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Palliative Care: What Every Physician Should Know to Make Patient Care Less Painful

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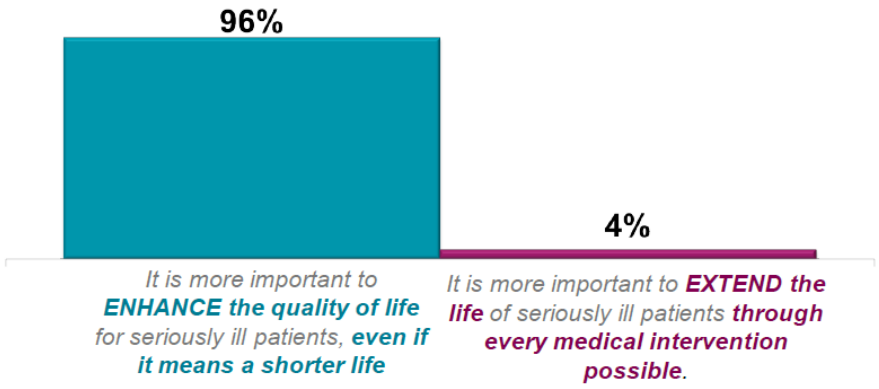
Physicians are nearly unanimous in their belief that it is more important to enhance the quality of life versus extend life by any means.

Which statement comes closer to your point of view?



Poll #4: n=500 board-certified U.S. physicians from AMA master file; October 28-November 2 ,2011

Nearly all physicians agree that palliative care should be widely available and that patients should be informed about their options for care.

*And, to what extent do you **AGREE** or disagree with the following statements…*

96% *The health care system in this country should **place a higher priority on providing palliative care** to all patients who need it and want it.*

96% *It is important that **patients and their families be educated** about palliative care and end-of-life care options available to them along with curative treatment.*

95% *Palliative care should be available to all seriously ill patients who need it and want it and this treatment should be **fully covered by health insurance.***

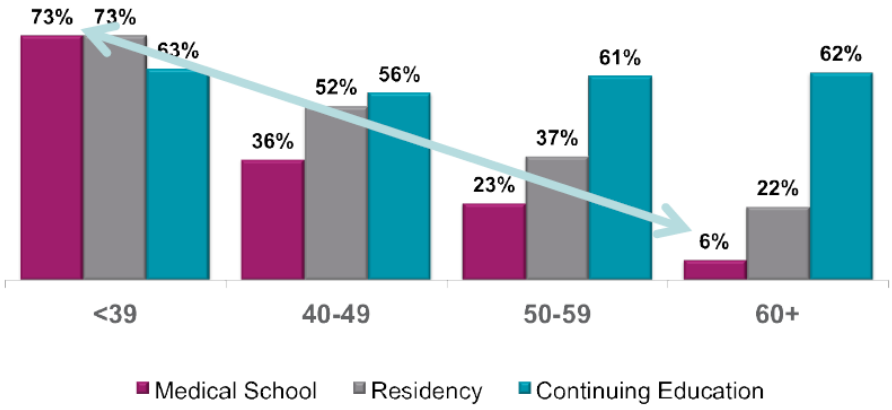
94% *Palliative care should be available to all seriously ill patients who need it and want it and this treatment should be **fully covered by Medicare.***

94% *Palliative care should be available to all seriously ill patients who need it and want it and this treatment should be **provided alongside curative intent treatment.***

Poll #4: n=500 board-certified U.S. physicians from AMA master file; October 28-November 2 ,2011

Younger physicians are being exposed to information about palliative care in Med School at a considerably higher rate than their predecessors.

% "Great Deal" or "Some" Exposure to Palliative Care by Physician Age



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OBJECTIVES

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- Understand the fundamentals of palliative care and its relationship to curative treatment and hospice care
- Discuss treatment of pain
- Implement assessment skills and treatment for non-pain symptoms in chronically ill patients

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END-OF-LIFE DEMOGRAPHICS IN THE UNITED STATES

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- The majority of deaths occur in older adults
- Seriously ill patients spend most of their final months at home, but most deaths occur in the hospital or nursing home
- Location of death varies regionally:
  - Portland: 35% in hospitals
  - New York City: >80% in hospitals

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QUALITY OF END OF LIFE IN THE UNITED STATES

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- Typical deaths are:
  - Slow
  - Associated with chronic disease in people with comorbidities
  - Marked by ↑ dependency and care needs
- Quality of life during the dying process is often poor
  - Inadequate treatment of distress
  - Fragmented care
  - Strains on family
  - Support system
- Difficult decisions about use of life-prolonging treatments are commonly necessary

