
FAMILY
MEDICINE
SUMMIT
MARCH 6-8, 2020
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MARCH 6-8, 2020
Rimrock Resort Hotel | Banff, AB
65
Years
ALBERTA COLLEGE of
FAMILY PHYSICIANS

What Family Doctors Need to Know to Provide Excellent Palliative Care

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Mar 6, 2020
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Presenter: Aynharan Sinnarajah

- Speakers Bureau/Honoraria: Contract, Palliative Consultant Physician – Alberta Health Services (AHS); Medical Informatics Lead Physician – AHS; Academic research physician - Alberta Health Services, University of Calgary
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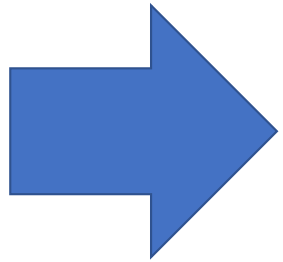
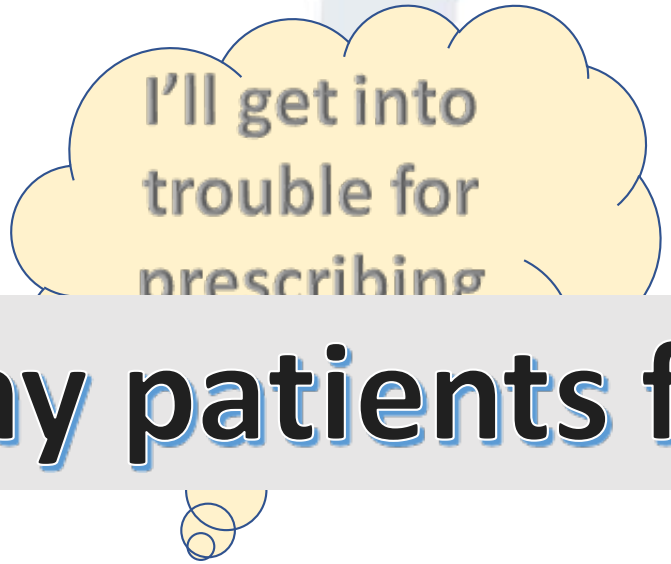
Learning Objectives

- Describe an approach to managing common palliative symptoms (dyspnea, nausea, delirium, bowel obstruction) in the palliative patient
- Explain different management approaches depending on underlying cause of pain in palliative patients
- Identify oncological emergencies
- Recognize the ways to access palliative care resources (including specialist consultation) in Alberta

Thank you!!!

- Dr Nicola Macpherson (BC Palliative Consultant Physician):
  - Slides (acknowledgment at bottom of slide) copied (with her permission)





I help my patients from cradle to grave!

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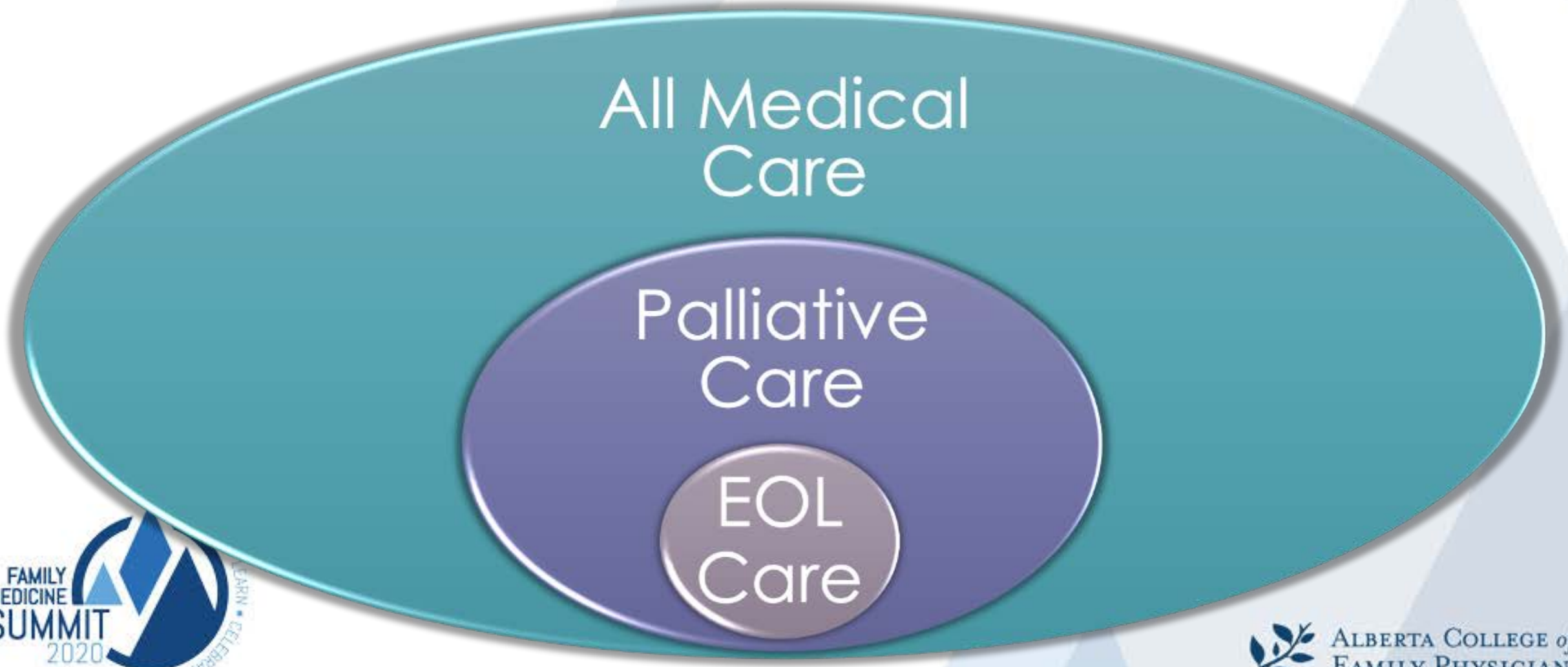
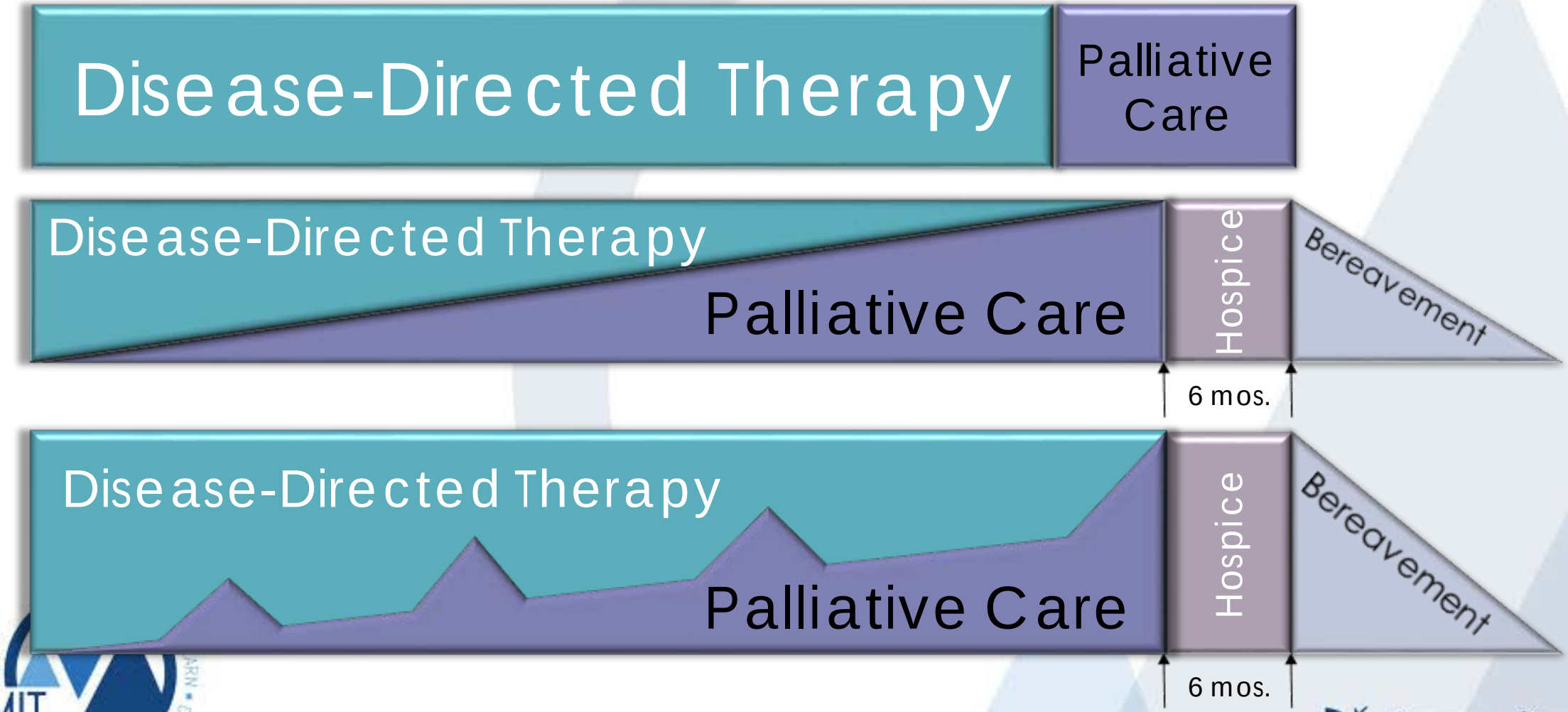
WHO Definition

