How to Help When Others Say They Can't:

Practical Tips for Palliative and End of Life Care

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Faculty/Presenter Disclosure

- **Faculty: Dinesh Witharana**
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One more disclosure…

Family Medicine has one of the highest burnout rates (Shanafelt, 2012).

I found it **very difficult** to provide good palliative care in a traditional clinic setting.

Recognize it is a medical practice, not a medical perfect.

BUT, the more you do it, the more **rewarding** and **easier** it becomes.

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Objectives

1. Give examples of five key “tips” for healthcare professionals caring for patients with life-limiting illnesses

2. Identify and explain how primary care physicians can access palliative care resources for their patients (e.g. hospice, palliative home care)

3. Provide practical advice for treating commonly occurring medication or condition adverse effects in palliative care.

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Tip #1 : Start The Conversation Early

"Would I be surprised if this patient died in the next 12 months?"

The surprise question performs poorly to modestly as a predictive tool for death, with worse performance in non-cancer illness. (Downar, 2017)

But it is widely adopted and is currently probably the best we got.

Tip #1 : Start The Conversation Early

In Alberta, the vast majority (97%) of those who died in hospital also saw a doctor in the community in their last year of life (2012–2013).

Of people in Ontario and Alberta in 2016–2017 who died, nearly **two-thirds (62%)** were formally identified as palliative patients **only in acute care and usually in their last month of life.** (CIHI, 2018)

Tip #1 : Start The Conversation Early

Evidence shows that advance care planning conversations **improve patient and family satisfaction** with care and concordance between patients' and families' wishes, increase the completion of advance care planning documents, **reduce the likelihood of patients receiving hospital care and the number of days spent in hospital**, and increase the likelihood of receiving hospice care. (Choosing Wisely, 2017)

Tip #2 : Opioid Initiation for Malignant Pain

First Line: Morphine 2.5-5mg PO q4h prn
Hydromorphone 0.5-1mg PO q4h prn
Oxycodone (*difficult to get subcutaneous route)

Principles:

a. Always go with oral route if possible
b. Start low, titrate up
c. For constant pain, use a schedule
(i.e. q4h, q6h, BID, QID, etc.)

Tip #2 : Opioid Initiation for Malignant Pain

Principles (con't)

d. Calculate a breakthrough dose - usually 10% of total 24 hour scheduled dose
(i.e. Morphine 2.5mg PO q1h prn)

e. Prescribe a laxative (Sennoside ii tabs qhs or PEG 3350 17g)
- no evidence for docusate (Choosing Wisely, 2017)

f. Prescribe an antiemetic (i.e. Maxeran 10mg PO q4h prn)

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Tip #3 : Opioid Titration for Malignant Pain

Principles

a. Assess reason for increased pain (i.e. Tumor growth, new pain syndrome, opioid toxicity)

b. Consider adjuvants (dexamethasone, radiation therapy, neuropathic pain medication, etc.)

c. Calculate total 24 hour dose (Schedule + Breakthroughs) and divide by schedule
(i.e. Morphine 5mg q4h ATC and 2.5mg q1h prn - 4 BT in past 24 hours
= 30mg +10mg
= 40mg in 24 hours
= approximately 7.5mg q4h ATC and 5mg q1h prn)

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Tip #4 : Consider Delirium: “Pain” may not be Pain.

15-25% of hospitalized cancer patients

Up to 88% of terminal cancer patients (Lawlor, 2000)

Is is **highly distressing** to patients, families & caregivers

Alters patients ability to interpret stimuli and other symptoms, and express themselves

Makes assessment and management of other symptoms more difficult

UNDER-DIAGNOSED and UNDER-TREATED

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Tip #4 : Consider Delirium: “Pain” may not be Pain.