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OLD MODEL: *"Nothing more we can do"*

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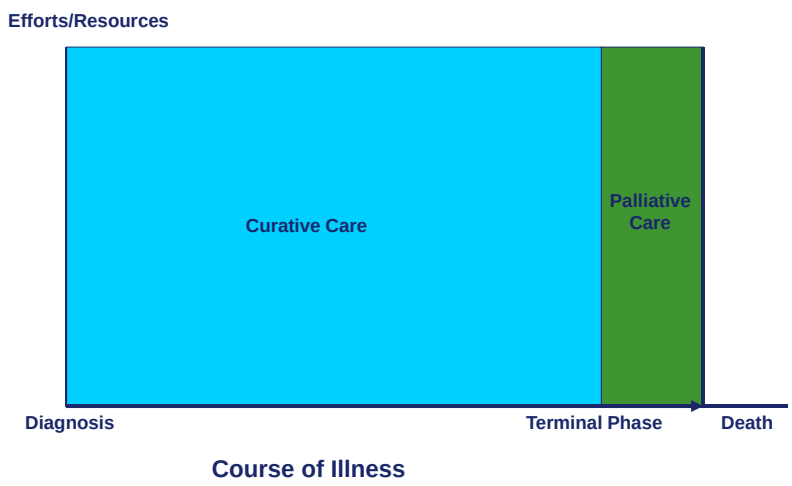

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MODERN CARE MODEL

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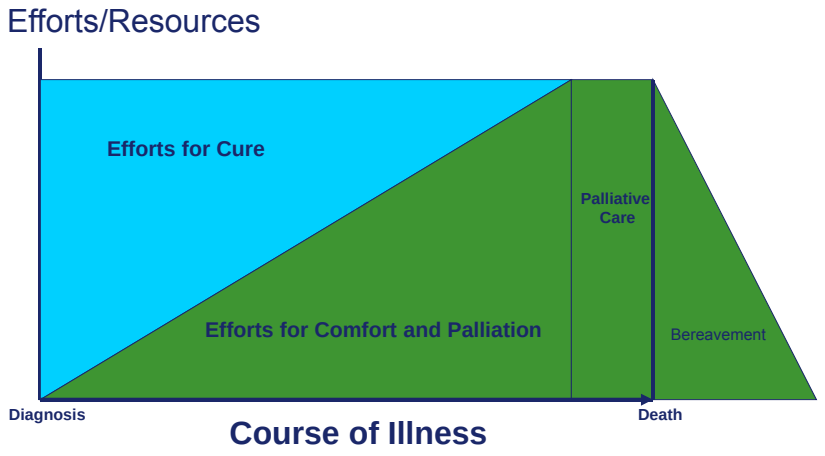

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MODERN CHRONIC CARE MODEL

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WHAT IS PALLIATIVE CARE?

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- Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering
- Throughout the continuum of illness
  - Offered simultaneously with all other appropriate medical treatment
  - Through all stages of disease, not limited to end of life care
- Addresses physical, intellectual, emotional, social, and spiritual needs
- Facilitates patient autonomy, access to information, and choice
- Interdisciplinary care

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PALLIATIVE CARE IMPROVES QUALITY

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- Randomized trial simultaneous standard cancer care with palliative care co-management from diagnosis versus control group receiving standard cancer care only:
  - **Improved quality of life**
  - **Reduced major depression**
  - **Improved survival**
    (11.6 mos. vs. 8.9 mos., $p<0.02$)

Temel et al. Early palliative care for patients with non-small-cell lung cancer NEJM2010;363:733-42

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TENETS OF PALLIATIVE CARE

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1. Symptom management
2. Establish goals of care that are congruent with the patient's values and preferences
3. Consistent and sustained communication between the patient and all those involved in his or her care
4. Support both to patients and their family:
   a) Psychosocial
   b) Spiritual
   c) Practical
5. Coordination across sites of care

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WHAT IS "HOSPICE"?

