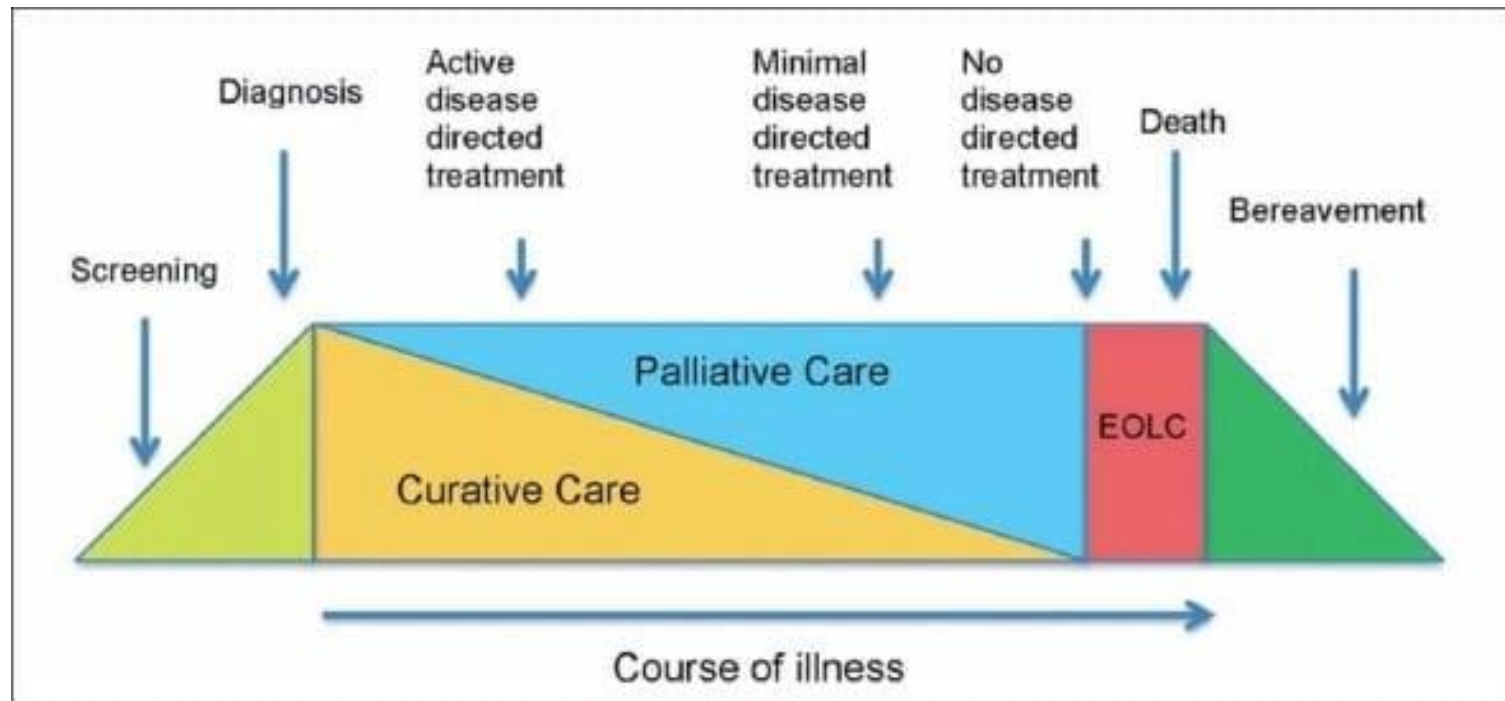


Palliative and Curative Care Exist Simultaneously



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**Palliative Performance Scale (PPSv2)
(version 2)**

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity and work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity and work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally bed-bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally bed-bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally bed-bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or coma +/- confusion
0%	Death	-	-	-	-

Categories of Care/Goals of Care



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Category 1: Full Treatment

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

Category 3: Full treatment excluding ICU

Category 4: Comfort Care

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?

Alleviation of Suffering:

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

Maximizing function and quality of life

- What is the role of psilocybin?

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.



Case Manager: Assesses services and equipment needed at home.

Symptom Management Kit

Chart in the 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.

PCFA



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Facilitated access for: scopolamine,
midazolam, phenobarbital

- 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)

“The hand that prescribes narcotics also prescribes laxatives”:

- PEG, lactulose, suppositories-glycerine and Dulcolax (bisacodyl)
- Senokot is a stimulant laxative often used to promote bowel motility
- Generally speaking, use osmotic rather than stimulant laxatives.

- 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)

Palonosetron:

For chemotherapy induced nausea: new 5-HT₃ receptor antagonist. Can be combined with dexamethasone to prevent acute, as well as delayed, hyperemesis.

Longer half-life, more effective, than ondansetron.

- 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
- his cough has increased a bit

- 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.

Approach to delirium



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

- When did it begin? Are the symptoms related to any obvious event ?
- 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??

- 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.

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

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?
- Can the patient easily swallow? Is an IV indicated?

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

Completion of Life Tasks >>



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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

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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