Drugs (i.e. opioid toxicity, benzos)

Infection (i.e. pneumonia)

Metabolic (i.e. Hypercalcemia)

Structural (i.e. brain mets)

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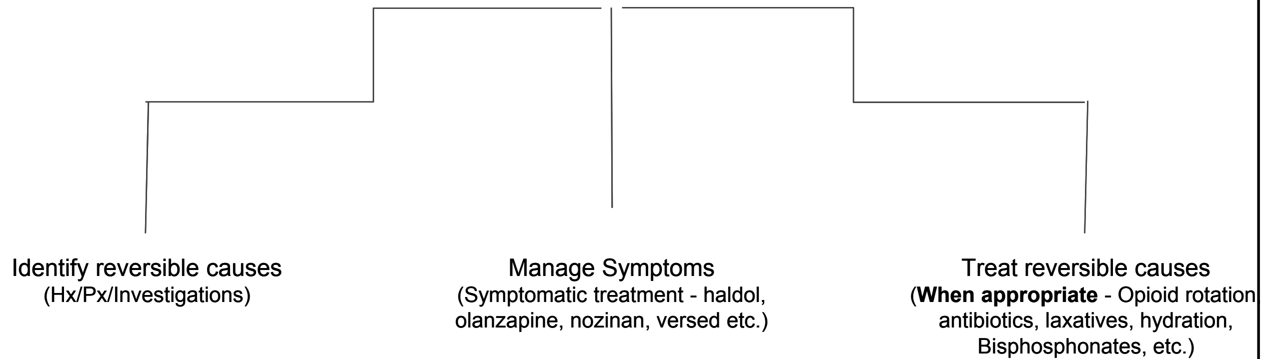
Tip #4 : Consider Delirium: “Pain” may not be Pain.



Tip #5 : Odansetron isn’t the Only Option

Causes: Medication (i.e. opioids), Delayed GI motility,
CNS disease (i.e. brain mets), Hypercalcemia, etc.

Management:

1st line - Maxeran
2nd Line - Odansetron (**constipating**)
3rd Line - Antipsychotics (i.e. Haldol)
Avoid: Gravol

Adjuvants: Dexamethasone, PPIs, Nystatin for Thrush

Palliative Care Resources: You

The majority of palliative care CAN and should be provided by Family Physicians

Resources:

On The Web: The Canadian Virtual Hospice
Palliative.org

On The Paper: Pallium Palliative Pocketbook

In person: LEAP courses
Victoria Hospice's 5-day Palliative Care: Medical Intensive (PCMI) course

Palliative Care Resources: Home Care

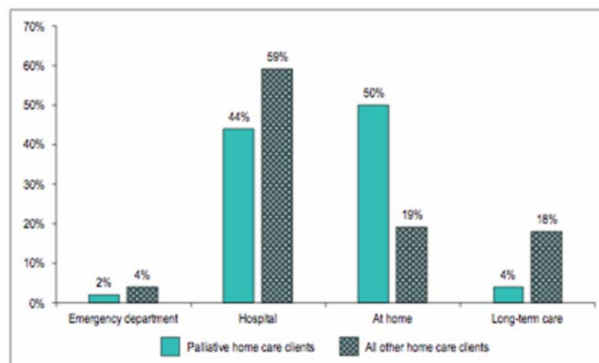
-You can contact 811 to be connected to a home care office in your zone.

-Request a home care referral form or refer by phone

In Edmonton - palliative home care is separate from regular home care - but same referral route

Palliative Care Resources: Home Care

Figure 5 Location of death in 2016–2017 for people who were home care clients in their last year of life, by client type



Notes
Includes deaths in Ontario and Alberta only.
"Hospital" refers to deaths in acute care, subacute care and complex continuing care.
Sources
Discharge Abstract Database, National Ambulatory Care Reporting System, Continuing Care Reporting System and Home Care Reporting System, 2015–2016 to 2016–2017, Canadian Institute for Health Information.