Palliative care is an **approach** that improves the quality of life of patients and their families facing the problems associated with life-threatening illness

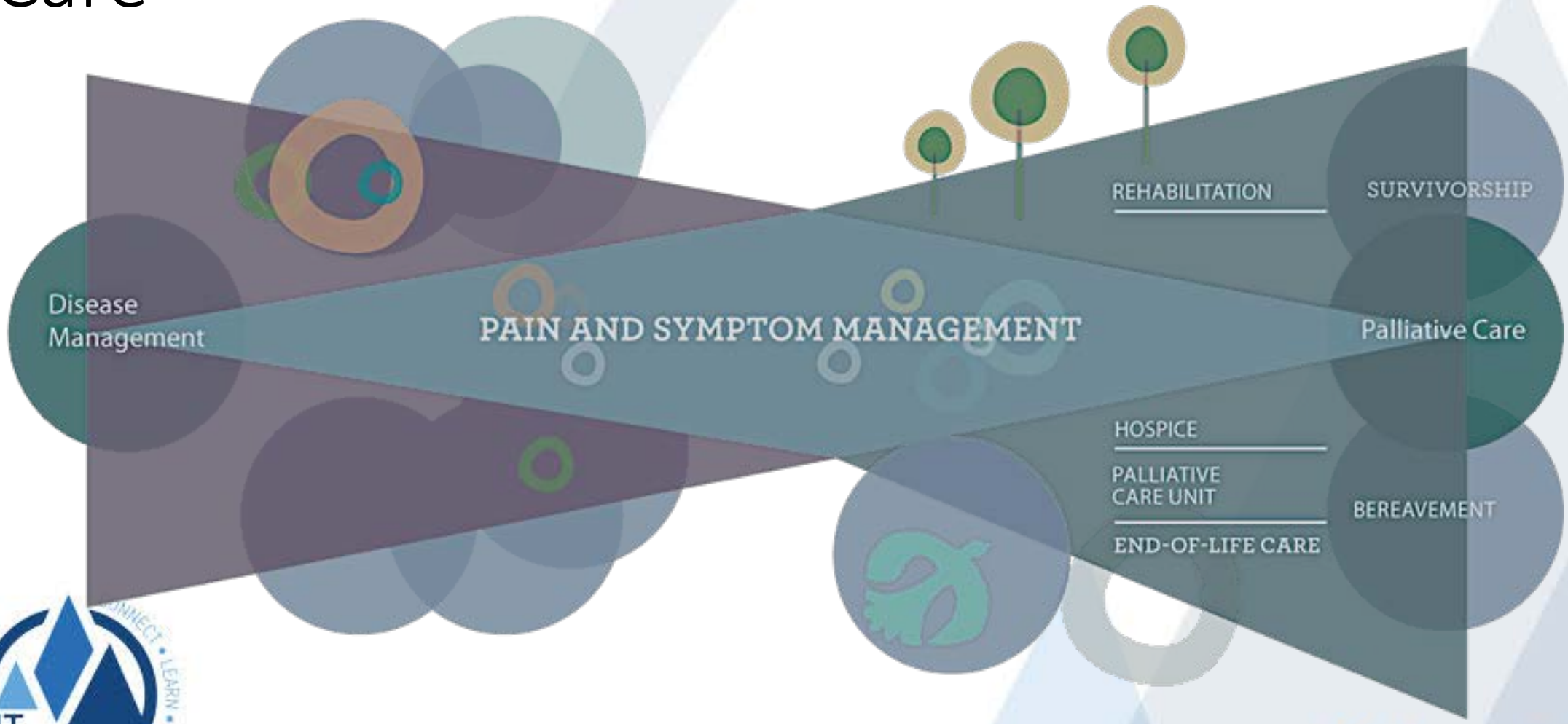
Clarifying Some Concepts



Older Modes of Thinking



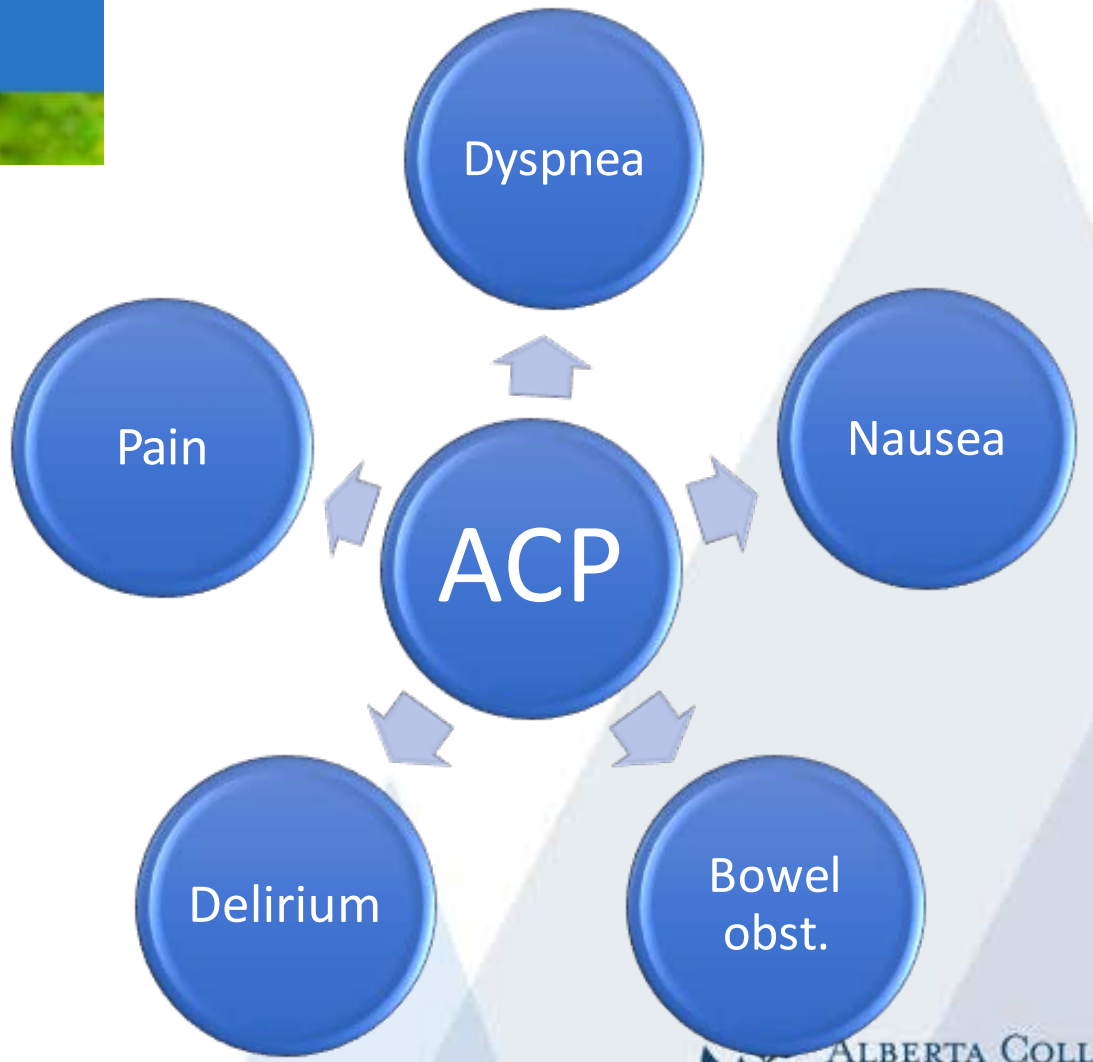
The Bow Tie Model of 21st Century Palliative Care



