

PALLIATIVE CARE SHOULD NOT BE A TERTIARY SERVICE - TIPS AND TRICKS FOR THE RURAL FAMILY DOC

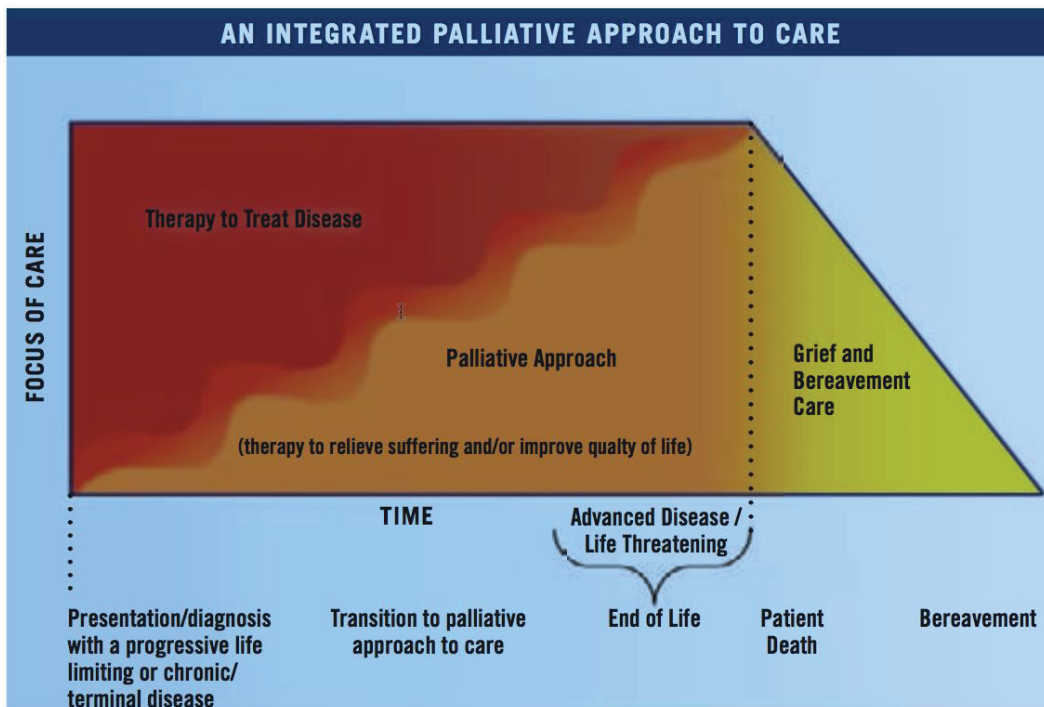
Practical tips and tricks in palliative care for rural doctors, focusing on palliative care emergencies, issues relating to wound care, and psychiatric concerns.

1. At the conclusion of the presentation, participants will be able to recognize a number of common palliative care emergencies 2. At the conclusion of the presentation, participants will be to provide initial treatment in a number of common palliative care emergencies 3. At the conclusion of the presentation, participants will have an approach to wound care in palliative care patients 4. At the conclusion of the presentation, participants will have an approach to psychiatric symptoms in palliative care patients

Rural Palliative Care Tips and Tricks

Speaker Notes

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Terminal Delirium

- Can be brought on by a vast array of possible factors
- Anything that causes regular delirium can be a precipitant of terminal delirium
- Terminal delirium can be more tricky to sort out though as sometimes the patient is too weak to exhibit normal signs of delirium or they might be only partially conscious...In other words no wandering, not aware enough to have day and night reversal... but will seem agitated in the bed, restless, etc.
- Don't under-estimate the fear-panic that people might be experiencing as they face death
- They may not know how to express that fear
- The causes of terminal delirium and distress are not always clear and this can lead to delays in treating the patient
- Don't go down the rabbit hole before treating the patient!
- Guide therapy based on the cause... but if that isn't clear and the patient is in distress... then **NEXT SLIDE**