People who received palliative home care in their last year of life were **2.5 times more likely** to die at **home** than other home care clients

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Palliative Care Resources: Edmonton Zone

Patient is followed by the Cross Cancer Institute (CCI)
- Refer to Pain and Symptom Clinic at the CCI
- Psychological Services located at Westmount Shopping Centre (780-643-4303)

Patient is at home
get advice over the phone:
Call Community Care Access (CCA): (780)496-1300

request a consultant to visit the patient (nurse, NP or MD will visit and provide recommendations)
Referral form available via Community Care Access

Patient requesting admission to hospice:
request a consultant to visit the patient (nurse, NP or MD will visit and provide recommendations)
Referral form available via Community Care Access. **If urgent**, **call** on-call palliative care consultant via CCA

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Palliative Care Resources: Calgary Zone

Palliative Care Consult Service (403-944-2304)

In the City of Calgary, there is a Palliative Care Consult Team that serves:

- each hospital
- Tom Baker Cancer Center
- Home Care
- Continuing Care and Supportive Living sites

Outside the City of Calgary, a Rural Palliative Care Consult Team serves patients, families, and staff in all care settings in the rural areas.

Patient requesting admission to hospice:

- Patients require a referral from the Palliative Care Consult Service (403-944-2304)

Palliative Care Resources: Other Zones

South Zone

A physician's referral is required to access this service.For inquiries call 403-432-8350 or Community Liaison 403-432-8887.

Central Zone

Referral process: New clients need to call the toll free intake line at: 1-855-371-4122 weekdays from 8:15 a.m.to 9:30 p.m. and weekends from 8:15 a.m. to 4:30 p.m. Existing home care clients should contact their local office as normal.

Psychological Services: This service is located at the Central Alberta Cancer Centre or Red Deer Regional Hospital Centre. People dealing with end-of-life issues, grief, and loss of a loved one can request support and counselling. Call 403-343-4832.

North Zone

Referrals can be sent to Continuing Care Access. Call 1-855-371-4122 or fax 1-855-776-3805.

For after-hours questions call Edmonton Palliative Care Consultant at 780-496-1300

Other 24/7

Physicians can access palliative physician specialist on-call consultations, no matter where they are in Alberta, via **RAAPID** (Referral, Access, Advice, Placement, Information & Destination) if they have no direct access to Alberta Health Services consult schedules and access numbers

Adverse Effects: Conditions

Spinal Cord Compression - A Palliative Emergency

Cause: Compression of Spinal Cord/Nerve roots by Tumor

Symptoms: Back pain —> impaired sensation —> impaired motor function —> caudal equina/bowel and bladder dysfunction

Management: Consider Dex 16mg once, then 8mg qam and qnoon,
Refer to Neurosurgery or Rad Onc for consideration of MRI/urgent RT/neurosurgery

Adverse Effects: Conditions

Hypercalcemia

Cause: Elevated calcium, common in patients with bony mets or multiple myeloma (remember to correct for albumin)

Symptoms: Nausea, Constipation, Fatigue, etc. —> Delirium

Management: Fluids (i.e. Clysis, bolus via EMS)
Bisphosophonates (i.e. Pamidronate infusion)

Adverse Effects: Medications

Opioid Toxicity

Cause: Thought to be build-up of metabolites of opioid, higher risk with hepatic/renal dysfunction
Symptoms: Sedation, Vivid Dreams, Myoclonus, Allodynia, Hyperalgesia —> Delirium

Management: Fluids (i.e. Clysis, bolus via EMS)
Opioid Reduction
Opioid Rotation - Take total daily dose (+/- breakthroughs) and decrease by 30% to account for incomplete cross tolerance

Adverse Effects: Medications

Opioid Toxicity (continued) - use a conversion chart/calculator

Oral Morphine to Other Oral Opioids

	Ratio
Morphine —> Hydromorphone	5:1
Morphine —> Oxycodone	1.5-2:1
Morphine —> Codeine	1:10

Oral Morphine —> Subcutaneous/IV Morphine 2:1

Adverse Effects: Medications

Polypharmacy

Cause: Medications prescribed to palliative patients where limited benefits do not justify ongoing therapy.

Management: **STOP** Lipitor, Vitamin D/Multivitamins, Glicazide, Fibrates
REDUCE Metformin, Antihypertensives, Insulin
AVOID Benzodiazepines, Anticholinergics including Gravol
CONTINUE Synthroid, Heart Failure Medication for Symptoms, Allopurinol
DISCUSS ASA, anticoagulants,

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THANK YOU

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