Hawley PH. The bow tie model of 21st century palliative care. J Pain Symptom Manage. 2014;47(1):e2-5.
Dr N Macpherson Slide

SATURDAY, MARCH 7, 2020

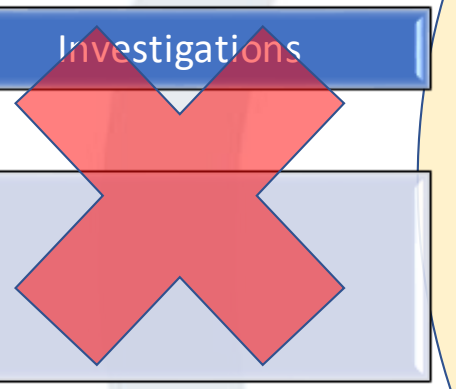
06:15–07:00	**Welcome the Day With Yoga!** (Dr. M. Churcher) Squash Court			
07:00	ACFP Registration Desk Opens			
07:30–08:15	Registrant Breakfast			
08:15–09:00	**Keynote: No Coverage/No Problem (Dr. M. Kolber & Mr. T. Nickonchuk)**			
09:00–10:00	**Alberta College of Family Physicians - Annual Meeting of Members (AMM)**			
10:00–10:30	**REFRESHMENT BREAK**			
Concurrent Workshops 10:30–11:15	**(2A) This is not ATLS - How to ACE a Trauma- informed Approach** *(Dr. K. Irwin)*	**(2B) Metacognition & Avoiding Clinical Errors in Medical Decision Making** *(Dr. V. Kiet Tran)*	**(2C) Teaching Tips in Community-Based Practice: Balancing the Learner and the Patient** *(Dr. S. Smith)*	**(2D) Advance Care Planning: Having These Important Conversations** *(Dr. A. Tan)*
11:15–11:30	**TRAVEL BREAK**			
11:30–12:15	**WorkshopRepeats**	**Workshop Repeats**	**Workshop Repeats**	**Workshop Repeats**



Alberta College of Family Physicians

General approach

Advance Care Planning

Etiology	Investigations
• Abcde • Uvwxy • …..	

Management

- Treat underlying cause
- Non-pharmacologic
- Pharmacologic

Dyspnea

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Dyspnea

- Subjective
- Predicts poor prognosis
- Often not related to SpO2
- Can be associated with anxiety
- Etiology
- Management:
  - Treat underlying cause
  - Non-pharmacologic
  - Pharmacologic

Dyspnea: Non-pharmacologic

- Energy conservation and breath control
- Air flow: Fan, open windows
- Environment: Cool, humid air
- Positioning: Upright, no abdominal pressure
- Support: Relaxation, ?acupuncture

https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Hospice-palliative-care/Dyspnea.pdf

Dyspnea: Pharmacologic

- Opioids (off-label, ++evidence): Start smaller and slower (more later)
  - No role for nebulized opioids
- Corticosteroids: Dexamethasone 8-24mg po/sc/iv od (off-label)
- ?Inhaled furosemide
- Methotrimeprazine 2.5-5mg q8h (off-label)
- Benzos (helps with anxiety): Lorazepam 0.5-2mg SL q2-4h PRN; Midazolam 0.5-1mg SC q1h PRN
  - Especially if crisis in last hours of life (with opioids) → q5-15mins PRN
- Oxygen: Very little evidence for benefit if not hypoxic

https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Hospice-palliative-care/Dyspnea.pdf

AADL Oxygen criteria: Palliative

(Updated Mar 1, 2019)

- A life limiting illness with prognosis < 6 months AND
- Documented shortness of breath (mMRC 3-4) despite appropriate non-pharmacologic and pharmacologic interventions, AND
- Resting SpO2 < 92% while awake x 3 minutes

Modified Medical Research Council (mMRC) Dyspnea Scale

	mMRC Grade
I only get breathless with strenuous exercise	0
I get short of breath when hurrying on the level or walking up a slight hill	1
I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level	2
I stop for breath after walking about 100 meters or after a few minutes on the level	3
I am too breathless to leave the house or I am breathless when dressing or undressing	4

Stenton C. *Occup Med (Lond).* 2008;58:226-227.

https://open.alberta.ca/dataset/82613368-7602-47a0-8e44-400e65dc1a6a/resource/e502a756-534e-41f7-ab9f-1ad9731f39c8/download/health-aadl-manual-r-respiratory-2019-02.pdf

Nausea

Mechanism of Action to Meds

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Matching Mechanism of Action to Meds 1

Chemoreceptor trigger Zone (Brain)	Drug Classes	Drugs of Choice
Nausea predominates, NOT relieved by vomiting: • Opioids • Chemotherapy • Liver failure • Uremia • Other toxins • Tumour emetogenic peptides • Hypomagnesemia • Hypercalcemia • Hyponatremia • Infection	Antidopamines	Methotrimeprazine
		Prochloperazine
		Haloperidol
	Mixed D2 & 5-HT	Metoclopramide
	Antiserotonins	Ondansetron
		Granisetron

Matching Mechanism of Action to Meds 2

Vestibular	Drug Classes	Drugs of Choice
• Motion sickness • Opioids • Acoustic neuroma • Metastases to base of skull • Labyrinthitis	Antihistamines	Dimenhydrinate
		Methotrimeprazine
	Anticholinergics	Hyoscine butylbromide

Dysmotility	Drug Classes	Drugs of Choice
• Stasis • Ileus	Mixed D2 & 5-HT	Metoclopramide
	Peripheral D2	Domperidone

Matching Mechanism of Action to Meds 3

GI Irritants	Drug Classes	Drugs of Choice
• Blood • Drugs	Antidopamines	Methotrimeprazine
		Prochloperazine
		Haloperidol
	Antihistamines	Dimenhydrinate
		Methotrimeprazine
	Mixed D2 & 5-HT	Metoclopramide
	Antiserotonins	Ondansetron
		Granisetron

Matching Mechanism of Action to Meds 4

Obstruction	Drug Classes	Drugs of Choice
• Bowel obstruction	Somatostatin Analogue	Octreotide
	Antidopamines	Haloperidol
	Anticholinergics	Hyoscine butylbromide

Higher CNS	Drug Classes	Drugs of Choice
• Anxiety, fear, anticipation, pain, sights, smells, memories	Benzodiazepines	Lorazepam
	Cannabinoids	Nabilone

Matching Mechanism of Action to Meds 5

Raised ICP	Drug Classes	Drugs of Choice
• Primary or secondary lesions	Steroids	Dexamethasone
	Antihistamines	Dimenhydrinate
		Methotrimeprazine

Bowel obstruction

Bowel obstruction

- Etiology
- Results
- Advance Care Planning
- Management:
  - Non-pharmacologic
  - Pharmacologic: 4-Anti

Management: Non-pharmacologic

- Bowel rest: NPO, Fluids
- Surgery?
- Stents: Duodenum, Colon
- Venting percutaneous gastrostomy

Management: Pharmacologic "4 Anti" Approach

- Anti-Pain
- Anti-Emetic
- Anti-Inflammatory
- Anti-Secretory

Rx – Palliative “4 Anti” Approach

Anti-Pain

- Calculate patient’s previous Daily Dose of opioid and convert to SC dose
- No studies to show any opioid to be better than any other

Rx – Palliative “4 Anti” Approach

Anti-Emetic

- Metoclopramide (unless complete MBO, with **no** flatus and **lots** of colicky pain)
  - 10mg SC qid
- Haloperidol (Less sedating) (off-label)
  - 2.5 to 5 mg per day
- Olanzapine (Zyprexa) (off-label)
  - 2.5 to 20 mg/day

Rx – Palliative “4 Anti” Approach

Anti-Inflammatory (i.e. steroids)

- Also potent antiemetic
- Reduces peritumour edema
- Meta-analysis in 1999:
  - Dexamethasone 4-8 mg SC od-bid (favoured resolution of MBO in advanced gyne and GI cancer)

Dr. Nicola Macpherson: 2018-05 Calgary Palliative Rotation

Tradounsky G. Palliation of gastrointestinal obstruction. Canadian Family Physician. 2012 Jun 1;58(6):648-52.