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- Form of palliative care
- Comprehensive care system for patients who are expected to live ≤6 months
- Patient can be at home or institutional setting
- Patient or their proxies must enroll in hospice

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HOSPICE MEDICARE BENEFIT

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- For beneficiaries with an expected prognosis of 6 months if the disease follows its usual course, certified by a licensed physician
- Forego curative treatments* and agree that the care plan for the terminal illness will be managed by hospice
- Includes:
  - Physician services
  - Nursing care
  - Medical equipment and supplies
  - Medications
  - Short-term inpatient care for symptom management & family respite
  - PT and OT
  - Bereavement services
  - Home-health aide services

* Some hospices have "open access" and allow certain treatment to continue

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HOSPICE VS. PALLIATIVE CARE

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Hospice	Palliative Care
• Focus is on pain and symptom management • Patient has a terminal diagnosis with life expectancy of less than six months • Not seeking curative treatment	• Focus is on pain and symptom management • Patient does not have to be terminal • May still be seeking aggressive treatment

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WHAT DO PATIENTS WITH SERIOUS ILLNESS WANT?

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- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Singer et al. *JAMA* 1999;281(2):163-168

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WHAT DO FAMILIES AND CAREGIVERS WANT?

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- Loved one's wishes honored
- Inclusion in decision process
- Support/assistance at home
- Practical help (i.e. transportation, equipment)
- Personal care needs (i.e. bathing, feeding, toileting)
- To be listened to
- Privacy
- To be remembered and contacted after the death

Tolle et al. Oregon report card. 1999 www.ohsu.edu/ethics

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DECISIONS IN PALLIATIVE CARE

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- Will it help the patient?
  - In their remaining life?
  - Within their goals of care?
- If it will help, what are the burdens?
  - Pain or other symptoms
  - Physical limitations
  - Risk of adverse events
  - Cost
- Is it worth it?

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CHALLENGES FOR SYMPTOM MANAGEMENT

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- Older age (two-thirds are age 65 years or older)
- Malnutrition, low serum albumin
- Decreased renal function
- Impaired cognition
- Lower seizure threshold
- Long-term opioid therapy
- Multiple drug therapy
- Frequent autonomic nervous system failure

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EFFECTIVE PAIN MANAGEMENT

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- Know the types of pain
- Assess the patient's level of pain
- Minimize pain with nonpharmacologic techniques
- Add pharmacologic analgesia when needed
- Anticipate and manage the side effects of opioids

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PAIN INTENSITY SCALES

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- Numeric Rating Scale— 0 is no pain, 10 is worst pain imaginable
- Faces Pain Scale— patient chooses a facial expression that corresponds to the pain
- Verbal Descriptor Scale— "no pain" to "pain as bad as it could be"

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PAIN IN COGNITIVELY IMPAIRED PATIENTS

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- Observe for possible pain-related behaviors and ask caregivers for their observations
  - Consider trial of analgesia for pain-related behaviors
- Validated scales (i.e. Hurley Discomfort Scale, Checklist of Nonverbal Pain Indicators)
- Provide empiric analgesia during procedures and conditions known to be painful

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3 TYPES OF PAIN SYNDROMES

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- Nociceptive— pain due to activation of nociceptive sensory receptors; often adequately treated with common analgesics
  - Somatic— well localized in skin, soft tissue, bone
  - Visceral— due to cardiac, GI, or lung injury
- Neuropathic— from irritation of components of the CNS or peripheral nervous system
  - May respond well to non-opioid therapies
  - Responds unpredictably to opioids
- Mixed or unspecified— has characteristics of both nociceptive and neuropathic pain; common in older adults

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NON-PHARMACOLOGIC PAIN THERAPIES

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- Patient education and involvement in decisions
  - Teach patients to take medications properly and how to use assessment instruments
  - Provide caregiver-guided pain management training
- Cognitive-behavioral therapy
- Regular physical activity
  - or supervised rehabilitation for frail patients
  - or regular repositioning and gentle massage for bed-bound patients
- Osteopathic Manipulative Therapy

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PRINCIPLES OF PHARMACOTHERAPY