Terminal Delirium

- **Click to Summary Slide**
- Lorazepam (Ativan) 0.5mg-4mg q4-6h (SC, IV, SL, IR)
- Midazolam (Versed) 1-10mg q4h (SC, IV) max 10mg/hour
- Methotrimeprazine (Nozinan) 5mg (5-50mg) q6h (SC, IV) max 300mg/day
- Phenobarbital 30mg (15-60mg) q6-12h (SC, IV, IR) if extremely agitated start with 120mg bolus (120-480mg) then 120mg q6h (60-360) max 2500mg per day
- Haloperidol 1mg (0.5-5mg) q1h prn or fixed doses q8h (max 25 mg/day)

SCC

Spinal Cord Compression

- Compression of vasculature with engorgement and edema, leading to cord ischemia
- Direct compression due to vertebral mets/collapse or paraspinal masses
- Main concern with SCC is failure of recognition!
- Presentations of SCC can be very subtle in its early stages.... you need to have a high index of suspicion
- Usually results in para/quadruplegia if not treated
- Neurological function at the beginning of treatment is the most important factor influencing outcome

Back Pain:

- most common symptom, but 4-17% patients have no pain
- it can predate sensory changes by weeks/months
- beware of any escalation of previously stable back pain
- band-like pain encircling the body, worse with coughing and straining
- pain often positional... worse when lying in bed
- hard to control with escalating opioid doses

Stiffness/weakness: often stiffness before weakness

Tingling/numbness: usually rapidly developing from feet upwards

Urinary symptoms: retention and/or incontinence, often preceded by degree of urinary frequency

Perianal numbness/poor anal tone: very late symptom!

Altered reflexes

Pain with straight leg raise

Unilateral/bilateral weakness (asymmetry is common)

Lax sphincters

*** A clear sensory level is NOT necessary for diagnosis ***

- MRI is gold standard (hmmm, you are thinking...)
- If MRI not readily available or if patient cannot undergo MRI, try to do plain films.... look for erosion of pedicles, vertebral collapse, fractures, paravertebral masses
- CT myelogram (hardly a rural reality)

- High Index of Suspicion!!!!
- Once diagnosis is suspected or confirmed, definitive decompression is needed, urgently!
- Dexamethasone 10mg IV/SC stat, then 4mg PO/IV/SC QID
- Call your nearest RadOnc referral centre, arrange for transfer if appropriate

Terminal Hemorrhage

Terminal Hemorrhage

- Severe acute haemorrhage as a terminal event is relatively rare but the conditions that lead to it are relatively common
- Minor self-limiting bleeding may precede an acute event
- Clinically significant bleeding occurs in 6-10% patients with advanced cancer
- 3% lung cancer patients have massive terminal hemoptysis

- Clearly this is distressing for all involved- patient, family, health care providers, volunteers, janitorial staff
- Very important to anticipate the possibility of a haemorrhage and to have a strategy for dealing with it
- The plan needs to be communicated early and everyone needs to be comfortable with it

Smaller, self-limiting bleed

- First aid to arrest bleed
- Pressure dressing
- 1:1000 epi-soaked topical dressings

Prevent Recurrence

- Radiation
- IR thromboembolic techniques
- Tranexamic acid 1gm TID-QID (can be made into liquid form to be used topically on persistently oozing lesions)
- For persistently oozing GI mucosa combo of Sulcrafate + PPI (+/- octreotide)

Crisis Orders:

- Want these to be readily available in order to allow patient to be unaware of the anxiety and distress that symptoms of rapidly developing shock can produce
- Need to balance prospect of increasing their anxiety and alarm by preparing them for the event against the anxiety of being prepared and waiting for the inevitable
- Important to explain to all that the purpose of the crisis orders is to give sufficient rapidly-acting meds to *deeply sedate the patient and prevent distress* while dying

- Preferably prescribe meds by IM or IV as S/C is not as well absorbed (get peripheral shut down in shock)
- Another option would be to give meds via metered aerosol device into nasal space or buccal mucosa (talk to your local pharmacist!)