Rx – Palliative “4 Anti” Approach

Anti-Secretory

- H_2 Blocker
  - Ranitidine 50 mg SC q8h, more effective than Octreotide (less expensive; off-label)
- Octreotide 100-300mcg SC q8-12h

Dr. Nicola Macpherson: 2018-05 Calgary Palliative Rotation

Currow et al, Double-blind, placebo-controlled, randomized trial of octreotide in malignant bowel obstruction. J Pain Symptom Manage 2015.

Delirium


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Delirium: Etiology

- DIMS:
  - Drugs – Benzos, opioids, ….
  - Infections
  - Metabolic – Electrolytes, Fluid dehydration, Nutrition, Organ failure…
  - Structural – CNS, Retention, Restraints

Delirium Management

- Advance Care Planning
- Treat underlying cause
- Management:
  - Non-pharmacological
  - Pharmacologic

Delirium: Non-pharmacological

- Educate staff & family
- Limit room & staff changes
- Minimize interruptions
- Calm & comfortable environment; Dimly lit, quiet
- Clock & calendar
- Re-orient gently or go along with patient
- Encourage normal wake-sleep cycles

Delirium: Pharmacological management

- **Haloperidol** 0.25-0.5 mg PO q 8h PRN for severe distressing psychosis or aggression with significant risk of harm to self or other, NOT responsive to non-pharmacologic interventions X 48h, then reassess (Avoid in patients with Parkinson Disease or Lewy Body Dementia) (Not very sedating, even at maximum recommended doses of 5 mg/day)

Delirium: Neuroleptics

- **Risperidone** 0.125-0.25 mg PO BID PRN for severe distressing psychosis or aggression with significant risk of harm to self or other, NOT responsive to non-pharmacologic interventions, X 48h, then reassess (Caution in patients with renal failure) ***OR:***
- **Olanzapine** 2.5 mg PO daily PRN for severe distressing psychosis or aggression with significant risk of harm to self or other, NOT responsive to non-pharmacologic interventions, X 48h, then reassess ***OR:***
- **Quetiapine** 6.25-12.5 mg PO qHS PRN for severe distressing psychosis or aggression with significant risk of harm to self or other, NOT responsive to non-pharmacologic interventions, X 48h, then reassess **(Recommended for patients with pre-existing Parkinson Disease, Lewy Body Dementia or parkinsonism)**

Delirium: Benzos

- Last resort (usually) → Symptomatic control
- Can also be used for Rapid symptomatic control
- Midazolam 0.5-2.5mg sc q30 mins PRN
- Can be used in conjunction with neuroleptics
- Palliative sedation: Midazolam infusion (https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-palliative-sedation-adult-all-locations.pdf)

Pain (& Opioids)

Pain

- Types:
  - Nociceptive (Somatic, Visceral)
  - Neuropathic

- Management:
  - Non-pharmacological
  - Pharmacological: **OPIOIDS**, ….

Types of Pain

- Nociceptive - sustained by ongoing tissue injury
  - Somatic
    - Injury to bone, joints, muscles
    - “Aching”, “stabbing”, “sharp”, “throbbing”
    - Localized
  - Visceral
    - Injury to viscera, visceral capsules (pleura, myocardium), hollow organs
    - “Gnawing”, “crampy”, “aching”
    - Diffuse

Types of Pain

- Neuropathic - injury causing abnormal sensory processing in peripheral or central nervous system
  - Dysesthesia - “constant burning”
  - Neuralgia - “shooting”, “lancinating”, “shocks”
  - Allodynia, hyperalgesia

- Assess for Mental, Social, Spiritual distress (can exacerbate pain)

Pain: Non pharmacologic

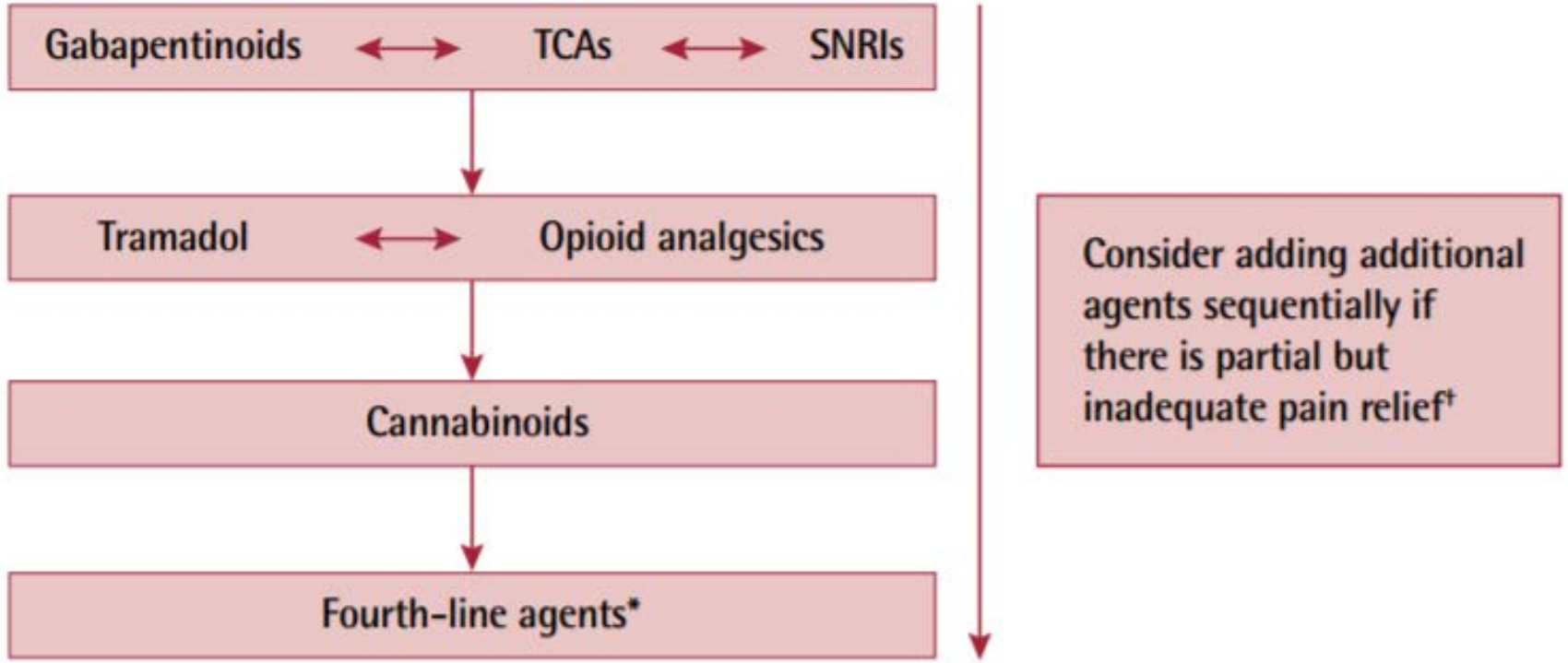
- Heat
- Ice
- Positioning
- Distraction, relaxation ….