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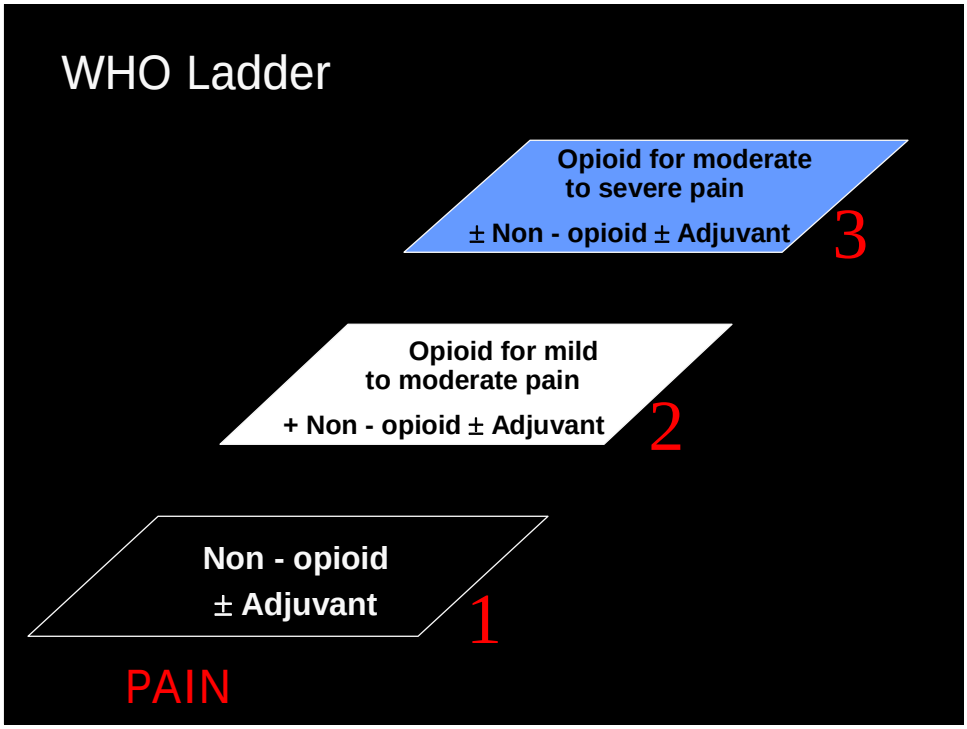
- Besides pain relief, the goals are improved function
- Individualize the initial dose and rate of titration
- In general, start opioids at lowest dose and titrate slowly, but if patient is in pain crisis, do not withhold medications
- Concepts for pain management are the same as any other care setting or patient population, but the medications or doses used might differ because of the risk/benefit ratio at the end of life



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TREATING MILD-MODERATE PAIN

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- Acetaminophen
  - Particularly for musculoskeletal pain
  - No more than 4 g every 24 h
  - Lower the dose by 50%, or avoid, in patients at risk of liver dysfunction, especially with history of heavy alcohol intake
  - Know all medications the patient is taking, as acetaminophen is a common ingredient in prescription and OTC drugs
- NSAIDs
  - Many significant adverse effects
  - Use judiciously, if at all, only after acetaminophen has been tried and only in highly select individuals

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TREATING MODERATE-SEVERE PAIN

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- To estimate opioid requirements, trial of short-acting
- Treat continuous pain with 24-hour opioids in long-acting or sustained-release formulations
  - To cover breakthrough pain, combine with fast-onset medications that have short half-lives
  - Breakthrough pain typically requires 5%–15% of the daily dose, offered q2h orally
- Cost and route of delivery can help guide the choice of opioid

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FEARS OF OPIOIDS

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- Respiratory Depression
- Addiction
- Rapid Tolerance
- Regulatory Reprisal

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OPIATE SIDE EFFECTS

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- Constipation
  - Most common side effect - expected
  - Mediated spinally and in GI tract
  - Decreased peristalsis & decreased intestinal secretions
  - Tolerance does not readily occur
  - Treat with peristaltic agent and softeners – prophylactically
- Vomiting
  - Occurs in 50 – 65% of patients on oral morphine
  - Varies with drug and route
  - Usually easy to control, occasionally severe and difficult to control

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OPIATE SIDE EFFECTS

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- Urinary Retention
  - Opioids increase smooth muscle tone (sphincter)
  - May also cause bladder spasms
  - Try changing opioids or insertion of catheter
- Pruritis
  - Caused by opioid induced histamine release
  - Tolerance generally develops quickly
  - Difficult cases may require a change in opioid
  - Usually treated with transient use of antihistamines

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OPIATE SIDE EFFECTS

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- Somnolence/Sedation
  - Common, but tolerance typically develops within a few days
  - Sedation varies with opioid and dosing schedule
  - Additive effects with other cerebral depressants
  - Decrease or discontinue other cerebral depressants
  - Concurrent use of Dextroamphetamine or Methylphenidate is helpful
- Hallucinations/Confusion
  - Less common, but may occur especially in older patients
  - Often an indication of excess dosing
  - Try dose reduction or different opioid