If patient is opioid-naive:

- Morphine 10mg and Midazolam 10mg
- Repeat q5-10min until distress is relieved

If patient is not opioid-naive:

- Regular opioid at double normal BT dose and Midaz 10mg

If patient is not opioid-naive:

- Regular opioid at double normal BT dose and Midaz 10mg

For using metered aerosol device

- 5-10mg midazolam
- If opioids are required by this route consider using low volume opioids (sufentanyl)

DON'T FORGET

- Green towels
- Dark sheets/pillow cases
- Warm facecloth
- Bowls with cloths inside (minimizes sound and splash)
- Keep patient warm

SVCO

SVCO

- Condition where return of blood from the upper body to the heart is impeded, which results in severe upper body venous congestion
- Now much more manageable thanks to radiation/chemo options
- That being said, if SVCO is the first presentation of a cancer it carries with it a very poor prognosis

Early:

- Periorbital edema, conjunctival suffusion, facial swelling (more obvious in AM and if stooped or supine)
- Cough, dyspnea (due to laryngeal edema or tracheal/bronchial compression)
- Dysphagia
- Chest pain

Late

- Engorged neck and chest veins (non-pulsatile)
- Tachypnea
- Plethora
- Upper extremity edema
- Cyanosis

Severe

- Headache
- Blurred vision
- Altered mental status
- Seizure
- Papilledema (very late sign!)

Immediately

- Relieve dyspnea/anxiety, feeling of drowning that can be extremely distressing
- Use opioids and/or benzodiazepines
- Small doses often suffice for anxiolysis and dyspnea (titrate based on whether patient is opioid-naive or not)

Then.....

- Raise the head of the bed
- Initiate high dose steroids
- Dexamethasone 16mg PO/SC qday x 5 days
- After 5 days, if not effective then d/c
- Or taper it if dose was effective and are waiting for other treatments to take effect

Then.....

- Contact nearest oncology centre to determine if radiation or chemo would be appropriate treatment options (consider patient's overall condition, goals of care, etc)
- Consider stenting of SVC with or without thrombolysis
- Consider diuretic (transient benefit only)

Wounds in Palliative Care

- Notice their skin Poor attention to skin care in the dying patient will result in pain, odor, swelling, reduced quality of life and increased care demands for family and other caregivers.
- Skin can withstand 30-60 minutes of poor perfusion, but not longer.

Prevention of ulcers is the highest level of care

- Assessment whether or not the wound is likely to heal
- If prognosis of months to years, with adequate nutrition, and blood flow to the tissue, then healing is possible.
- If the patient has a prognosis of days to weeks, anorexia/cachexia, and/or the wound has inadequate perfusion, then symptom control alone is appropriate and uncomfortable/burdensome treatments are not appropriate.

- Always provide adequate analgesia!
 - Necrotic tissue must be removed for ulcer healing; surgical debridement is the fastest and most effective method when there is healthy surrounding tissue.
 - Note: If the patient is close to dying, and/or the wound will never heal, then debridement should not be attempted.
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- Cleanse wounds that are expected to heal with non-cytotoxic fluids (e.g. saline).
 - Cytotoxic fluids (e.g. Betadine) will kill granulation tissue.
 - Clinical Pearl: do not cleanse an ulcer with any fluid you wouldn't put in your eye if you want the ulcer to heal.

- Few things can worsen a patient's quality of life greater than an oozing, odorous, painful, and bleeding malignant skin wound.