Non-Opioids

- ASA/NSAIDS - Mild pain, tissue inflammation, arthritis, serositis and bone pain
  - Side effects
- Acetaminophen
- Adjuvants – Can reduce opioid requirements
  - Corticosteroids, antiepileptics, antidepressants, bisphosphonates?
- Ketamine

Neuropathic pain

Figure 1. Algorithm for the pharmacologic management of neuropathic pain



SNRI—serotonin-norepinephrine reuptake inhibitor, TCA—tricyclic antidepressant.
*Fourth-line agents include topical lidocaine (second-line for postherpetic neuralgia), methadone, lamotrigine, lacosamide, tapentadol, and botulinum toxin.
†There is limited randomized controlled trial evidence to support add-on combination therapy.
Adapted from Moulin et al.[7]

Mu et al. Pharmacologic management of chronic neuropathic pain: Review of the Canadian Pain Society consensus statement. CFP. Nov 2017

Pain: Other interventions

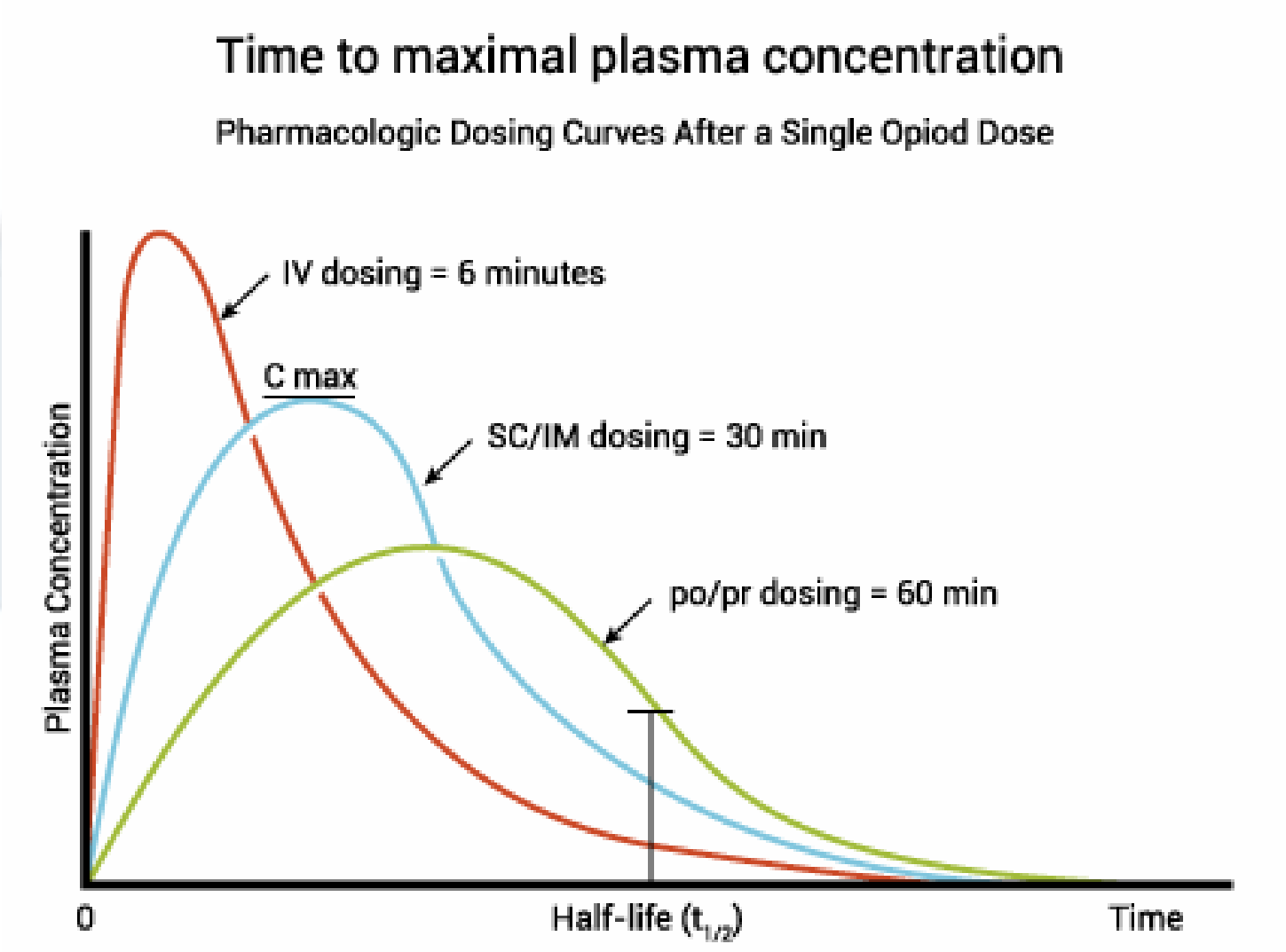
- Radiation Therapy
- Chemotherapy
- Surgery
- Neuraxial analgesia: Epidural, Intrathecal
- Psychosocial interventions

Opioids

- Codeine
- Tramadol
- Morphine
- Hydromorphone
- Oxycodone
- Fentanyl
- Methadone

Opioid Pharmacology

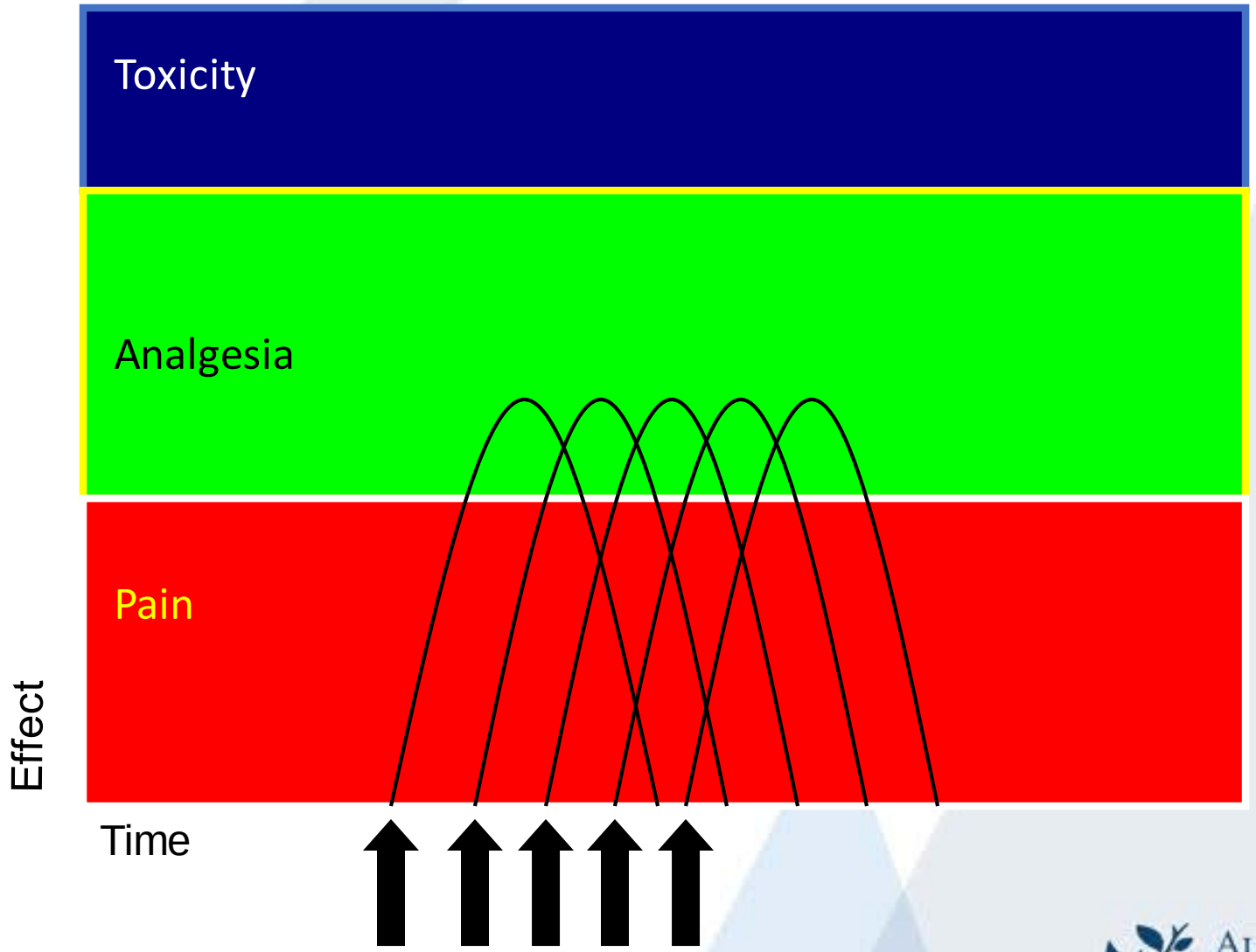
- T1/2 = 3-4 hours



https://geri-em.com/symptom-management/opioids/

Opioids

Round the Clock Pain = Round the Clock Dosing!



Palliative Medicine Resident Seminars: Pain
Dr N Macpherson slides

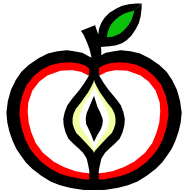
Use SHORT-ACTING Drugs to “Dose Find’

mg PO q 4h regularly

AND

mg PO q 1h PRN for BTP

OR



mg SC q 4h regularly

AND

mg SC q ½ h PRN for BTP

Don’t mix (usually)!

What dose?

