Symptom Management in Primary Palliative Care- Hospitalist Edition

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Financial Disclosure

- No relevant financial disclosures

- There will be some discussion of off label treatments

Needs Statement

- Many patients in Kentucky are living with one or more serious chronic illness with recurrent admissions to the hospital and high health care utilization. Appropriate symptom management and psycho-social support would reduce their symptom burden and improve their quality of life. If more health care providers are aware of these needs and equipped with skills to manage their symptoms this would help to improve the quality of life of these patients and their families.

Expected Outcome

- Hospitalists will be able to identify distressing symptoms in patients with chronic illnesses and list treatment options to provide relief of these symptoms

Learning Objectives

Upon completion of this activity, participants will be able to:

- Define Primary Palliative Care
- Identify common symptoms associated with chronic illnesses
- Develop an initial treatment plan for common symptoms encountered in palliative care patients

Outline

- Palliative care and Primary palliative care definition
- Symptom management in hospital and beyond
  - Look at a basic approach for managing these symptoms

Definition of Palliative Care

- Specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family. *(CAPC: Center for Advancement of Palliative Care)*

- An approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. *(WHO: World Health Organization)*

Highlights of Definition

- Living with serious illness
- Aim to relieve symptoms
- Identify, assess and treat distress
- Improved quality of life for patient
- Improved quality of life for family
- Address physical, social, spiritual distress
- No mention of on-going therapeutic care
- No mention of expected length of life

Approximately what percentage of highest need patients (as measured by cost of health care) are in the last year of their life?

- A 11%
- B 22%
- C 55%
- D 77%

Benefits of palliative care to patient

- Relief of symptoms
- Better communication between patient and treating team
- Alignment of treatment options with patient's priorities
- Improved care coordination
- Increased family support
- Less 911 calls, ED visits and hospitalizations
- Increased life expectancy

Benefits of palliative care to system

- Reduced readmissions
- Cost savings
  - Fewer and shorter hospital stays
  - Fewer and shorter ICU stays
  - Decreased in hospital deaths
- Improved satisfaction

TABLE. Palliative Care Quality and Cost Outcomes

Value Equation	Outcome	How Does Palliative Care Help?	Evidence
Higher quality	Patients live longer with higher quality of life	More communication, improved symptom management	Temel, *N Engl J Med*, 2010[5]
	Greater family satisfaction with quality of care	More communication, greater comfort, preferences met	Casarett, *Arch Int Med*, 2011[18]
	Improved pain, symptoms, and satisfaction with care	Symptom management and multidisciplinary team	Bernacki, *JAMA Intern Med*, 2014[19]; Wright, *JAMA*, 2008[20]
Lower cost	Lower costs per day	Goal-concordant care	Morrison, *Arch Int Med*, 2008[15]
	Shorter hospital length of stay	Improved symptom management, goal-concordant care	May, *Palliat Med*, 2017[21]
	Shorter ICU length of stay	Goal-concordant care	Norton, *Crit Care Med*, 2007[22]
	Fewer ICU admissions	Improved symptom management, goal-concordant care	Gade, *J Palliat Med*, 2008[23]
	Reduced readmissions	Symptom management and goal-concordant care with use of standardized triggers for palliative care consult	Adelson, *J Oncol Pract*, 2017[24]
	Fewer hospital admissions and inpatient deaths	Better symptom management and higher hospice utilization with in-home palliative care	Lustbader, *J Palliat Med*, 2016[25]
	Fewer 30-day readmissions	Referral to outpatient support (palliative care or hospice)	Enguidanos, *J Palliat Med*, 2012[12]

NOTE: Abbreviation: ICU, intensive care unit.

