

Palliative Medicine Overview

Francine Arneson, MD

Palliative Medicine

Palliative Medicine: Definition

- Palliative care: “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.”

<http://www.who.int/cancer/palliative/definition/en/>

Palliative Medicine

- Symptom Management
- Define goals of care
- Hospice referrals
- * * Excels in communication and facilitation of transitions and continuity across care settings
- * * Most effective when initiated early in course of illness and continued throughout disease process, can be utilized at any stage of an illness

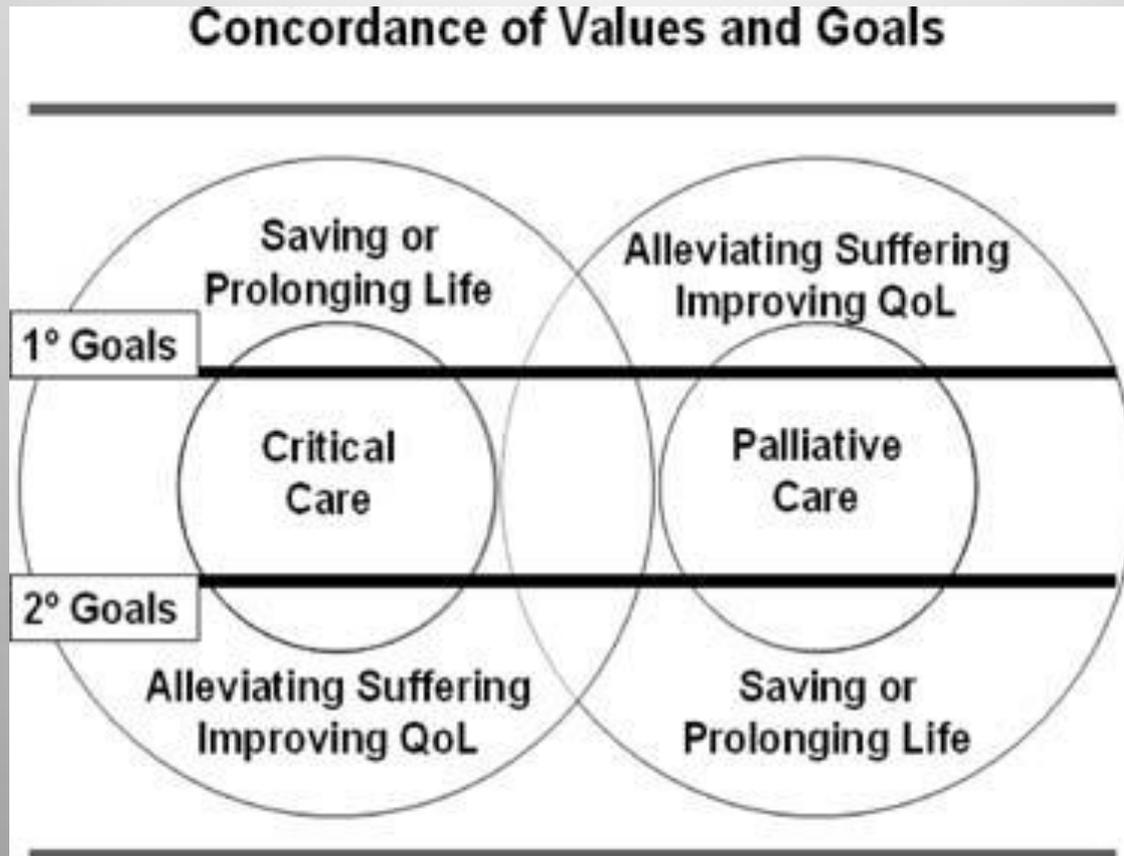
What is hospice?

- Patient, family, and many healthcare provider perception:
 - A place where people go to die
- Reality:
 - Not a place, a philosophy of care: Live as well as we can for the time that we have
 - Goal is to neither not prolong nor hasten the end of life
 - Can be provided in different settings and different levels of care

What are the differences?

Palliative Medicine	Hospice
- Consult only	- Ongoing comprehensive care
- Do not meet hospice criteria or do not embrace hospice philosophy of care	- Terminal illness with life expectancy of < 6 months and embrace philosophy
- Can be utilized in conjunction with curative treatments and skilled care	- Typically not utilized in conjunction with Medicare skilled level of care or with disease-modifying therapies
- Business hours	- 24 hour availability
- Does not cover DME, supplies, meds, or treatments	- Covers all meds, DME, supplies, and treatments that are related to terminal prognosis

Palliative Medicine and Critical Care



Improving palliative care in intensive care units: Identifying strategies and interventions that work

Ira Byock, MD

Crit Care Med 2006 Vol. 34, No. 11

When to Refer to Palliative Medicine.....



"There's no easy way I can tell you this, so I'm sending you to someone who can."

