PALLIATIVE CARE AND MALIGNANCY

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PALLIATIVE CARE 101

- **"Palliative care is an approach that *improves the quality of life of patients* and their families facing the *problem associated with life-threatening illness*, through the *prevention and relief of suffering* by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"**

BACKGROUND

- Medicine through Monash University
- Internship, Residency, BPT through St Vincent's
  - PMCC (x 2)
  - Werribee (x 3)
  - Sale
  - Warrnambool
- "Year off"

BACKGROUND

- Advanced Trainee in Palliative Medicine (AT1 PM)
  - Western Health
  - Austin Health
- Why Palliative Care?
  - Patient-centred care
  - Huge variety of cases (in last week: CJD, Huntington's disease, ventilator-dependent motor neuropathy, end-stage liver failure, metastatic malignancy +++)
  - Opportunity to make real difference in patients' lives

WHEN TO CALL= THE CTPA OF REFERRALS

- **If you are thinking about referring to Palliative Care…**
- **Please refer to Palliative Care**
- **Better too early than too late**

SPICT

- Supportive & Palliative Care Indicators Tool
- Used to screen patients who have indicators of deteriorating health, who may have unmet needs that could benefit from Palliative Care
- General
  - Recurrent unplanned admissions, deteriorating performance score, unexpected LOW, persistent symptoms despite optimal management of underlying disease
- Cancer-Specific
  - Functional ability deteriorating due to progressive metastatic cancer
  - Too frail for oncology treatment, or treatment goal is for symptom control ("palliative chemotherapy")
- https://www.spict.org.uk/

THE SURPRISE QUESTION

HOW TO BREAK THE ICE

- Set the scene
  - Make time and space
  - Set phone to silent, give pager to HMO/registrar
  - Sit down with your patient
- Assess knowledge
  - What do they know about their condition and prognosis?
- Values
  - If you were to become more unwell, what would be important to you?
  - Who would you want to be around you?
- Introduce as coworkers, not as new team

HOW TO BREAK THE ICE

- **Normalise the referral process**
  - **We work with patients with a serious illness**
  - **Cancer-specific: beneficial for people at any stage of advanced cancer**
  - **We work alongside the [referring specialty] team to provide relief from symptoms, pain, and stress of having a serious illness**
  - **You can use our service for a brief or long period of time**
  - **You can have palliative care while still being on active treatment for cancer**
- **Patient concerns**
  - **End of the road - giving up on them**
  - **Association between PC and hospice for many people**
  - **"My mum went on Palliative Care and died"**

HOW TO BREAK THE ICE

- **Increasingly will have had family members who have had PC involved**
- **<u>Please tell the patient you are going to refer to us!</u>**

HOW TO REFER TO PALLIATIVE CARE

- **Put yourself in our shoes**
- **ISBAR?**
- **<u>RISBA (or IRSBA)</u>**
  - **Tell us what you want upfront**
  - **Helps the referee focus on pertinent information**
  - **Can also save you time**

WHAT TO TELL US

- Brief disease summary
  - When diagnosed, what stage, where is the disease (eg. liver mets and Targin…)
  - What is the prognosis? Has the patient been told this?
- Current and future treatment options
  - BSC vs. further options
- Home situation
- Capacity to make legal decisions
  - MTDM
- Important family members and conflicts

WHAT TO TELL US

- Current symptoms
  - Pain
  - Dyspnoea
  - Nausea/vomiting
  - Bowels
- Current Ix
  - Recent staging scans
  - Renal and hepatic function
  - Calcium
- Goals of care

A QUICK REFRESHER ON LEGAL THINGS

- A patient is assumed to have decision-making capacity unless there is evidence to the contrary
  - Understand, retain, weigh information, communicate decision
- MTDM
  - Legally appointed MTDM/MPOA
  - Spouse/domestic partner > carer > adult child > parent > adult sibling
- Palliative Care in a patient without decision-making capacity
  - A doctor is able to administer palliative care to a patient who does not have decision making capacity
  - A MTDM cannot refuse palliative care on the behalf of the patient
  - A patient cannot refuse palliative care in an advance care directive
  - https://www.publicadvocate.vic.gov.au/definitions#A
  - https://www.publicadvocate.vic.gov.au/power-of-attorney/medical-treatment-decision-maker/20-medical-consent/267-palliative-care

SYMPTOM MANAGEMENT IN THE HOSPICE SETTING

DR PETER SHERWEN

HOW MUCH OF IT IS ABOUT PAIN?