Fail MPP, J of Hosp Medicine 12/2017

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Limitations to accessing palliative care

- Patient factors
- Treating team factors
- System factors
  - Recognized shortage of palliative care physicians
  - Lack of skills and training for other providers
  - Financial considerations

Primary Palliative Care

- Palliative care provided by non- specialists in palliative care
- Basic skills and competences required of health care professionals to provide ‘basic’ palliative care

Primary palliative care

- SHM identifies the responsibilities of hospitalists in 3 key domains
  - Leading goals of care discussions, and advanced care planning
  - Screening for and treating common physical symptoms
  - Referring patients to community services to provide post discharge support

Common symptoms

- Dyspnea
- Pain
- Nausea/Vomiting
- Constipation
- Delirium
- Fatigue
- Depression
- Anorexia

Symptom Management: resources

- CAPC has curriculum on symptom management
- SHM Palliative Care Toolkit
- BC Centre for Palliative Care (2019). B.C. Inter-professional Palliative Symptom Management Guidelines.
- https://bc-cpc.ca/wp-content/uploads/2019/10/SMG-Interactive-Oct-16-2019.pdf

- 65 year old Bunny W diagnosed with COPD x 10 years ago. Treated with LTOT 3L. Hx of HFrEF, EF=25% from ischemic cardiomyopathy. He is awaiting evaluation in advanced heart failure clinic at a tertiary center, but he keeps missing his appointments because he is back in the hospital with shortness of breath. Diuresis and up titration of GDMT is often limited by hypotension and worsening kidney function.
- He has developed back pain, from sleeping in his recliner, for which he has been taking NSAIDS without good effect. Back pain has progressed to now prevent him from sleeping

- Bunny's wife, Rita worked night shift at the diner but recently quit because she is concerned about leaving Bunny at home alone at nights.

- They no longer go to social activities incl to church because they are limited by Bunny's decreased mobility

- Bunny W is admitted for shortness of breath, he has undergone diuresis and is at goal weight. His COPD treatment is optimized and he has no wheezes on exam. He continues to complain of subjective shortness of breath. O2 sats 92% on his home 3L. He reports some relief with the use of a fan clipped to his bed railing. Repeat CXR, ABG V/Q scan all unremarkable. What are the next options for therapy?

- A) add low dose benzodiazepine
- B) add low dose morphine
- C) change his current MDI triple regimen to nebulizer therapy
- D) increase his O2 therapy to 5L to achieve a higher O2 sat

Dyspnea: Principles of approach to management

- Hypoxia treat with Oxygen
- Not Hypoxic= no oxygen (although there is some role for limited trial of O2)
- Non-pharmacological:
  - Airflow- fan to the face is effective and evidence based
  - Positioning- sitting up in bed leaning over on bedside table
  - Teaching energy conservation techniques
- Opioids first line pharmacological therapy
- BDZ to treat the associated panic or anxiety no evidence it improves shortness of breath

Opioids in Dyspnea

- Can be used on opioid naïve patients
  - Morphine orally: 2.5 mg immediate release every 4 hours.
  - Morphine parenterally: 1 to 1.5 mg SC or IV every 4 hours.
- Any opioid can be used (May 2023; Yamaguchi et al)
- Initiation of treatment with long-acting opioids not effective (May 2022; Ekström et al)

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- 3 weeks following dc Bunny W presents to the ER after a fall. He reports his shortness of breath is improved with initiation of Morphine. He reports that on his last admission he was taken off his NSAIDS…."something about his heart failure. But my back pain has not been too bad since last admission." He can walk in his home with his walker. Tonight, he was trying to get up from his recliner and it got caught in a new rug and he tripped. Work up in the ER shows that he has a L3 lumbar fracture. He is admitted to the hospitalist service to facilitate work up. What is the next management step?
- a) consult surgery for possible intervention
- b) switch to long-acting morphine for better pain control, he will need it now
- c) resume diclofenac, for additional pain control
- d) transfer to hospice, this is a life limiting event

Pain: Principles of approach to management

- Identify cause of pain
- Correct underlying cause
  - Weigh potential discomfort of investigation and management techniques. Eg palliative radiation vs debulking surgery; kyphoplasty
- Introduce patients to the concept of ‘function over pain-free’
- Involve patients in decision making

Pain: Principles of approach to management

- Follow WHO pain management guidelines
- Multimodal approach incl non medication tools
  - Physiotherapy
- Match cause of pain to treatment modality
- Familiarize yourself with various opioids
- Keep in mind the concept of tolerance
- Don’t forget the Narcan and teaching family members how to use

Pain: Principles of approach to management

- Consider utilizing expertise of pain management clinic especially with current or previous history of opioid use disorder

Pain: pharmacological management

- Acetaminophen
- NSAIDS
- Corticosteroids
  - Start high dose and then taper down. If no effect after 7- 10 days then DC
- Opioids
  - Start low go slow
  - Consider route
  - start with fixed admin doses
  - Breakthrough doses until complete titration
  - Anticipate and plan for side effects