- fundamental decision needs to be made about whether the wound can eventually heal or not.
- choice of dressing is generally the same as with pressure ulcers
- *however*, malignant wound management has some particularities worth mentioning

Exudates

- can be substantial from malignant wounds
- overall goal is to prevent exudate macerating other normal tissues or dripping off the patient into clothes/linens (cosmetic and infection control goals)
- use absorbent foams to minimize the frequency of dressing changes and maximize absorption
- a gauze pad (such as an 'ABD' pad) is placed on top of the foam.
- Alginate dressings have a role in wounds that have exudates and/or are bleeding (absorptive, hemostatic, help to control infection; do not have to be pulled off and can be washed off in the shower)

Infection

- high risk of superficial infection (esp. anaerobic or fungal species)
- odor is often first sign of anaerobic infection (along with a purulent exudate)
- if only superficial, topical treatment (metronidazole, silver sulfadiazine) may be sufficient.
- if there is evidence of deeper tissue infection, systemic metronidazole should be used.
- if the wound is determined to be non-healing, then topical agents like povidone can be used; but some patients find it irritating and painful
- Povidone is cytotoxic to bacteria and will help keep the wound clean. *Povidone should not be used for wounds that are expected to heal because it is cytotoxic to normal granulation tissue.*

Odour:

- Odour absorbers; kitty litter or activated charcoal can be placed on a cookie tray underneath the bed
- charcoal dressings that can be used to cover a particularly malodorous wound.
- a burning flame (such as a candle) in the room in an attempt to combust the chemicals causing the odour (be careful- fire safety!)
- introduce a competing odour; bowls of vinegar, vanilla, or coffee
- remember fragrances and perfumes are often poorly tolerated by patients and should be avoided.

Bleeding :

- common as the surface of a malignancy may be friable and predispose to bleeding
- present as oozing (microvascular fragmentation) or vascular disruption from necrosis or sloughing leading to “a bleeder.”
- any dressing in contact with it may adhere and tear the surface when it is pulled off (e.g. saline wet-dry dressings).
- prevent this by using a mesh synthetic polymer, non-stick, non absorptive dressing (e.g. Mepitel)
- other options to control bleeding are alginate dressings, topical low dose (100 U/ml) thromboplastin, silver nitrate, 1:1000 epi-soaked gauze, cautery.

Nausea and Vomiting

Nausea and Vomiting

- As a patient nears the end of life they may experience nausea and vomiting for a number of different factors. Such factors include, but are not limited to: medications, diseases affecting the gastrointestinal tract, central processes such as brain tumours or metastases, anxiety and metabolic disturbances.
- **History and Physical Exam:** Ensure that patient does not have signs of mechanical obstruction. If any signs of obstruction exists, contact an MD immediately. Signs of obstruction include abdominal pain, distension, signs of peritoneal irritation, absence of bowel movements and gas per rectum in addition to nausea and vomiting.
- **Patient's Level of Care:** Ensure that patient and/or their proxy wish treatments to be undertaken. For any potential conflict discuss with MD directly.
- **Non-pharmaceutical treatments:** These should either be tried first, or in conjunction with first line medications. Counsel patients and their families regarding the avoidance of sights, sounds, smells, or other triggers of nausea and vomiting.
Suggest avoidance of spicy, fatty, and highly-salted foods.
Suggest use of ginger chews or ginger teas

Nausea and Vomiting

Prescribed medications should, if possible, target the etiology of the symptoms.

- If nausea and vomiting are caused by medications (such as opioids), consider rotating or switching the drug.
- Consider adrenal insufficiency for a patient who may have abruptly stopped a steroid. A longer taper may alleviate nausea and vomiting in this case.
- Address issues of constipation.
- For patients with increased intracranial pressure, steroids are the first-line treatment. Carbamazepine can also be helpful, especially if the cause is leptomeningeal carcinomatosis.

Nausea and Vomiting

- Consider dietary changes for patients with gastroduodenal motility issues.
- Interventions to manage mechanical bowel obstruction include surgery, stents, and nasogastric decompression.
- The patient's disease state and care objectives will guide therapy.
- Glucocorticoids can treat nausea both by reducing peritumoral edema and through their own antiemetic properties. A typical starting dose of dexamethasone is 4 mg twice daily.
- Sandostatin analogs, such as octreotide, can help decrease intraluminal secretions, decrease pain, and decrease motility.