Not much

PRACTICAL CLASSIFICATION OF PAIN

1. **NOCICEPTIVE**
   - **SOMATIC**
   - **VISCERAL**
2. **NEUROPATHIC**
3. **WIND-UP**

EVERYDAY ANALGESIA

Morphine

Oxycodone

Fentanyl

Hydromorphone

Methadone ??

EVERYDAY NEUROPATHIC AGENTS

Pregabalin

Gabapentin

Amitryptiline

Duloxetine

One major issue is route of administration

NOCICEPTIVE PAIN/OPIOIDS

Drug	Route	Trade name	Dose
Morphine	Ō, SC, IV, IM, Spinal, Nebulised	SA: Morphine Mixture LA: MS Contin Kapanol	70mg Ō/day 20-25mg sc/day
Fentanyl	TD, SC, IV, Spinal	-	25mcg/hour 600mcg/day
Oxycodone	Ō, SC	SA: Endone OxyNorm LA: Oxycontin	40mg Ō/day
Hydromorphone	Ō, SC	Dilaudid (SA)	10mg Ō/day 3.4mg sc/day
Methadone	Ō, SC	Methadone Physeptone	LONG HALF LIFE

OPIOID ROTATIONS??

? Reduce dose

? Rotate or add different agent

NOT SO EVERYDAY

Methadone – oral or SC, rotation or addition?

Ketamine – SC, 100mg – 500mg/day

Lignocaine Infusion SC, 500 – 1500 mg/day with monitoring

OTHER MODALIITIES

Radiotherapy

Nerve blocks

Cordotomy

Spinal Analgesia

VERY OCCASIONAL

Terminal sedation/ CDS

- **Rarely required for pain**
- **More often for other distressing symptoms**

GI SYMPTOMS ARE COMMON IN PALLIATIVE PATIENTS WITH:

UP TO 70% OF PATIENTS HAVING NAUSEA

UP TO 65% OF PATIENTS HAVING CONSTIPATION

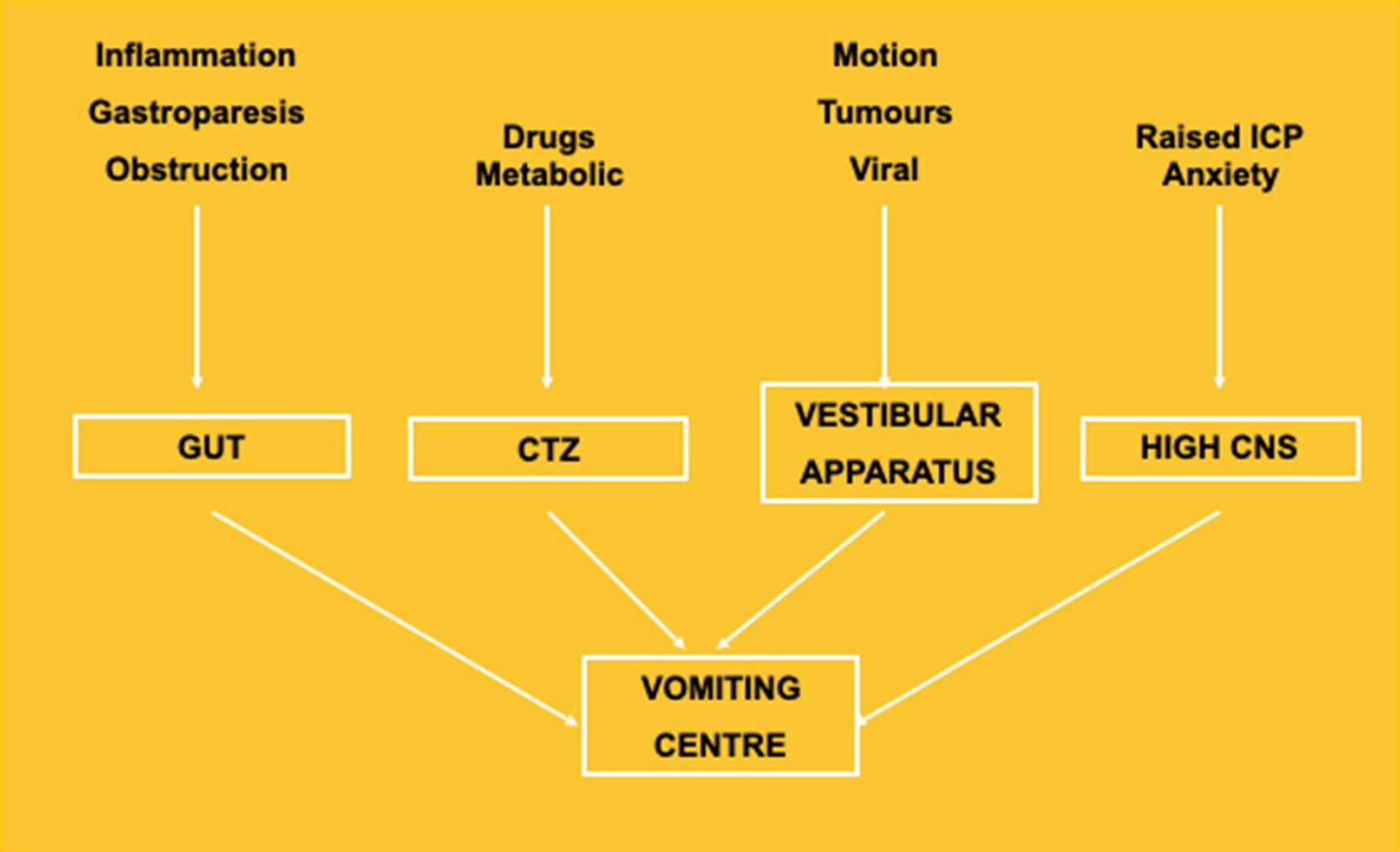
ALMOST ALL PATIENTS (85%) HAVING ANOREXIA

