The Office of Lifelong Learning & the Physician Learning Program

Palliative Care in Practice: Strategies for community management and referral insights for Family Physicians | Pearls for practice

Palliative Care: Some Practical Clinical Pearls
Dr. Sarah Burton-MacLeod

Dyspnea Management-Tailor to Etiology

Pulmonary/Pleural
- Consider pleural effusion (thoracentesis or PleurX), infection, lymphangitic carc. Or SVCO (steroids), COPD or asthma or IPF.

Cardiac
- Heart failure

Other
- Ascites/ hepatosplenomegaly
- Anemia
- Anorexia-cachexia

Dyspnea- Managing Symptoms

Tailor to etiology
Considerations for oxygen; steroids
Opioids
- Safe and effective even in patients with tendency towards Co2 retention
- Start low, go slow

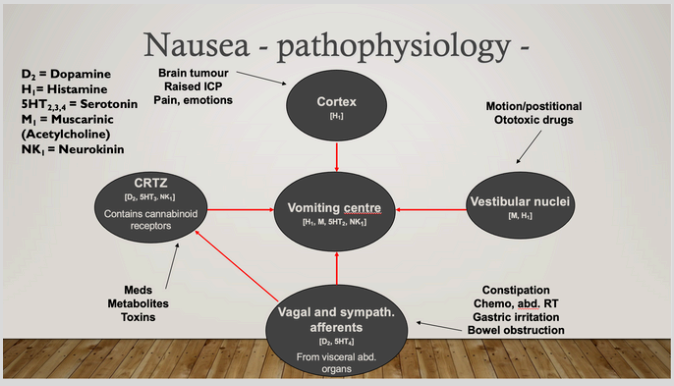
Anxiety
- Choice of agent depends on comorbidities. ?neuroleptic vs benzodazepines.

Refractory & End-stage Dyspnea

- Discussions with patient and family
- Readdress Goals of Care
- Consider Methotrimeprazine (Nozinan) if available
- If in final hours/days, dyspnea is refractory and goal is comfort: ATC benzodiazepines (including intermittent Ativan or even an infusion of Midazolam, depending on resources)

Clinical Pearls for Dyspnea

- Dyspnea is a subjective sensation
- Opioids can be considered in end-stage disease
- Anxiolytics are helpful adjuvants



Nausea- Treatment

Treat reversible causes:
- CONSTIPATION
- Increase in Ca2+
- Gastric irritation
- Increased intracranial pressure
- Bowel obstruction (not always reversible)

Treatment for ongoing causes based on suspected etiology....
Plus cost and potential interactions/SE

Nausea- Treatment

Metoclopramide:
- Chemoreceptor trigger zone (CRTZ) and effect on gut as well
- Especially if your patient is on opioids
- Still watch for EPS and avoid if complete bowel obstruction
- And if primarily CTZ target needed, use Haldoperidol for more potent Dopamine blockade

Oncology-Treatment related:
- Ondansetron

And, in setting of cancer, nice to have 'in your back pocket':
- Dexamethasone (or other steroid)

Clinical Pearls for Nausea

- Consider pathways/receptors most likely to be at play
- In the setting of advanced cancer, a trial of dexamethasone or equivalent corticosteroid may help if you are stuck.

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Delirium in advanced cancer

Frequency:

- 28-48% with Advanced cancer at time of admission to Acute Palliative Care Unit
- 89% in last hours/days

Often missed:

- Lack of objective screening
- Hypoactive/mixed type
- Delirium on dementia
- Formal cognitive assessment on acute palliative care unit, cognitive failure missed
  -23% missed by physicians
  -20% by nursing staff (Bruera et al. JPSM 1992)

Opioid Neurotoxicity

Opioid toxicity

- Myoclonus
- Vivid dreams, Hallucinations (usually visual), delusions
- Drowsiness
- Confusion

TREATMENT is rotation and OFTEN hydration;

- Consider switching (or rotating) opioids!
- Could there be a component of dehydration? If so, consider a trial of fluids (watching for overload).