Opioid-naïve, generally healthy younger adult:

Morphine IR 5 - 10 mg PO q4h ***AND***

2.5 - 5 mg PO q 1 h PRN for Breakthrough Pain

Opioid naïve, older patient:

Morphine IR 2.5 - 5 mg PO q4h ***AND***

2.5 mg PO q 1 h PRN for BTP

What dose?

For frail seniors, with compromised renal function, or who might become dehydrated:

Hydromorphone 0.5 mg PO q6h

AND

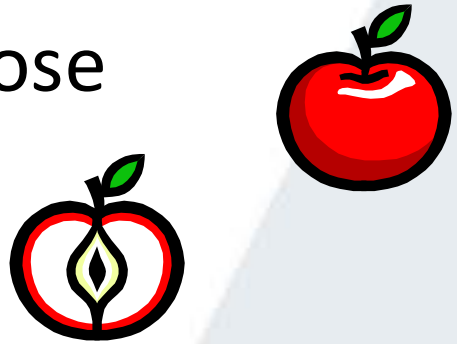
0.25 - 0.5 mg PO q2h PRN

How to titrate? (Method 1)

- Reassess, reassess, reassess!!
- Total up all of the opioid used in the previous 24 hours
- Divide by 6 to get the new q4h reg dose
- Half that dose is the new q1h BTD

How to titrate? (Method 2)

- If overall pain control is “fair” but could be better:
- Increase TDD by 20-ish%
- Divide by 6 to get the new q4h reg dose
- Half that dose is the new q1h BTD
- See if patient notes an improvement



Switching to Long-Acting (Contin)

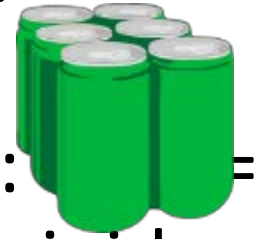
- Continue the previous q 4h short-acting opioid for 8-10 hours after starting the long-acting version
- Patient takes their first long-acting dose at 8, 9, or 10 AM and continues the q 4 h doses until the evening dose, then takes the long-acting only
- Continue the q1h PRNs for BTP
- First few days may be a little rocky until new equilibrium established

Calculating BTD when on LONG-ACTING drugs (Method 1)

- **10% of TDD**
- If:  = TDD of Long-Acting (Controlled Release) opioid
- Then:  = BTD (oral) q 1 h PRN of Short-Acting (Immediate Release) opioid
- Aiming for ≤ 3 BTD per 24 hours

Calculating BTD when on LONG-ACTING drugs (Method 2)

- **1/6th of TDD**



- If: = TDD of Long-Acting (Controlled Release) opioid

- Then: BTD (oral) q 1 h PRN of Short-Acting (Immediate Release) opioid
- Aiming for ≤ 3 BTD per 24 hours

Transdermal Fentanyl

- MUCH more potent than morphine
  - (100 mcg IV fentanyl ≅ 10 mg IV morphine)
- Patch strengths are in mcg/hr
- Delayed onset of the ***first*** patch as subcutaneous reservoir is established
- Need to overlap previous opioid (short-acting or long-acting) by 8-12 hours

Incident Pain

- Acute exacerbation of baseline pain intensity with movement/activity
  - Predictable - dressing changes, physiotherapy
  - Unpredictable - coughing, sneezing, etc
- Different from breakthrough pain, which is intermittent pain unrelated to a specific event
- Ideal PRN treatment
  - Fast onset of action
  - Short duration of action (and side effects)
  - Ease of administration for patient (at home and care settings)
- Lipophilic drugs increase transmucosal absorption = more rapid onset/offset
  - Fentanyl, Sufentanil

Opioid Side-effects

- Proactively manage
- Constipation: Always order laxatives (Senokot, …)
- Drowsiness: Subsides after few days
- Nausea / vomiting: Metoclopramide

Opioid Induced Neurotoxicity (OIN)

- Multifactorial syndrome: Confusion, Hallucinations, Delirium, Myoclonus, Seizures, Hyperalgesia
- Can occur with any opioids
- Often precipitated by opioid dosing increase
- If new OIN in patient with stable opioid dose (> 2 weeks), look for other precipitating causes (e.g. dehydration, infection, other drugs)

OIN: Treatment

- Rotate to another opioid ('automatic reduction' of 30%)
- Hydrate to flush out accumulated metabolites
- DO NOT discontinue opioids if you know they had pain or dyspnea, and underlying cause (e.g. cancer) hasn't gone away

Pain Vs. Delirium?

PAIN

- May be able to localize discomfort to site consistent with known pathology
- Irritable, restless, unable to sleep due to pain
- Facial grimacing, moaning due to pain
- Relieved by analgesics
- No change in behavior with haloperidol

DELIRIUM

- Unable to localize discomfort
- Irritable, restless, myoclonus
- Day/night reversal
- Facial grimacing, moaning
- No known pathology
- May worsen with analgesics
- May improve with haloperidol

Opioid Rotation

OPIOID EQUIANALGESIC DOSE TABLE			
Parenteral (mg)	**Drug**	**Oral (mg)**	**Ratio**
10	Morphine	20	-
2	Hydromorphone	4	5x
N/A	Oxycodone	13.33	1.5x
130	Codeine	200	0.1x
0.1	Fentanyl	N/A	100x

Fentanyl 25mcg/hr
= ~60-120mg po
Morphine per day

Opioid Rotation: Example

- Patient on morphine 5mg po q4h + 5mg po q1h PRN
- Now has OIN

So.. How do I rotate opioids again?

Opioid Rotation

- Step 1: Calculate total dose
  - 5mg q4h + 2 x 5mg BT (Average 24/h) = 40mg MEDD
- Step 2: Decrease by 20-30% for incomplete cross tolerance
  - 40mg x .75 = 30mg MEDD
- Step 3: Convert to new opioid using conversion chart
  - 30mg morphine = 6mg Hydromorphone
- Step 4: Give frequency and BT dose
  - Hydromorphone 1mg q4h with 0.5-1mg q1h prn
- *Titrate and once pain controlled and on steady dose, change to long acting formulation

Opioid Safety

- Opioid guidelines to minimize use apply to chronic non-cancer pain

2017 CANADIAN OPIOID PRESCRIBING GUIDELINE

GOOD PRACTICE STATEMENTS

Acquire informed consent prior to initiating opioid use for chronic noncancer pain. A discussion about potential benefits, adverse effects, and complications will facilitate shared-care decision making regarding whether to proceed with opioid therapy.

Clinicians should monitor chronic noncancer pain patients using opioid therapy for their response to treatment, and adjust treatment accordingly.

Clinicians with chronic noncancer pain patients prescribed opioids should address any potential contraindications and exchange relevant information with the patient's general practitioner (if they are not the general practitioner) and/or pharmacists.

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CDC Guideline for Prescribing Opioids for Chronic Pain

CDC developed the Guideline to provide recommendations for prescribing opioids for chronic pain to patients 18 and older in primary care outside of active cancer, palliative, and end of life care. The Guideline addresses:

- When to initiate or continue opioids for chronic pain;
- Opioid selection, dosage, duration, follow-up, and discontinuation; and
- Assessing risk and addressing harms of opioid use.

Opioid Safety: CPSA

- Standard of Practice – Prescribing: Drugs Associated with Substance Use Disorders Or Substance-Related Harm
  - Good assessment and re-assessments of pain
  - Discuss efficacy of other meds, potential side effects and expected benefits
  - Review PIN initially and regularly
  - (even though excludes cancer, palliative) ALSO:
    - Establish and measure and document pain & function goals
    - Screening for opioid risk
    - Re-assess patient regularly
    - Ensure measurable clinical improvement in function and/or pain

Oncologic Emergencies

RAPID FIRE

Oncologic Emergencies: A Guide for Family Physicians

- https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guide-oncologic-emergencies.pdf
- AHS CancerControl Alberta: Guidelines Resource Unit
- www.ahs.ca/guru

Advance Care Planning!!!

