Palliative Care 2018

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Case 1: Palliative Management of Fatigue

Robert is 60 years old and was diagnosed one month ago with pancreatic cancer. His initial visits were dominated by a focus on his pain and nausea—two symptoms that are now, mercifully, under better control. While willing to pursue any treatment options offered, it is becoming clear that his most recent round of chemo does not appear to be halting progression of his disease. He spends most of the day laying on the couch, apart from occasional walks around the block. He's interested in getting some relief from his fatigue so he can spend whatever time he may have left really present with his wife and dogs.

Causes of Fatigue in Cancer Patients

Associated with
- pain
- depression
- deconditioning
- anemia
- sleep disturbance

However in many cancer patients the source cannot clearly be identified

Case 1: Palliative Management of Fatigue

(1.1) Both Robert and his wife are eager to find solutions to his fatigue, but worried about taking more medication. They think that his fatigue might be entirely related to his opioids, and propose reducing his long acting MS Contin and prn Oxycodone. How do you respond?

a. Cancer is causing the fatigue, and worsened pain is unlikely to make that better
b. Agree to a trial of lowering the MS Contin with plenty of PRN Oxycodone available in case pain worsens
c. Encourage Robert to try low dose methylphenidate prior to titrating pain medication

Pharmocologic treatments of Fatigue

Anemia Treatment
Amphetamines: Methylphenidate, Dextroamphetamine, Pemoline, Modafinil, Armodafinil, Nonprescription caffeine.
Stimulating antidepressants: Buproprion, Venlafaxine
Dexamethasone
American Ginseng

Case 1: Palliative Management of Fatigue

(1.2) His wife thinks he should be exercising more, and gets him up for a walk around the neighborhood three times a day. She wonders, though, whether more intensive aerobic physical activity might benefit him. How do you respond?

a. His primary focus should be rest, sleep and energy conservation
b. Aerobic exercise can help fatigue in cancer patients
c. Psychological interventions, such as MBSR, might be helpful
d. All of the above

Non-Pharmocologic Interventions for Fatigue

Exercise
CBT
Activity and Rest
Patient Education
Acupressure
Psychological interentions, including Web-based

Case 1: Palliative Management of Fatigue

Questions For the Panel:

What interventions do you routinely prescribefor patients presenting with cancer related fatigue?

What have you found to be the most effective interventions (pharm or non-pharm)?

Case 1: Palliative management of Fatigue

Case 2: Palliative management of Delirium

Case 3: Opioids in Oncology

Case 4: Primary Palliative Care in Oncology

Case 2: Palliative Management of Delirium

Steven is a 71 year old retired engineer, with renal cell cancer metastatic to bone. He has repeatedly stated his desire to pursue any and all available measures to prolong his life, often changing the subject when end of life planning is discussed. After several weeks of increasing fatigue, and confusion, sleep-wake cycle disturbances and hallucinations, his wife calls into clinic requesting urgent admission to the hospital for workup of his new altered mental status.

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Delirium

- an acute change in mental status that fluctuates
- has underlying physiologic causes
- can be categorized as *hyperactive*, *hypoactive*, or *mixed*

Common *reversible* etiologies include

- constipation
- urinary retention
- medications (benzodiazepines, opioids, steroids, and anticholinergic drugs)
- electrolyte abnormalities
- sleep deprivation

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Case 2: Palliative Management of Delirium

(2.1) Robert and his wife attend an oncology visit where they are advised that his altered mental status may be due to paraneoplastic syndrome, infection, or electrolyte abnormalities, but that regardless, his prognosis is poor given his overall decline and deconditioning. His wife asks, "How can we most rapidly get a diagnosis regarding what is going on?" How do you respond?

a. Admission to the hospital to the neurology service for CT/LP/infectious workup
b. Encourage her to recognize this as potentially untreatable regardless of cause, and consider the possibility that further diagnostic workup may not ultimately change his prognosis
c. Advise her that you don't know what is causing his altered mental status, but that you can send outpatient labs in order to figure it out

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Most common identifiable causes of hospital delirium

- **drugs**: anti-cholinergics (e.g. anti-secretion drugs, anti-emetics, anti-histamines, TCAs)
  sedative-hypnotics (e.g. benzodiazepines)
  opioids
- metabolic derangements (elevated sodium or calcium, low glucose or oxygen)
- infections
- CNS pathology
- drug/alcohol withdrawal

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Terminal delirium

delirium in a patient in the final days/weeks of life
is not a distinct diagnosis
but very common at the end of life (possibly > 70%)
(therefore often only a descriptor in retrospect)
treatment of the underlying cause is typially
impossible, impractical,or not consistent with the goals of care

Case 2: Palliative Management of Delirium

(2.2) His wife elects to admit him to the hospital, where he is admitted to the neurology service. He is sedated for a lumbar puncture, which is non-diagnostic, and has a feeding tube placed. He continues to decline and on the third day of admission, palliative care is consulted, and a decision is made to remove the feeding tube, and transfer to hospice. His wife notes that she doesn't want him to "be a zombie" but is worried that he will hurt himself, as he is intermittently thrashing around in his bed. What medication or interventions do you recommend?

a. Promote sleep wake cycles with bright room during the day, dark room at night
b. Consider Haloperidol, 0.5-1mg prn agitation in escalating doses
c. Stop anticholinergics
d. Consider adding a benzodiazepine
e. All of the above

Using a medication for delirium is a complex decision

Neuroleptics for delirium may *increase* mortality
Benzodiazepines added to neuroleptics may be effective for *agitated* delirium

If a decision is made to use medication:
The drug of choice for most patients traditionally has been a neuroleptic
Haloperidol is administered in a dose escalation process similar to treating pain
Haloperidol 0.5-2 mg PO or IV q1hour PRN. May use doses up to 10 mg

Atypical antipsychotics have also been studied for delirium are probably as efficacious
And respiridone may have less morbiidity than haloperidol

Case 2: Palliative Management of Delirium

Question for Panel:

How do you navigate a patient and/or family desire for answers with concern that altered mental status may be reflective of the patient approaching the end of their life?