ART.
COM

Palliative Medicine Consultation

- Symptom Management
- Goals of Care
- Hospice Information

Palliative Medicine Referral Triggers

- Uncontrolled pain or symptom
- Poly-pharmacy
- Decline or weight loss
- Prior to PEG, dialysis, other aggressive measures in frail, elderly
- Frequent falls
- Multiple hospitalizations
- Uncertainty about prognosis

Palliative Medicine Referral Triggers, continued....

- **Communication:**
 - Questions regarding aggressive versus comfort care
 - Unrealistic expectations
 - Confusion among family members regarding expected clinical course and prognosis
 - Discussion of advance directives (Living wills, POST forms, Surrogates)

Common Symptoms

- Pain
- Dyspnea
- Anxiety
- Nausea
- Constipation
- Agitation
- Fatigue

Symptom Management

- Always looking for lowest dose to achieve symptom management to limit side effects
- Sometimes need to choose between comfort and alertness

Pain

- Depending on location, quality, severity, etc
- Neuropathic versus nociceptive?
- Mild?
- Moderate-severe
- Myths about narcotics
- Equivalent doses, conversions, side effects, huge therapeutic window
- Therapeutic index= toxic dose/effective dose
 - Anxiolytics (100:1), Narcotics (70:1), alcohol (10:1), digoxin (2:1)
- Other adjuvant therapies: Steroids, radiation, NSAIDS, etc



Dyspnea

- Fan
- Cooler temp
- O₂, nebs, inhalers, etc
- Narcotics
- Treat anxiety if present....

Anxiety

- Chronic: SSRI's
- Acute, episodic: Benzos
- Underlying symptom causing distress (pain, etc)



Nausea

- Serotonin antagonists: Zofran, Kytril, Anzemet (1st line for chemo/radiation)
- Dopamine antagonists: Haldol, compazine, reglan, benadryl
- Steroids
- Antihistamines: Benadryl, dramamine, meclazine, phenergan
- Anticholinergics: Scopolamine
- Cannabinoids: Marinol
- Anxiolytics: Benzos
- BAD-R pump



Constipation

- When using narcotics, never forget to think about a bowel regimen
 - Easier to prevent than fix
- Senna-s, titrate
- Miralax
- Lactulose, mag citrate, MOM
- Suppositories
- Enemas



Agitation

- What is causing it—think about pain in dementia patients
- Anti-psychotics, schedule if needed



Fatigue

- Think about underlying condition and treat if possible (sedating meds, infection, electrolyte imbalance, sleep disturbance, etc)
- Energy Banking, Exercise
- Drug Therapy
 - Stimulants
 - Methylphenidate
 - Modafanil
 - Steroids



Nutrition

- Artificial nutrition
- Pleasure feeding
- Agents to stimulate appetite



Goals of Care

- There is no “one right answer”
- Palliative care tries to assess:
 - What the patient/family understands medically
 - How the patient was at baseline and what are acceptable qualities of life for that particular person
 - Is it medically possible to achieve that quality of life and what we need to do to try
 - If not, what are the realistic options
- *The goal we are trying to reach is more important than the procedures needed to reach it*

So What is Hospice?



Hospice Criteria for Admission

- Prognosis of 6 months or less if disease runs usual course (statement by attending physician and hospice physician)
- The patient chooses the philosophy of care (comfort as opposed to curative measures) and sign a statement choosing the benefit over other routine Medicare covered benefits
- Medicare Part A coverage, most private insurance plans also cover, many charity cases accepted for care by hospice organizations

So what are the barriers?

- My patient is not sick enough, I am not ready
- My patient is “not ready”, I don’t want to take away hope
- There are more things we can still do



"You've got six months, but with aggressive treatment we can help make that seem much longer."

Is my patient sick enough?

How can I be sure?

- Are we accurate in our prognosticating?
- Can we tell when our patients are sick enough?





Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study.

Christakis NA, Lamont EB

Department of Medicine, University of Chicago Medical Center, Chicago, IL 60637, USA.

- Only 20% (92/468) of predictions were accurate (within 33% of actual survival)
- 63% (295/468) were overly optimistic and 17% (81/468) were over pessimistic
- Doctors overestimated survival by a factor of 5.3

Implications

- Most all physicians regardless of specialty overestimate life expectancy
- The better a physician knows his patient, the more likely he will err in determining prognosis
- Experienced physicians are more likely to make accurate predictions