- Breakthrough 10% of total daily dose
- Using same opioids as using for scheduled dose
- Up titrate if used 3 or more breakthrough doses
- If using IV consider equivalence, use an opioid calculator!
- Once reach suitable dose then switch to long acting

- Fixed admin doses: Oxycodone 5mg po q 4h
  - Not combination, (can add acetaminophen separately), scheduled, waking from sleep to admin in the first 1-2 days
- Breakthrough dose: 2.5mg q1h or q2h prn
  - 10% of total daily dose of 30mg
- Adjustment after 24hrs: Calc total dose in 24hrs then divide accordingly
  - Consider adjusting frequency based on patient factors

Adjunct meds: matching cause of pain to treatment

- Neuropathic pain*: burning, electric shock like, known central or peripheral neuro lesion*
  - Antidepressants- Amitriptyline or Nortriptyline 75 - 150 mg PO qhs

    - Duloxetine 60 -120 mg PO daily Venlafaxine 75 -225 mg PO daily (start at 37.5mg)
  - Anticonvulsants- Gabapentin 300 to 800 mg PO every q8h to q6h (start at 100mg qhs)

    - Pregabalin 150 to 300 mg PO q12h
  - Second line: NMDA Antagonists-Ketamine, Antiarrhythmics- Lidocaine

Adjunct meds: matching cause of pain to treatment

- Superficial Somatic Pain: sharp, sore, burning, well-localized
  - Topical NSAIDS
- Deep Somatic Bone Pain: aching, throbbing, diffuse
  - Consider Bisphosphonates, Monoclonal antibody- bone modifying
- Deep Somatic Soft Tissue Pain: aching, throbbing, diffuse
  - Skeletal muscle relaxant eg Diazepam 2 to 10mg hs
  - Baclofen 5mg daily increase to 15mg tid… max dose 100mg daily
  - Tizanidine 2mg
- Visceral: squeezing, aching, diffuse
  - Hyoscine butyl bromide

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- Bunny is seen by neurosurgery team which recommends conservative management and pain control. His morphine is up-titrated and with good pain control he is transitioned to long-acting morphine with breakthrough doses. He is wearing a brace and is up with physical therapy. He is ready for dc but complains of no bowel movement for 4 days. He has no vomiting or nausea, still has flatus, he has no abdominal distension, and has normal bowel sounds on exam. What do you do next?

- a discharge, he may be more comfortable at home not using a bedpan
- b give lactulose
- c give methynaltrexone
- d give bisacodyl
- e start docusate

Constipation: Principles of approach to management

- Prevention:
  - Stool softeners in patients at high risk
    - Docusate 50-100mg
  - Opioids- give laxative unless bowel obstruction or diarrhea
  - R/o overflow incontinence in patients with diarrhea

- Consider multiple etiologies:
  - Primary: decreased intake, low fiber diet, poor fluid intake
  - Secondary: drugs, metabolic eg hypercalcemia, structural
- Non pharm tx:
  - Hydration, prunes, ? Probiotics
  - Manual dis-impaction
- Pharm Tx
  - r/o mechanical obstruction
  - Avoid if patient is completely obstructed
  - Avoid rectal route at the end of life

Pharmacological management

Stimulants

- Sennosides / Senna: 1 to 2 tablets or 10 mL syrup PO at bedtime. Onset 6-12 hrs
- Bisacodyl: 5mg po daily, 1 tab pr. Onset 20mins to 3 hrs

Osmotic

- Lactulose: 15 mL PO daily w/food. Onset 1-2 days
- Polyethylene glycol: 17G po daily. Onset 1-3 days
- Sodium phosphate enema: 130ml pr

- Glycerin suppos 1 tab pr
  - osmotic also acts as stool softener
- Mineral oil enema
  - Stool softener

Opioid Induced Constipation

- Methylnaltrexone: SC weight-based dosing 6mg to 18mg, Onset of action 24mins to 4hrs

- Naloxegol 12.5mg to 25mg po daily, onset of action 12 to 24hrs

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Nausea and Vomiting:
Principles of approach to management