Nausea and Vomiting

Dimenhydrinate: _____ (Usual dosage is 25-50mg PO/IV/IR q6-8hours) An option for short term relief but is rarely sufficient for long term symptom control. Causes sedation.

OR

Metoclopramide: _____ (Usual dosage is 10mg (from 5-10mg) q4h IV/SC. Max TDD is 40mg.) Avoid if patient shows sign of bowel obstruction or if known prolonged QTc, tardive dyskinesia, Parkinsonism or psychiatric conditions requiring dopamine agonists.

OR

Haloperidol: _____ (Usual starting dosage is 0.5mg-1.0mg PO/SC qhs.) Can titrate dosing frequency and amount as needed to control symptoms. Good option for refractory nausea and/or vomiting, and for those with sleep disturbances.

OR

Olanzapine: _____ (Usual dosage is 5mg qday-BID PO/SL. Max TDD is 10mg.)

AND consider

Dexamethasone: _____ (Usual dosage is 4mg stat and then 2-4 mg qDAY-QID). Consider this when N/V could originate from mechanical obstruction secondary to tumour mass or from raised ICP.

Respiratory Distress

Respiratory Distress

Crucial to explain to all that the purpose of the crisis orders is to give sufficient rapidly-acting meds to deeply sedate the patient and prevent distress while dying.

A. Terminal Distress *For rapid relief of intolerable suffering, nausea, anxiety, dyspnea and pain in patients at the end of life*

In Syringe #1:

Midazolam (Versed) **5mg*** or _____ **mg SC** STAT and q 10-20min PRN** until distress is relieved
Midazolam dose can be increased to 10 mg if the patient is over 70kg or if patient was already receiving 3-12 mg/24hrs of lorazepam (Ativan) or its equivalent. If the patient was receiving > 12mg/24 hrs of lorazepam then administer 15mg midazolam.

In Syringe #2:

Scopolamine 0.4 mg* SC** or _____ **mg STAT and q10-20min PRN** until distress is relieved
Scopolamine can be increased to 0.8mg SC if patient has been receiving regular scopolamine or glycopyrrolate

AND EITHER

Morphine 10 mg* SC** or _____ **mg STAT and q10-20min PRN** until distress is relieved OR
 Hydromorphone (Dilaudid) 2 mg* SC** or _____ **mg STAT and q10-20min PRN** until distress is relieved

Terminal Pain Crisis

- If you have the time consider switching the formulation, route or even type of opioid

Terminal Pain Crisis

Morphine 10 mg SC or _____mg STAT and q10-20min PRN until distress is relieved

OR

Hydromorphone 2 mg* SC or _____mg STAT and q10-20min PRN until distress is relieved**

- If patient opioid-naive then start with Morphine 5-10mg or hydromorphone 1-2mg
- If patient not opioid-naive then give double their breakthrough doses q10-20min prn

Total Pain

Total pain is a clinical idea and approach developed by Cicely Saunders, the founder of the modern hospice movement.

Total pain recognizes pain as being physical, psychological, social and spiritual.

But how to treat it...

Realizing that patients may experience their psychological pain as physical symptoms

Involving professionals from other domains where appropriate and available...psychologists, traditional healers, elders, church leaders...

Engaging in those conversations where you ask the patient what they think will help... understanding the end of life care options that are available in your community

Palliative care, continuous palliative sedation and medical aid in dying

Other palliative care emergencies

- Hypercalcemia
- Total Pain
- Seizures
- Obstructive nephropathy
- Cardiac tamponade
- Tumor lysis
- Febrile neutropenia
- Hyperviscosity
- Increased intracranial pressure
- SIADH
- Hypoglycaemia

- Online resources!
- Virtualhospice.ca
- palliativedrugs.com,
- fast facts at mypcnow.org