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Acute Bleeding

- Correct underlying coagulopathies
- Disseminated Intravascular Coagulation (DIC): Transfusions
- GI Bleeding (overt): Pantoloc, Octreotide, GI referral
- Hematuria: Cystoscopy, RT, Tranexamic acid
- Hemoptysis: RT, Bronchoscopy

- End of Life: Massive bleeding
  - Support & Non-pharmacological interventions (Dark towels / bedsheets)
  - Midazolam 2.5-10mg SC q10-30mins PRN

https://www.palliativecareguidelines.scot.nhs.uk/guidelines/palliative-emergencies/Bleeding.aspx

Brain mets, Increased Intracranial Pressure, Seizures

- Dexamethasone 8-16mg po/sc od
- Benzos: Diazepam
- Phenobarbitol, Phenytoin
- (no need for anticonvulsants in brain mets without history of seizures)

https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guide-cns011-dexamethasone.pdf

Febrile Neutropenia

(>38.3C) OR (>38.0C for >1 hour)

AND

Recent chemo within 1 month

AND

Absolute Neutrophic count < $0.5x10^9$ cells/L

ED or Call on-call Oncologist ASAP

Piperacillin-tazobactam 4.5g IV q8h

Spinal Cord Compression

- Dexamethasone 8-16mg po/sc od
- Urgent MRI
- Surgery >> Radiation therapy

Lancet. 2005 Aug 20-26;366(9486):643-8.

Direct decompressive surgical resection in the treatment of spinal cord compression caused by metastatic cancer: a randomised trial.

Patchell RA[1], Tibbs PA, Regine WF, Payne R, Saris S, Kryscio RJ, Mohiuddin M, Young B.

FINDINGS: After an interim analysis the study was stopped because the criterion of a predetermined early stopping rule was met. Thus, 123 patients were assessed for eligibility before the study closed and 101 were randomised. Significantly more patients in the surgery group (42/50, 84%) than in the radiotherapy group (29/51, 57%) were able to walk after treatment (odds ratio 6.2 [95% CI 2.0-19.8] p=0.001). Patients treated with surgery also retained the ability to walk significantly longer than did those with radiotherapy alone (median 122 days vs 13 days, p=0.003). 32 patients entered the study unable to walk; significantly more patients in the surgery group regained the ability to walk than patients in the radiation group (10/16 [62%] vs 3/16 [19%], p=0.01). The need for corticosteroids and opioid analgesics was significantly reduced in the surgical group.

Hypercalcemia: Myth of Correction!!!

- https://thischangedmypractice.com/myth-of-calcium-correction/

What I recommend (practice tips)

Formulae to adjust total calcium for the albumin concentration should be abandoned. The use of these formulae overestimates ionized calcium in patients with hypoalbuminemia, causing false negatives for hypocalcemia and false positives for hypercalcemia. Measurement of ionized calcium is now relatively inexpensive and is available in most hospitals and many outpatient settings.

1. Measurement of ionized calcium is recommended over total calcium when calcium homeostasis is in question.
2. If calcium is ordered as a 'screening' test without specific clinical suspicion for a disorder of calcium homeostasis, it is reasonable to assess unadjusted total calcium. If this level is abnormal, confirmation with ionized calcium may be sought prior to further workup or therapy.
3. Where ionized calcium is not available, total calcium should be assessed without the application of any correction formula.
4. Order serum albumin only if clinically indicated for reasons other than adjusting total calcium.

Other

- Airway obstruction
- Hyperviscosity syndrome
- SIADH: Syndrome of Inappropriate Antidiuretic Hormone secretion
- Tumour Lysis Syndrome

Alberta Palliative Care resources

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AHS Provincial Palliative Care

- https://www.albertahealthservices.ca/info/Page14559.aspx

Tools & Resources

- Assessment Tools
- Resources
- Patient Resources – MyHealth.Alberta.ca
- Programs & Services
- Knowledge Resource Service

Policies, Guidelines & Initiatives

- Patient's Death in the Home Care Setting
- Advance Care Planning / Goals of Care
- EMS PEOLC Assess, Treat & Refer
- Continuing Care - Policies, Procedures & Standards

Education & Publications

- Newsletter
- Courses & Conferences
- Palliative Care Dashboards
- Palliative Care Tips

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Palliative Care Tips

Palliative & End of Life Care (PEOLC), Info for Health Professionals

- Assessment and Management of pain in older adults with moderate to severe dementia
- Anticoagulation in patients with advanced cancer cared for at hospice/palliative care units in Edmonton
- Palliative Radiotherapy
- Total Parenteral Nutrition (TPN)
- Access to Palliative Home Care & Palliative Care Consultation Service in the Edmonton Zone
- Management of Noisy Respiratory Secretions in the final hours to days of life
- Hydration
- Bowel Obstruction in Advanced Cancer
- Cancer Pain
- Hypercalcemia of Malignancy
- Approach to Infections in Advanced Disease
- Nausea & Vomiting in advanced cancer
- Dyspnea/Breathlessness
- Constipation in Advance Illness
- Delirium in patients with advanced cancer and those who are imminently dying

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AHS Cancer Guidelines

www.ahs.ca/guru

▼ Palliative & Supportive Care

Guidelines

- Cancer Pain
  - Summary for Health Professionals
- Cancer-Related Fatigue
- Chemotherapy Induced Peripheral Neuropathy
  - Summary – Chemotherapy Induced Peripheral Neuropathy
- Chemotherapy & Radiotherapy Induced Nausea/Vomiting
  - Summary – Chemotherapy & Radiotherapy Induced Nausea/Vomiting
- Influenza Immunization
  - Clinical Factsheet
- Metastatic Colorectal Cancer: Early Palliative Approach
  - Interactive Care Pathway
  - Referral Based Services for Advanced Cancer Care
  - Local Tips for Providers
  - Advanced Cancer Shared Care Letters
    - Sample Physician Letter
    - Sample Patient Letter
  - Introducing Palliative Care: Tips for Health Care Professionals
- Oncologic Emergencies
- Palliative Radiotherapy: Brain Metastases
- Palliative Radiotherapy: Bone Metastases and Spinal Cord Compression
- Palliative Radiotherapy: Superior Vena Cava Obstruction, Dyspnea, and Hemoptysis
- Palliative Radiotherapy: Bleeding and Gastrointestinal Obstruction
- Pneumococcal Immunization in Patients with Cancer
- Prevention and Management of Venous Thromboembolism in Patients with Cancer
  - VTE: A Guide for Patients with Cancer (this resource was developed and is maintained by Provincial Patient Education, CancerControl Alberta)
- Tobacco Cessation
  - 11x17 poster: Breathe Easier Through Your Cancer Treatment
  - Trifold poster: Breathe Easier Through Your Cancer Treatment

Symptom Management Summaries

- Anxiety
- Depression
- Oral Care
- Tenesmus
- Sleep Disturbance

Additional Resources

- ASCO Anxiety and Depression Guideline
- ASCO Fatigue Guideline
- CAPO Pan-Canadian Sleep Disturbances Guideline

24/7 Palliative Physician On-Call Service

Palliative & End of Life Care (PEOLC), Info for Health Professionals

- 7 days a week
- Any setting

RAAPID North (for patients north of Red Deer, Alberta)
1-800-282-9911 (Canada ONLY)
780-735-0811

RAAPID South (for patients in and south of Red Deer, Alberta)
1-800-661-1700 (Canada ONLY)
403-944-4486