- Identify suspected etiology and treat accordingly
- Avoid strong smells
- Prevent/treat constipation
- Aromatherapy: peppermint, ginger
- Oral Hydration: ice chips
- Clinically assisted hydration

Nausea and Vomiting: pharmacological management

- Chemical eg chemotherapy: *nausea not relieved by vomiting*
  - Haloperidol 0.5 to 1.5 q8h
  - Ondansetron 4 to 8mg po/sc/IV
- Cortical eg pain, anxiety: *anticipatory nausea, distress*
  - Lorazepam 0.5mg sl qid prn
  - Cannabinoids
- Cranial: eg raised intracranial pressure: *Hx, morning headache, vomiting w/o nausea*
  - Dimenhydranate 50mg po/sc/pr q 8h prn +/- corticoetroids
  - Haloperidol
- Vestibular eg drugs, vestibular tumor: *associated with movement*
  - Dimenhydranate
  - Scopolamine 1-2 patches TD q 72h

- Visceral eg bowel obstruction/constipation, pharyngeal stimulation (from difficult to handle secretions): abd pain, vomiting undigested material
  - Dimenhydrinate
  - Ondansetron

- Gastric stasis eg drugs, massive ascites: epigastric pain and fullness, reflux
  - Metoclopramide: 5mg tidac po/IV

Nausea and vomiting: additional principles

- These are starting points
- Consider other agents additional
- Consider Olanzapine in non-chemo induced vomiting (Oct 2023; Bonar et al)
  - 2.5mg qhs uptitrate up to 5mg
  - as an adjunct to other antiemetics
  - Patients already on at least 2 antiemetics

Cough

- Etiology: related to primary pulm cause, medications, other non directly pulm cause
- Treat underlying cause
- Dry cough
  - Dextromethorphan 15 to 30 mg PO Q4 to 8H
  - Simple syrup: (unknown mech of action ? Sugar decreases cough reflex
  - Opioids: morphine 2.5 to 5 mg PO Q4-6H, hydrocodone, hydromorphone

- Wet cough
  - Guaifenesin 200 to 400mg mg po q4h

Anorexia

- Multifactorial
- Consider reversible underlying cause: drugs, oral candidiasis, gastric stasis, constipation
  - Corticosteroids eg Dexamethasone 2 to 4mg daily
    - Onset in a few days
  - Megestrol Acetate start 160mg po daily
    - off label, effects take up to 2 weeks
  - Mirtazipine start 7.5mg daily
    - Off-label, effects full after several weeks (increase every 3-7 days)

Hiccoughs

- Consider secondary causes: gastric distension, Reflux, medications incl steroids
- Treat underlying cause- first line is PPI
- Pharm Tx if persistent> 48hrs
  - Baclofen 10mg po once; onset 30mins to 3hrs. May continue tid for 2-5 days
  - Gabapentin if suspect central dose
  - Chlorpromazine 25mg po tid (mostly replaced by above agents)
  - Midazolam: end of life

Delirium: Principles of approach to management

- Screen high risk patients
- ID and treat reversible causes--- look at current meds!!
- Non pharm approaches:
  - Re-orientation
  - Avoid immobility, indwelling catheters, intravenous lines or equipment that impedes mobility
  - Don’t forget hearing aides and glasses
  - Promote one-to-one observation to maintain safety, reduce fear, and support re-orientation
  - NOT physical restraints, increase risk
- Pharm: no evidence to support any agents effective

- Ensure not treating the team's distress.
- Haloperidol (off label use, black box warning)
  - No dose established but consider 0.5mg (0.25mg in elderly) q 1hr until calm
- BDZ but remember this may have paradoxical effect
- Consider palliative sedation
- Counselling families go a long way!!!

Indications for referral to Specialty palliative care

- Refractory pain or other symptoms
  - large doses of opioids, methadone
  - Severe delirium
- Major conflict within family or treating team
- Unrealistic expectations
- Resistance to discharge
- Complex depression/grief/anxiety
- Spiritual suffering

Questions?

Take Home Points

- Palliative care focuses on symptom management to achieve improved quality of life in patients living with serious illnesses.
- Basic palliative care can be provided by Hospitalists
- Symptom and distress management requires a multimodal and multi-disciplinary approach
- Look for underlying cause and treat cause
- Consider possible etiology when selecting pharmacological agents for symptom management

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