Hot Topics In Palliative Medicine

Gregg VandeKieft, MD, MA
Medical Director for Hospice & Palliative Care
Providence St. Peter Hospital, Sound Home Care & Hospice

Rebecca Hawkins, MSN, ANP, AHPCN
Providence Palliative Care System Coordinator,
Palliative Care Nurse Practitioner

Objectives

• At the end of this session, participants will be able to:
  – List 3 “hot topics” in hospice & palliative care
  – Describe the role of the interdisciplinary team in caring for patients with complex symptom management needs

Disclosures

• Neither Gregg VandeKieft nor Becca Hawkins have any financial conflicts of interest to disclose.
Palliative Care During Active Cancer Treatment

Case 1

- 67 year old woman newly diagnosed with Multiple Myeloma
  - Planning for chemotherapy, has not started yet
  - Admitted to hospital with out-of-control bone pain from pelvic and spine lesions; also very nauseated
  - Hospitalist consults Medical Oncology, Radiation Oncology, and Palliative Care

Coordinated Care

- Medical Oncology recommends a newer chemo agent that, while not curative, will prolong life and be well tolerated
- Palliative Care manages pain and nausea
  - PCA hydromorphone, transitioning to an oral regimen
  - Extensive discussion about home caregiving arrangements, long-term treatment goals, etc.
- Radiation Oncology begins XRT to pelvis and spine
Evidence Supporting Palliative Care During Active Cancer Treatment

PC during active cancer treatment

- 151 patients at MGH Cancer Clinic with newly diagnosed non-small cell lung cancer
  - Half the group received outpt PC by MD and ARNP
- Outcomes – group that had PC reported
  - Better quality of life
  - Improved symptom
  - Less depression
  - Less like to receive aggressive end-of-life care
  - Longer life – 11.6 vs 8.9 months

Is PC available to cancer patients?
Models for concurrent care

- Massachusetts General Hospital
  - Board certified physician and specialized ARNP
- Providence Regional Cancer System, Olympia
  - Pilot supported by Providence ACT grant program
  - Palliative care social worker and physician assistant working in oncology practice
  - Objective: >75% of patients with high mortality cancers referred to palliative care at onset of cancer treatment
- Providence Partners in Palliative Care, Everett
  - Palliative care RN based in primary care practices
  - Patients may be referred whenever clinician "would not be surprised" if patient would die with 2 years

HOT TOPIC?

- What barriers prevent cancer patients from receiving palliative care during active cancer treatment?
- How can PC providers build collaborative relationships with oncologists and cancer programs?
- What model of palliative care team can effectively serve cancer patients in your community?
- How can discussions about treatment goals be done in a way that doesn't take away hope?
- What other chronic illnesses would benefit from early intervention by a palliative care team?

Collaborative Management of Complex Symptoms
Walt’s Story

• 43yr old with squamous cell of the right ankle
• Metastasis to the right groin (within a year)
• Football coach
• Family man
• Man of faith

Treatment for Walt

• Initial treatment with surgery and radiation
• Delayed diagnosis of reoccurrence
• Reoccurrence Treatment
  – Resection
  – Chemotherapy
  – Pain management
  – Drainage control

Drainage Control

• Started with a JP drain
• Multiple trials of absorbent dressings
• Ended up with wound vac

• Required wound debridement every 3 days under general anesthesia
Wound Management

- Odor Control
  - Charcoal dressings
  - Metronidazole (flagyl) crushed

Pain Assessment

- Physical Pain
  - Both visceral and nerve pain
- Emotional Pain
  - Numerous Losses
  - Deep love for family
- Spiritual Pain
  - Confused about his calling
  - Where was God in his suffering

Pain Management

- Progressed through hydrocodone, morphine, oxycodone, and hydromorphone, with escalating doses
- Added fentanyl patches without much improvement
- Eventually added methadone with short-acting opioid for breakthrough pain
- Also lorazepam and gabapentin with opioids
- Trialed steroids without much success
Local Pain Management

- Started with a lidocaine infusion through wound vac
- Moved to cocaine instillations
- Propofol infusions at bedside

Other Pain Measures

- Began ketamine infusion
  - Turned into a PCA with boluses
  - Eventually went to CADD pump and went home
- Tried a temporary epidural (worked fantastic!)
- Later changed to an implanted intrathecal pain pump
  (worked less well)

The PC and Hospice Points of Merger

- Symptom Management
  - Managing the lidocaine infusion at home
  - Ketamine PCA at home
- Wound management and need for pain control during dsg change
- Family support
- Spiritual support
End of Life Care

- Ended up in the hospital to die
- Uncontrolled pain and anguish despite all measures
- Move to comfort care only
- Discussed and intuited palliative sedation after a team discernment and discussion with family

Walt's Final Days

- No food or fluids for 34 days (except through iv drugs)
- Meds needed for Palliative Sedation and Comfort
  - Intrathecal pump:
    - High doses of Morphine, Bupivicaine, Fentanyl
  - Peripheral meds
    - Fentanyl, Morphine, Versed, Ketamine, and Propofol (added as Palliative Sedation)

HOT TOPIC?