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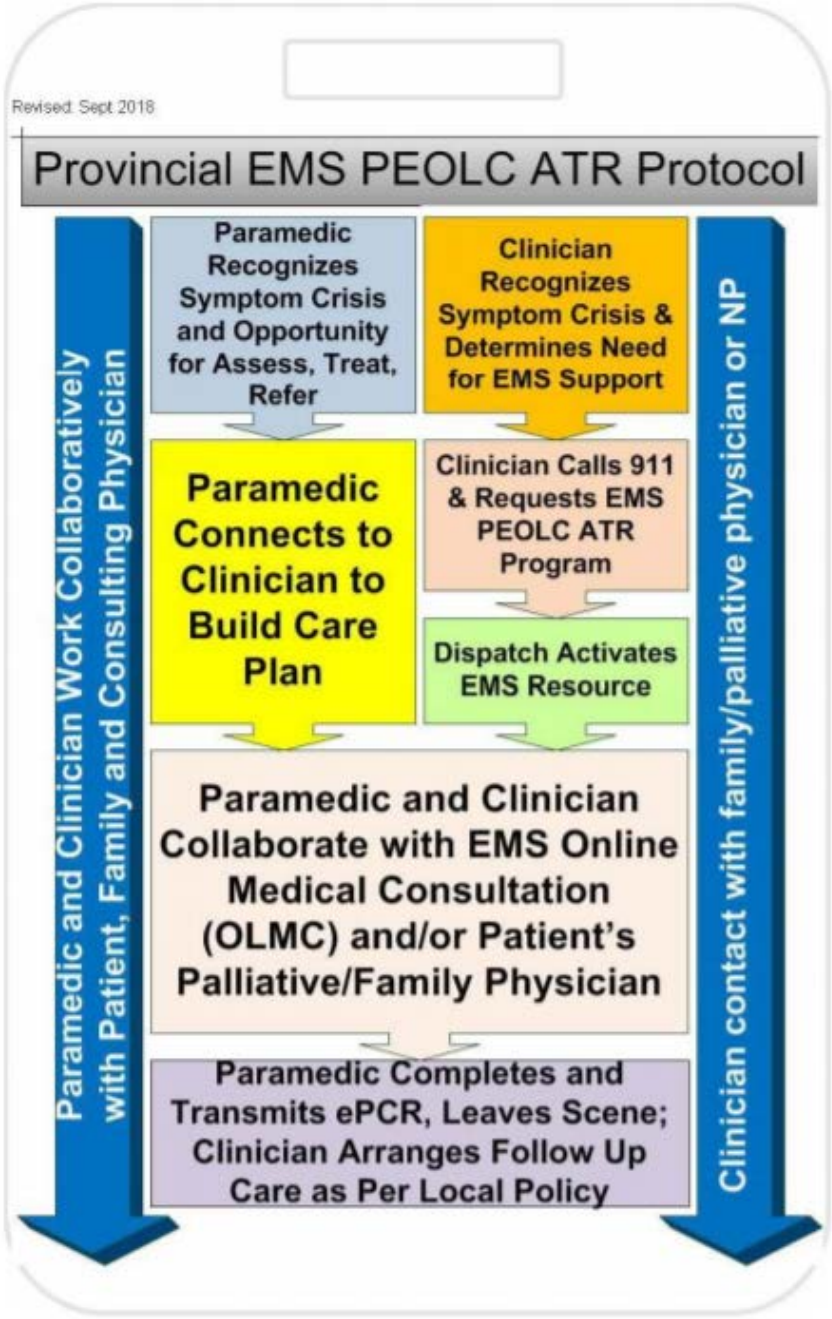
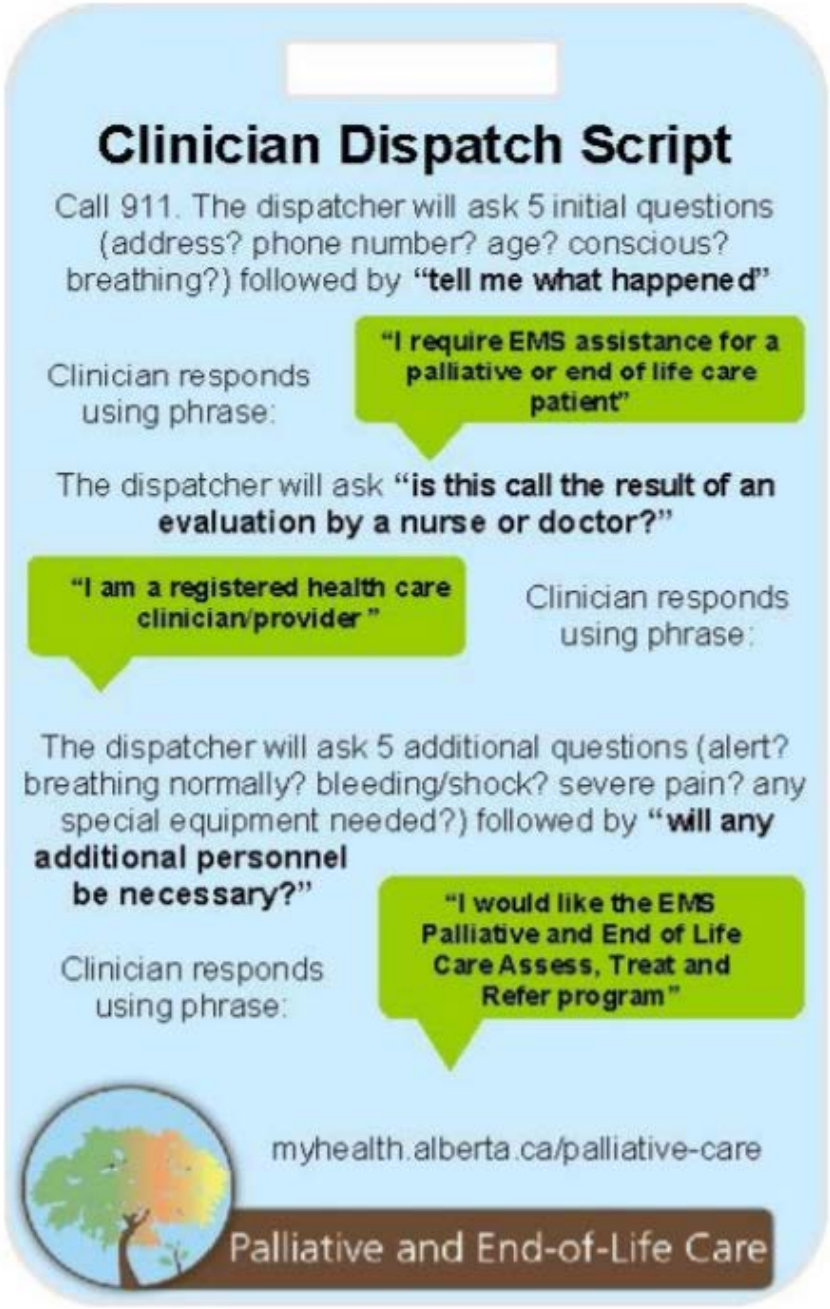
EMS





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LEGE of ICIANS

Calgary

Primary Care Networks
CALGARY AND AREA

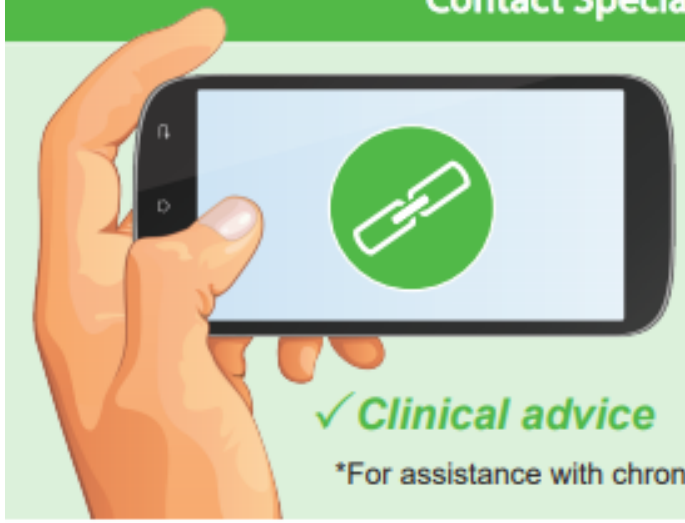
Specialist *LINK*

Alberta Health Services

PRIMARY CARE ACCESS TO PALLIATIVE CARE

NON-URGENT ADVICE

Contact Specialist LINK or make an eReferral Advice Request



Local: **403.910.2551** | Toll free: **1.844.962.5456 (LINK)**

specialistlink.ca

Get a call-back within **one hour!**

✓*Clinical advice* ✓*Confidence* ✓*Clarity* ✓*Conversation* ✓*Collaboration*

*For assistance with chronic non-cancer pain, consider Specialist LINK chronic pain or referral to chronic pain clinic

Log into Alberta Netcare and submit your questions electronically

albertanetcare.ca/ereferral.htm

Get a response within **five calendar days!**

✓*Supports patients* ✓*Secure* ✓*Specialty-specific* ✓*Submit online*

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https://www.specialistlink.ca/files/PalliativeCareAccessPathwayAug2019links3.pdf

Alberta College of Family Physicians

Summary

I help my patients from cradle to GRAVE

- Palliative care >> End of life care
- Pain: Nociceptive (Somatic, Visceral) vs Neuropathic
- OPIOIDS: Starting, 
- Bowel obstruction: Ranitidine / Octreotide / Dexamethasone
- Dyspnea: Oxygen if hypoxic
- Nausea: Mechanistic approach
- Oncologic emergencies: ++, Calcium correction myth
- References & Call a Friend: RAAPID / Specialist Link

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THANK YOU

ayn.sinnarajah@ahs.ca

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