Rotation as per Equianalgesic dosing

Steps:

- Add total daily dose of original opioid (usually do not include prn doses)
- Calculate the dose of the new opioid (see table)
- Reduce new opioid by 25-30% to account for incomplete cross-tolerance
- Divide reduced amount of new opioid into Around the Clock dosing
- Calculate the Breakthrough dose if using it (10% of total daily dose)

Management of Symptoms

Neuroleptics

- Short-acting, so as to use prn and as breakthrough
- Consider route, subcutaneous option might help
- Haldol, Olanzapine, Loxapine, Nozinan

Avoid Benzos
Unless....

- Irreversible delirium with refractory agitation

Other agents:

- Phenobarbarbital
- Depo-clopixol

Equianalgesic dosing

Opioid	Dose compared with Morphine
Codeine	- 0.1:1 (Morphine 10x stronger!)
Morphine	- 1:1
Hydromorphone	- 5:1 (Hydromorphone 5x stronger than Morphine
Oxycodone	- 1.5-2:1 (Oxycodone between 1.5 and 2 x stronger than Morphine)

Clinical Pearls for Delirium

•More likely to be irreversible in advanced cancer as the disease progresses, so a good idea to float this possibility for family to consider...earlier than later
•Median 3 contributors
•For opioid toxicity, consider rotation, hydration as well as delirium work-up

Refractory agitation in irreversible delirium

- Revisit overall goals and GCD, work-up
- Families will usually perceive agitation as unmanaged pain, so communication around this is important. Staff may need reassurance too.
- Review purpose of any new agents proposed
- Add in other agents: Ativan prn
- For imminently dying pts with refractory symptoms where goal is comfort: Benzodiazepines around the clock (including midazolam infusion, if feasible, vs intermittent).

- **Remember your friendly Palliative care consult Team!

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Pain

- Important to recognize if there is psychological distress impacting pain
- Measure pain through patient report using daily pain intensity
- Make sure not treating psychological pain as physicial pain even if it can be expressed in this way.
- Look for supports, inter professional teams, spiritual/pastoral care/social work
- relaxation exercises or rehabilitation intervention

Troubleshooting pain management

- Is there an element to total pain?
- Could there be a different mechanism of pain, perhaps more neuropathic?
- Is there any element of taking the opioid to cope? Higher risk of substance use disorder
- Is there unrecognized cognitive impairment (consider cognitive assessment tools)

Clinical Pearls for pain

- Be aware the psychological distress and 'total pain' can impact pain expression
- The team approach can help in complex pain
- Consider appropriateness of titrating to function as main marker rather than subjective pain rating report in complex patients

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Conversations

- Aligning yourself with the patient 'I hope too hope that you will be able to stay out of hospital for a long time, but I worry….'
- Wish/Worry/Wonder are gentle ways to bring up new information
- Holding two opposing things at once is not denial
- Hope is important
- If angry and questioning why this is happening, usually just listen. Our patients know we don't have all the answers.
- Keep family in the loop…they are part of the 'unit of care'

Useful reference: Serious Illness Conversations by Ariadne Labs

https://www.ariadnelabs.org/serious-illness-care/

Our own Wellbeing

- Our work can be very rewarding, BUT takes physical psychological, emotional investment
- 'Put on your own oxygen mask…'
- Take note of the rewarding moments, remind yourself of them when you need them

Building resilience in the workplace

Look out for each other

- We know burnout can be insidious
- Help reframe blame
- Maybe a buddy program and Mentorship can help

For Leaders:

- Monitor and moderate intensity and amount of high-risk work
- Promote psychological safety in the workplace

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Finding Meaning

Practical tip:

- Creating moments that allow for connection, creating meaning plus helping patient care
- One example: Dr. HM Chochinov's 'Dignity Question':
- "What do I need to know about you as a person to give you the best care possible?"

(https://dignityincare.ca/en/the-patient-dignity-question.html)
A beautiful article about using this in a rural hospice in Ontario by Dr. Pam McDermott:
McDermott P. Patient Dignity Question: Feasible, dignity-conserving intervention in a rural hospice. Can Fam Physician. . 2019;65(11):812-819.