GASTRO-INTESTINAL SYMPTOMS

1. **Nausea and Vomiting**

2. **Bowel Obstruction**

1.1 NAUSEA & VOMITING

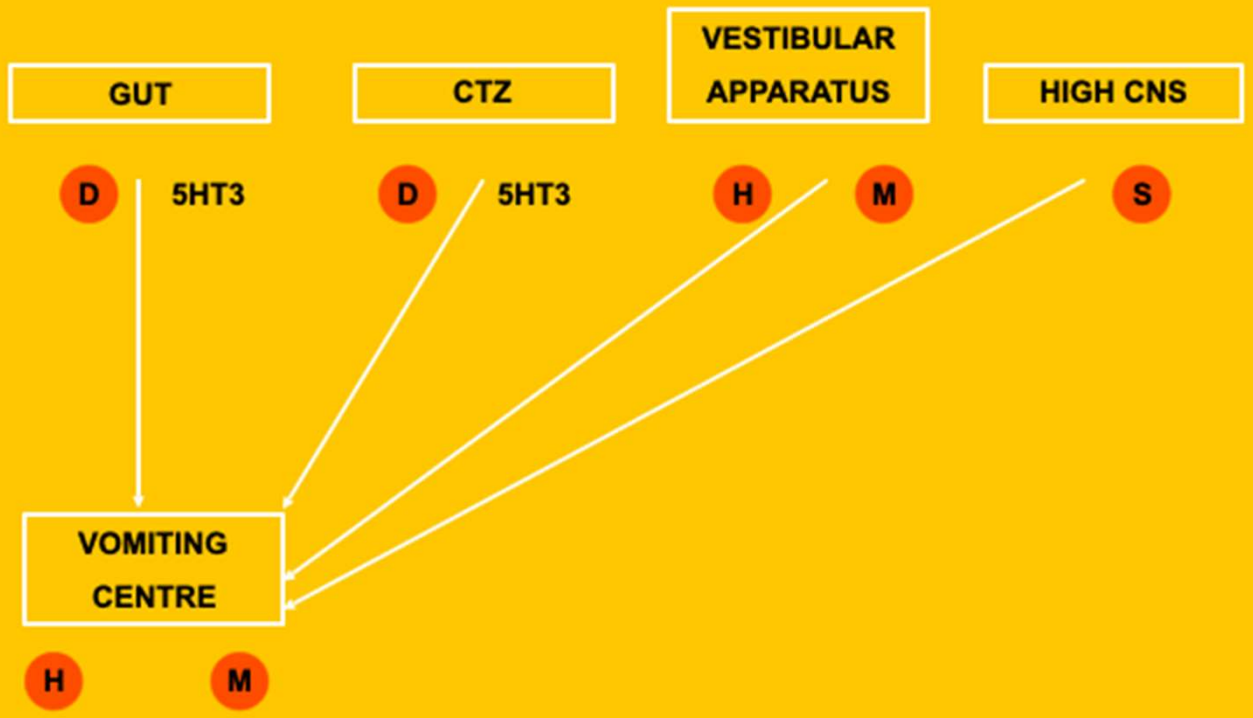


NAUSEA & VOMITING (CONT'D)