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OPIATE SIDE EFFECTS

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- Myoclonus
  - Can occur with all opioids
  - Typically due to high doses and/or dehydration
  - Long half-life metabolites are typically implicated
  - Reduce dose, change opioids, change routes and/or hydrate patient
- Respiratory Depression
  - Cause of death in opioid overdose
  - Tolerance develops rapidly
  - Rarely a concern with appropriate dose escalations
  - If accidental overdose occurs in a patient chronically receiving opioids, dilute Naloxone 1:10 and titrate very carefully to reverse respiratory depression without precipitating withdrawal or reversing analgesia

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OPIOID RESISTANT PAIN

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- Headaches
- Muscle Spasm
- Tenesmoid (Bowel / Bladder)
- Incident to movement
- Decubitus
- Deafferentation (i.e. RSD)

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NON-OPIOID PAIN MEDICATION

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- TCAs (off-label) are the best-studied drugs for neuropathic pain
- Optimal analgesia requires treatment of depression
  - SSRIs are less well studied than TCAs as analgesics, but they are better tolerated in antidepressant doses
  - Duloxetine is approved as both an antidepressant and for treatment of pain from diabetic neuropathy
- Antiepileptics are commonly used for neuropathic pain
- Corticosteroids are useful adjuvants for neuropathic pain and pain associated with swelling, inflammation, and tissue infiltration

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PALLIATION OF NON-PAIN SYMPTOMS

- Constipation
- Nausea and vomiting
- Diarrhea
- Anorexia and cachexia
- Fatigue
- Delirium
- Depression
- Dyspnea
- Cough
- Loud respiration

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CASE

On nursing home rounds, you stop in to see a 62 year old man with advanced Parkinson's Disease. He is happy to see you and denies any complaints.

On exam, his abdomen is mildly distended, but non-tender, with good bowel sounds.

On review of his chart and from talking with the charge nurse, you find out that he hasn't had a bowel movement in one week and he is only eating 25-40% of his meals.

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Are you constipated?

- Establish what the patient considers to be his or her normal bowel regimen
  - Range from 1 BM every 3 days to 3 BMs every day
- Questions to ask:
  - Change in frequency?
  - Change in consistency?
  - Abdominal discomfort?
  - Any nausea or vomiting?
  - Change in appetite or oral intake?

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MULTIPLE CAUSES

- Medications (opioids, CCB, diuretics, iron, anticholinergics, chemo agents)
- Decreased mobility
- Ileus
- Mechanical obstruction
- Diet
  - Dehydration
  - Metabolic abnormalities
  - Low fiber diet
- Neural abnormalities
  - Spinal cord compression
  - Autonomic dysfunction

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CONSEQUENCES OF CONSTIPATION

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- Abdominal pain
- Bloating
- Nausea & vomiting
- Urinary retention
- Overflow incontinence
- Tenesmus
- Fecal impaction
- Bowel obstruction

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MANAGEMENT OF CONSTIPATION

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- Treat reversible causes
- Encourage fluid intake as tolerated
- Increase activity level if able
- Consider dietary fiber
- Stimulant laxatives: prune juice, stool softener & bowel stimulant (docusate sodium & senna or bisacodyl)
- If ineffective, add osmotic laxative (sorbitol, lactulose, polyethylene glycol)
- If no bowel movement in 4 days, consider enema
- If impaction occurs: disimpact manually or with enemas before starting laxative therapy
- Prokinetic agents: metoclopramide

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DIARRHEA

- Consider fecal impaction presenting as watery diarrhea in immobile older patients on opioids
- Review medications for excessive laxative therapy

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CASE

A 76 year old woman with advanced ovarian cancer and peritoneal carcinomatosis.

She calls you complaining of increased nausea over the last few days with intermittent vomiting. She feels too sick to come to the office.

"Can you give me something?" she asks.

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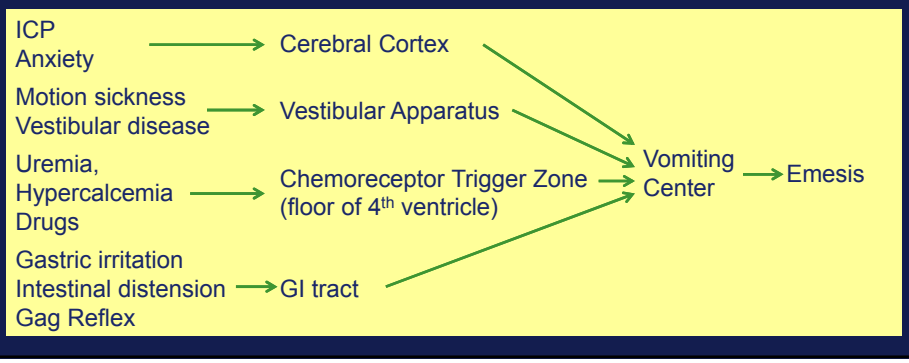
NAUSEA AND VOMITING