- How best to work as a team throughout the continuum, especially when you are from different networks
- What to do with new and innovative strategies that stretch a team's skills?
- How to keep all providers informed of goals, treatment changes and concerns?
- How to best care for patient and family with several providers involved?
- What would you do differently?
Case 3: Palliative Sedation

- 52 year old woman with widely metastatic cervical cancer
  - Severe bone pain – pelvic fracture and lumbar compression fracture verging on acute spinal cord syndrome
    - temporary improvement with radiation therapy
    - high dose hydromorphone infusion and fentanyl patch
  - Great deal of anxiety and spiritual distress
    - Buddhist chaplain connected with her at a very deep level
    - Combo of citalopram, clonazepam, & prn lorazepam helped

Case 3 (cont.)

- Primary goal: to go home
  - Sister and niece very supportive, will be her primary caregivers
    - PICC and port in place
  - Pain management and anxiety main concerns
    - initially p.o. methadone and later IV methadone q 8 hours
    - Initially transdermal fentanyl patch, went to IV hydromorphone, included IV Toradol x 5 days
    - sister taught how to give IV lorazepam
Case 3 (cont.)

- Patient eventually requested palliative sedation to unconsciousness ... at home
  - Spiritually at peace and ready for death
  - Her anxiety was an issue, but controllable
  - Her pain would flare with any movement, it was only fully controlled if she was completely immobilized or fully sedated
  - She had great support at home, did NOT want to go back to hospital, had IV set-up in place

Three levels of sedation

- Ordinary sedation
  - The use of sedating medications for anxiety, agitated depression, insomnia, etc.
  - Goal is symptom relief without lowering patient’s level of consciousness

- Palliative sedation
  - Use of sedating medications at least in part to reduce patient’s awareness of distressing symptom, when more specific symptom-directed therapies have failed
  - Level of sedation is proportionate to level of distress; alertness is preserved as much as possible

Three levels of sedation (cont.)

- Palliative sedation to unconsciousness
  - Administration of sedating medications to the point of unconsciousness when less extreme sedation has not relieved distressing symptoms
  - Used only for most severe, intractable suffering at the end of life

- From: American Academy of Hospice and Palliative Medicine’s position statement on Palliative Sedation
- http://www.aahpm.org/positions/default/sedation.html
Should PS be pursued lightly?

Ethical issues in palliative sedation

- Clinician’s intent is to relieve suffering
- Degree of sedation must be proportionate to degree of suffering
- Patient should give informed consent
  - For incapacitated patient, surrogate should give consent and affirm PS is consistent with patient’s values and goals of care

HOT TOPIC?

- What level of sedation is reasonable at home?
  - Ordinary sedation? Palliative sedation? to unconsciousness?
- What are the barriers or requirements to sedation in the home?
  - Clinical ... technical ... ethical
- How can goals be clarified sufficiently to assure most appropriate therapy is provided?
- What level of oversight should be required, or at least is recommended, for palliative sedation?
  - 2nd opinion? ... interdisciplinary input? ... ethics consult?
Palliative Care and Wellness: Unlikely Partners

Wellness and Chronic Diseases

- Cancer
- Parkinson’s Disease
- Multiple Sclerosis
- Heart Disease
- ALS
- Dialysis patients
- COPD

Effects of Exercise on Quality of Life and Prognosis in Cancer Survivors


- Purpose of the study was to review the research on physical activity on QOL and disease progression in cancer survivors
  - QOL during treatment
  - QOL during survivorship
  - QOL during palliative care
  - Disease prognosis end points
- Improvement shown in the treatment and survivorship groups but data during PC is limited
- Suggested that activity may reduce the risk of recurrence and extend survival in some cancer
Physical Activity and Palliative Cancer Care
Recent Results Cancer Research, 2011, 186; 349-365

- Discuss utilizing physical activity to combat fatigue, anorexia and cachexia
- Some preliminary evidence that some palliative care patients are willing to engage in physical activity

Annette’s Story
- 42 yr old women with delayed diagnosis of breast cancer
- Stage 3 breast cancer
- Treatment included
  - Mastectomy
  - Radiation
  - Chemotherapy
- Return visit for post chemotherapy
- Found to have recurrent disease

Results of Work Up
- Metastatic bone disease to spine
- Metastatic lung
- Elevated LFTs
- Underwent further radiation therapy
- More chemotherapy
- Herceptin
Hot Topic?

- Little literature on wellness and palliative care integration
- New paradigm shift for PC
- Need to base it on what we know about wellness in chronic diseases
- May help improve the understanding of PC as starting early and not as "end of life care"
- Need further research and literature to integrate the two