Trajectories

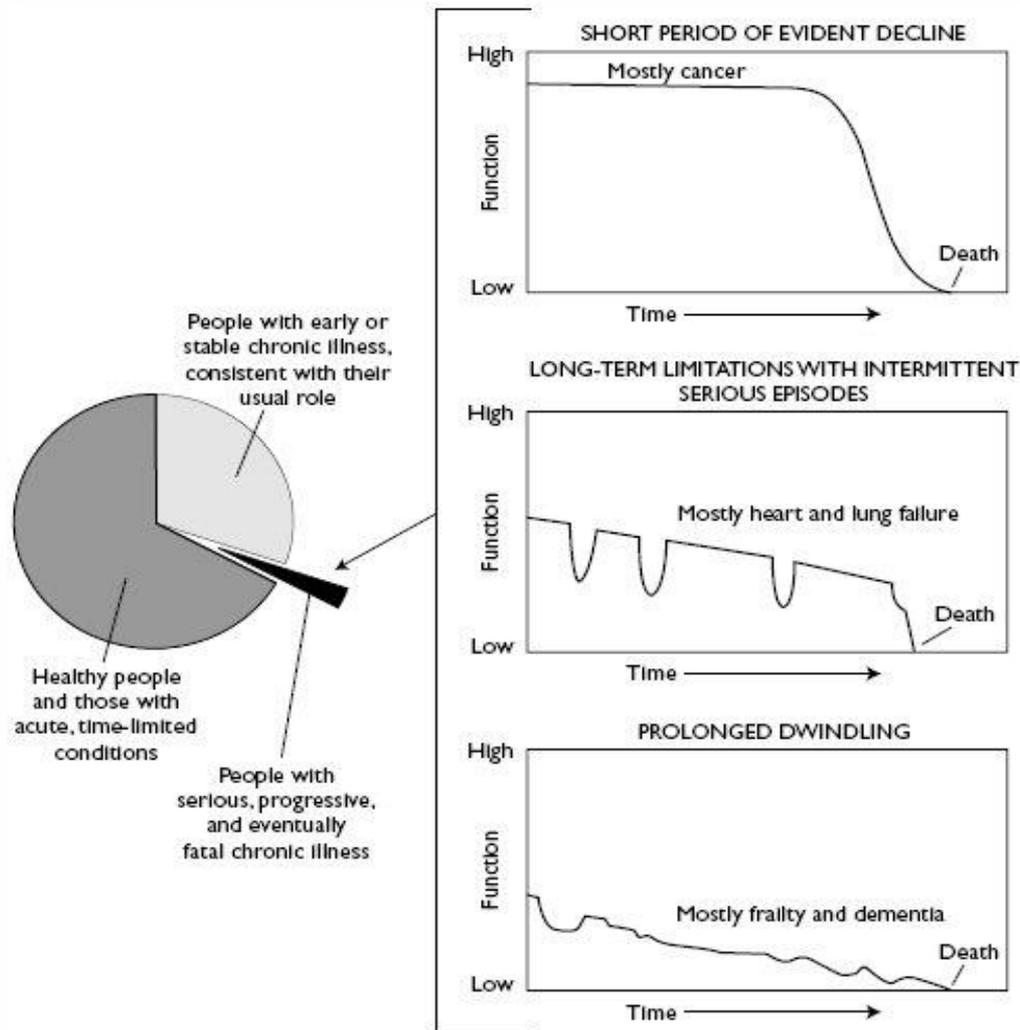


Figure 5. Trajectories of eventually fatal chronic illnesses. Source: Lynn and Adamson 2003.

What do patients want from us?



Barriers continued:

- Won't it just make my patient die quicker?
 - “Every time I send a patient to hospice, they die within days”
 - “Maybe you are waiting too long to refer them?”

Hospice Facts

- In 2010 ~42% of deaths in US under hospice care
- Median length of service 19.7 days

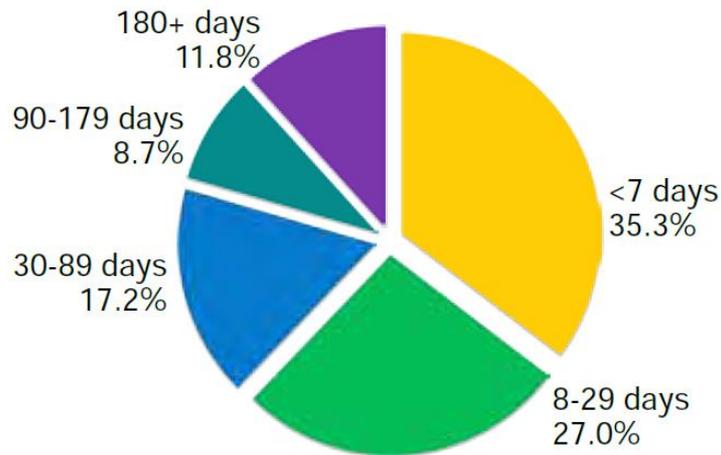


Figure 6. Proportion of Patients by Length of Service in 2010¹



Figure 3. Hospice Utilization in U.S.

Palliative Medicine Consultation

- Just like any other consult (cardiology, ID, etc)
- Currently inpatient consultation service only
- Make recommendations to team
- Follow-up visits as needed