- Key facts
  - Occur in 40% to 70% of patients with advanced cancer
  - May be caused by disease or its treatment
- Select antiemetic agent on the basis of:
  - Likely cause
  - Pathway mediating the symptoms
  - Neurotransmitters involved



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ASSESSMENT OF VOMITING

- *Most patients have multifactoral causes*
  - Onset
  - Frequency
  - Relationship to eating
  - Relationship to medications
  - Alleviating factors
- General Treatment:
  - Cold foods tolerated better
  - Avoid triggers
    - Avoid odors of cooking (ventilation)
    - Perfumes, scents, etc.

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CAUSED BY DRUGS & TOXINS

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- Common causes
  - Drugs: opioids, digoxin
  - Biochemical disorders: hypercalcemia, uremia
  - Toxins: tumor-produced peptides, infection, radiotherapy, abnormal metabolites
- Pathway
  - Chemoreceptor trigger zone in vomiting center
  - Dopamine, serotonin, histamine, acetylcholine receptors
- Treatments – remove cause if possible, consider opioid rotation
  - Dopamine antagonists (i.e. haloperidol)
  - Prokinetic agents (i.e. metoclopramide)
    - Can augment with dexamethasone or other corticosteroid
  - Serotonergic antagonists (i.e. ondansetron)

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ORIGINATING IN THE GUT

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- Common causes
  - Gastric irritation, gastric distension, liver capsule stretch
  - Opioid stasis, constipation, tumors, peritoneal inflammation
  - Upper bowel, genitourinary, biliary stasis
- Pathway
  - Gut
  - Receptors: serotonin, histamine
- Treatments
  - Resolve constipation
  - Motility agents for stasis (i.e. metoclopramide 10mg q 4 hours)
    - Contraindicated in obstruction
  - Serotonin antagonists (i.e. ondansetron)
  - Antihistamines (i.e. hydroxyzine, diphenhydramine)

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OTHER ORIGINS

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- Vestibular apparatus
  - Receptors: muscarine, acetylcholine, histamine
  - Common causes:
    - Drugs (aspirin, opioids)
    - Motion sickness (Ménière's disease, labyrinthitis)
    - Local tumors (acoustic neuroma, brain tumors, bone metastases to base of skull)
  - Treatment: scopolamine, hydrobromide, meclizine
- Cerebral cortex
  - Common cause: raised intracranial pressure
  - Treatment: dexamethasone, radiation

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CASE

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A 75 year old man with a history of end-stage heart disease who comes in for a routine visit.

You notice that he's lost 12 pounds in the last two months.

He says he has little energy and just doesn't feel hungry most of the time.

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ANOREXIA

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- Definition: Loss of appetite associated with a decrease in food intake
- Common complication of advanced cancer, COPD, HF, HIV and other serious illnesses
- Multiple causes including endogenous cytokines, metabolic disturbances, and infections as well as other reversible physical & psychosocial problems

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REVERSIBLE CAUSES OF ANOREXIA

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A ches and pains
N ausea, vomiting, diarrhea
O ral problems (candidiasis, loss or alteration of taste, poor dental hygiene or ill-fitting dentures)
R eactive depression or fatigue
E vacuation problems (constipation & urinary retention)
X erostomia (dry mouth)
I atrogenic (radiation, chemotherapy, or RXs)
A cid-related problems (gastritis, ulcers)

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PSYCHOSOCIAL ISSUES & APPETITE

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- Anorexia is often distressing to family members and caregivers
- Food in almost every culture represents nurturing, love, and sustaining life
- Lack of appetite and weight loss may be perceived as “failure” and a possible source of suffering
- Educate the patient, family & caregivers
  - Loss of appetite is part of the disease process
  - Patient is not uncomfortable

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IMPROVING APPETITE

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- Treat comorbid conditions
- Eliminate foods with odors and tastes that are disagreeable to the patient
- Eliminate dietary restrictions
- Choose favorite foods
- Add high calorie beverages
- Increase calorie content of foods (e.g. add butter to bread, gravy to potatoes)