Common Drugs:

Metoclopramide	D
Haloperidol	D
Cyclizine	H
Hyoscine	M
Ondansetron	$5HT_3$
Dexamethasone	S

NAUSEA & VOMITING (CONT'D)



Metoclopramide	D
Haloperidol	D
Cydizine	H
Hyoscine	M
Ondanestron	SHT_3
Dexamethasone	S

NEW AGENTS

Levomepromazine (Nozinan)

Broad spectrum of activity

D - ++

H - +++

M - ++

5HT2 - +++

Helps pain, nausea and sedating

Side-effects: sedation, hypotension

BOWEL OBSTRUCTION

Multifactorial – mechanical obstruction, bowel paralysis

May be Acute or Subacute

May be total or partial

BOWEL OBSTRUCTION

1. Acute

IV Fluids

Nil orally

NG tube

Definitive Rx - surgery

BOWEL OBSTRUCTION

2. Sub-Acute

Prokinetics vs Antispasmodics (Buscopan)
Octreotide
Steroids

Should the patient eat and drink? – often happy to vomit once or twice per day

2.1 DYSPNOEA

1. **What Is Causing The Dyspnoea?**

2. **What Can Be Done About It?**

DYSPNOEA (CONT'D)

CASE STUDY:

A 60 Year old man who had NSCLC was diagnosed 8 months ago. He had radiotherapy at the time of diagnosis but the cancer was considered inoperable. He has no known distant metastases.

Q: What else does he probably have?

DYSPNOEA (CONT'D)

Until 1 month ago he was able to walk his dog to the park.

2 weeks ago he became SOB walking to his letter box and is now SOB at rest.

Q: Why has his dyspnoea worsened?

DYSPNOEA (CONT'D)

Respiratory Causes:

Infection (Pneumonia)

Pleural Effusion

Obstruction of Airway/Collapse

Pulmonary Emboli

Extension of Cancer

Lymphangitis Carcinomatosis

Other Causes:

Cardiac Failure - IHD, Pericardial Effusion

Anaemia??

DYSPNOEA (CONT'D)

Q: If none of the above conditions are found or treatable, what can we do to help his dyspnoea?

Simple Measures:

Rest, Reassurance, Modify Activities

Fans, Open windows

O_2

DYSPNOEA (CONT'D)

Drugs to Improve Dyspnoea:

1. **Bronchodilators**
2. **Steroids**
3. **Opioids such as Morphine**

   Tend to use p.r.n short acting preparations.
4. **Benzodiazepines**

   Short Acting

3.1 SPINAL CORD COMPRESSION (SCC)

WHO:

Lung,

Prostate

Breast

Kidney

Lymphoma

Multiple Myeloma

Unknown Primary.

SCC (CONT'D)

1. **Usually Extradural Compression**

   Venous Outflow Obstruction —> Oedema —> Raised Pressure —> Reduced Capillary Inflow —> ISCHAEMIA.

2. **Acute injury from bone fragments from pathological fracture.**

SCC (CONT'D)

WHERE:

Thoracic > Lumbar > Cervical

SCC (CONT'D)

SIGNS & SYMPTOMS:

- **Pain: local and radicular**
- **Weakness**
- **Loss of sensation**
- **Incontinence (retention)**

SCC (CONT’D)

INVESTIGATION:

- **MRI**

SCC (CONT'D)

TREATMENT:

1. **Steroids: Dexamethasone (16mg)?**
2. **Radiotherapy (Mainstay)**
3. **Neurosurgery**

SCC (CONT'D)

OUTLOOK:

Depends on functional status at time of diagnosis and tumour type.

Very poor if paraplegia established (5-10% chance of recovery only)

Good chance (60-80%) of maintaining ambulation if diagnosed early.

QUESTIONS?