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APPETITE STIMULANTS

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- Megestrol (Megace®)
  - Increases appetite and body weight by increasing fat and water retention but not lean muscle mass
  - 400 – 800 mg PO for HIV/AIDS
  - 160 – 1600 mg PO for cancer
- Corticosteroids (prednisone or dexamethasone 4mg qd)
  - Increase appetite without any increase in body mass
- Dronabinol (Marinol®)
  - Increase in appetite and mood without any weight gain
  - 2.5 mg PO BID, titrate up to 20 mg/day
- Omega-3 fish oil
  - Increase of 1-2 kg of lean body weight
  - 3 g PO daily

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ARTIFICIAL NUTRITION

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- Types:
  - Enteral
  - Parenteral – partial or total
- Intended to be used temporarily, until a person with a reversible problem regains the ability to eat and drink normally
- Has <u>not</u> been shown to prolong life in terminally ill
- Associated with a high incidence of aspiration pneumonia, use of restraints, and symptoms such as nausea, rattling respiratory secretions
- Does <u>not</u> increase the comfort of terminally ill patients

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DYSPHAGIA

Causes	Treatment
Dry mouth from radiation or disease	Saliva substitute; Pilocarpine 5-10mg TID; No glycerine swabs or lemon juice
Dry mouth from medications	Flouride to prevent dental damage; Pilocarpine 5mg BID
Oral Candidiasis	Nystatin swish and spit; Clotrimazole 10mg 5x/day; Diflucan 100mg daily
Bacterial Infection	Oral hygience and ABX; chlorhexidine 0.12% swish and spit BID
Viral Infection	Acyclovir 400mg 5x/day for acute or 800mg TID for chronic suppression
Reflux Esophagitis	PPI, H2-blocker; Positioning upright for meals

Modify food and drink consistency

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CASE

An 88 year old woman with a history of metastatic lung cancer and recurrent, left-sided pleural effusion who comes to the ER for worsening shortness of breath over the last two days.

She has had two thoracenteses in the past six weeks; the last one was complicated by a pneumothorax. She tells you that she doesn't want any more procedures.

With tears in her eyes she asks you if you can do anything to make her feel better?

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DYSPNEA

- Definition
  - Uncomfortable awareness of breathing, discomfort in breathing
  - Breathlessness, shortness of breath, work of breathing
  - Respiratory effort and dyspnea are not the same
- Assessment
  - Patient self-report is the only reliable measure
  - Respiratory rate and lab tests often do not correlate
  - May be associated anxiety, fear, panic and even terror
- Management
  - Treat underlying cause, but do not delay symptom management
  - Use O_2 if saturation < 90%; cautiously in patients who retain CO_2
  - Activity modification, relaxation techniques
  - Use fan, open window to stimulate 5th cranial (trigeminal) nerve
  - Opioids reduce respiratory drive, dyspnea
  - Benzodiazepines control anxiety but not dyspnea

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CAUSES AND TREATMENTS OF DYSPNEA

B ronchospasm – HHN albuterol/ipratropium; steroids (especially if tumor mass)

R ales – d/c IVF, tube feeds; diuretics; ABX for pna

E ffusions – thoracentesis; indwelling chest tube

A irway obstruction – diet consistency; body positioning; suction

T hick secretions – if cough reflex intact: nebulized saline; if no cough reflex: hyoscyamine, scopolamine

H emoglobin low – transfusion

A nxiety – benzo, SSRI; environmental

I nterpersonal issues – counseling; IDT

R eligious concerns – chaplain or religious adviser; IDT

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OPIOIDS FOR DYSPNEA

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- First line agent
- Proposed mechanisms
  - Decrease chemoreceptor response to hypercapnia
  - Increase peripheral vasodilatation with decrease in cardiac preload
  - Decrease anxiety
- No studies that demonstrate one opioid having clear benefits over others

Severity	Opioid-Naïve Patient	Opioid-Tolerant Patient
Mild Dyspnea	Hydrocodone, Codeine, Morphine	Start with opioid the patient is already taking and titrate to efficacy by dose or frequency
Severe Dyspnea	Morphine, Oxycodone, Hydromorphone	Rotate opioids
Titrate upward by 25-50% every 12-24 hours		

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COUGH

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- Causes
  - Production of excess fluids
  - Inhalation of foreign material
  - Stimulation of irritant receptors in the airway
- Management
  - Treat underlying cause
  - Add opioids if underlying disease not resolvable
    - Dextromethorphan: few sedative effects
    - Codeine, hydrocodone elixirs
    - Methadone syrup for longer duration of action
  - Nebulized anesthetic for irritated pharynx of local infection or malignancy

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CASE

An 87 year old woman with osteoarthritis, hypertension, and breast cancer metastatic to the bone who comes in to the office for follow-up.

She states that she is always very tired and spends most of the day sleeping.

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FATIGUE

Evaluate for reversible causes:

- Anemia - Red blood cell transfusion or an erythropoiesis stimulating agent, most useful in patients receiving chemotherapy who have severe anemia
- Deconditioning - exercise
- Depression - antidepressants
- Infections - antibiotics
- Dehydration - intravenous or subcutaneous fluids
- Hypoxia - oxygen, if hypoxemic
- Metabolic and endocrine disorders - correction of disorder (i.e. thyroid or testosterone replacement)
- Pain - NSAIDs, opioids

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FATIGUE

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Treatment

- Discontinue medications that may be contributing to fatigue
- Optimize fluid and electrolyte balance
- Energy conservation techniques; adjust activity level and get help with ADLs & IADLs - consider OT, PT
- Educate patient and family about “fatigue” & giving patient “permission to rest”
- Yoga, exercise, cognitive-behavioral therapy
- Pharmacotherapy:
  - Dexamethasone 3-6 mg q am or Prednisone 20-40 mg q am
  - Methylphenidate 5 – 10 mg q am & q Noon, titrate to effect
  - Megestrol acetate 480 - 800 mg daily
  - modafinil (Provigil®)

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INSOMNIA

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- Impact on quality of life
  - Heighten the intensity and awareness of other symptoms such as pain, anxiety, or delirium
- Evaluate for reversible causes
  - Uncontrolled pain
  - Urinary frequency
  - Dyspnea
- Sleep hygiene
  - Take a warm bath
  - Drinking a glass of warm milk prior to bedtime
  - Avoid caffeinated beverages following dinner
  - Empty the bladder just before going to bed
  - Schedule naps earlier in the day
- Hypnotics

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DEPRESSION

	Grief	Depression
Definition	Feelings and behaviors that result from a particular loss	Depressed mood, decreased interest and pleasure, appetite and sleep disturbance, psychomotor agitation or retardation, decreased concentration, loss of energy, feelings of worthlessness, guilt, hopelessness, helplessness, and thoughts of death with impairment of functioning lasting at least two weeks
Symptoms and signs	Somatic distress, sleep and appetite disturbance, diminished concentration, social withdrawal, sighing	Hopelessness, helplessness, anhedonia, worthlessness, guilt, suicidal ideation most useful diagnostic clues
		Somatic distress, sleep and appetite disturbance, diminished concentration, social withdrawal, sighing are also common
Other differentiating factors	Patient retains capacity for pleasure	Nothing is enjoyable
	Comes in waves	Constant
	Passive wishes for death	Intense, persistent suicidal thoughts
	Able to look forward to the future	No sense of anything to look forward to

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DEPRESSION TREATMENT

- Treatment success
  - Generally, each antidepressant takes 4-6 weeks to evaluate full response
  - Complete response in 25% of patients
  - Adding augmenters can increase response to 30%
    - Trazodone: for sleep
    - Buspar: nonsedating anxiolytic
    - Psychostimulants: Methylphenidate (Ritalin), amphetamine (Adderall), modafinil (Provigil)
    - Antipsychotics: risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa)
    - Benzodiazepines: for anxiety – use with caution

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DELIRIUM

- Common and distressing for both patients and their families
- Usually multifactorial
- Identify potentially reversible causes
  - Infection
  - Impaction
  - Uncontrolled pain
  - Urinary retention
  - Medication
  - Metabolic
- Treatment
  - Non-pharmacologic – vision/hearing; reorientation; sleep hygiene; hydration; remove tethers
  - Use low doses of non-sedating antipsychotic (haldol 0.5-1mg)
  - Avoid benzodiazepines

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SUMMARY

- Palliative care aims to relieve suffering, improve quality of life, and optimize function
- Palliative care is offered simultaneously with all other appropriate medical treatment
- Pain should be assessed in all patients, and adequate treatment may combine drugs with non-pharmacologic interventions
- Clinicians should watch for and treat other symptoms: constipation, nausea & vomiting, diarrhea, anorexia & cachexia, depression, delirium, dyspnea, and cough

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"IT IS MORE IMPORTANT TO KNOW WHAT PATIENT HAS A DISEASE, THAN WHAT DISEASE THE PATIENT HAS."
--Osler

"To cure sometimes,
treat often,
comfort always."
--Hippocrates

"Death I understand very well, it is suffering that I cannot understand."
--Singer

"The secret of the care of the patient is in caring for the patient."
--Peabody