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Case 3: Opioids in Oncology

Ms. T is a 42 year old woman with a history of depression, well-treated with lexapro and breast cancer, metastatic to bone only. She has ongoing, severe pain treated with Methadone 5 mg TID and Effexor 150 mg qD. Her husband joins her for one of your visits and demands "People are dying from these medications you are pushing. You are going to get her hooked. I want her off of this junk."

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Case 3: Opioids in Oncology

(3.1) Which are risk factors for substance use disorder?

a. Family history of substance abuse
b. Personal history of substance abuse
c. History of Pre-Adolescent Sexual Abuse
d. Psychological disease
e. All the above

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Risk for Harm

1% of the US (2 million) with an opioid use disorder
Many started with *access* to opioids

Since 1999, prescription painkiller overdoses as a proportion of all deaths have risen by:

- 265% in men
- 400% in women

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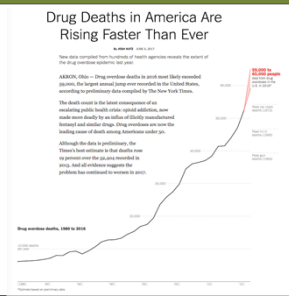

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Substance Use Disorder

Patterns of symptoms resulting from the use of a substance that the individual continues to take, despite experiencing problems as a result.
-American Psychiatric Association 2013: DSM-V

Distinguish from **Dependence**, **Tolerance**, **Pseudo-addiction**

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A Rational Approach

- Elicit substance use history ("chemical coping")
- Screen using risk assessment tool and risk-stratify patient
- Develop management strategy based on risk
- Monitor for at-risk behavior

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Risks for Substance Use Disorder

- Family history (alcohol, illegal drugs, prescription drugs)
- Personal history (alcohol, illegal drugs, prescription drugs)
- Age 16-45
- History of preadolescent sexual abuse (in women)
- Psychological illness (ADD, OCD, Schizophrenia, BAD, Depression)

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Case 3: Opioids in Oncology

(3.2) Which of the following monitoring strategies has been proven effective at preventing harms from substance use disorder in cancer patients?

a. Urine toxicology monitoring
b. Monitoring of state online prescription databases (PDMPs)
c. Opioid agreements
d. All of the above
e. None of the above

Monitoring for Substance Use Disorder

- Urine toxicology monitoring
  - Alerts especially to diversion and illicit drug use
- State prescription drug monitoring programs (PDMPs)
  - All states now (even Missouri)
  - Alerts to doctor-shopping
- Opioid agreements
  - **An opportunity to educate**

Others:
- Minimize doses
- Short presciptions
- Frequent follow-up/**reassessment of cost-benefit**

Case 4:
Questions for the panel—

What is the balance of strategies for management of opoid risk that you follow?

Should the focus on opioid use evan apply to patients with cancer? If so, should it be based on prognosis?

Case 1: Palliative management of Fatigue

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Case 4: Primary Palliative Care in Oncology

Mr. C is a 75 year old man with prostate cancer, now resistant to hormonal manipulation and metastastic to bone. His pain is well-controlled with 8-10 Norco/day. He is cared for in a 3-person community oncology practice.

Case 4: Primary Palliative Care in Oncology

(4.1) Which professional organizations would recommend palliative care for Mr. C?

a. ASCO
b. The Commision on Cancer
c. The NCCN
d. The European School of Oncology & the European Society of Medical Oncology
e. All of the above

Concurrent Oncologic/Palliative Care Now is Standard

Based on the RCT evidence of benefits:

- better quality of life and symptom control
- less anxiety and depression
- greater prognostic awareness
- less caregiver distress,
- equal or better survival
- equal or lower costs

ASCO: **"**every patient with advanced cancer should be seen by a PC interdisciplinary team within 8 weeks of diagnosis—establishing a new standard of care.**"** (Ferrel, JCO, 2017)

Case 4: Primary Palliative Care in Oncology

(4.2) How will the majority of oncologic patients receive palliative care?

a. Via referral to outpatient palliative care specialist teams
b. Via referral to inpatient palliative care specialist teams
c. From their Primary Care Physician
d. From the oncology team

All oncologists must be competent in basic skills of palliative care

Basic management of pain and symptoms
Basic management of depression and anxiety
Basic discussions about
- Prognosis
- Goals of treatment
- Suffering
- Code status

Quill & Abernethy, NEJM, 2013

Reasons for Primary Palliative Care in Oncology:

Patient-centeredness
Oncologists know their patients well
Patients trust their oncologists
Integration is key
Workforce shortage of Specialty PC

Case 4: Primary Palliative Care in Oncology

(4.3) How much time does it take to provide Primary Palliative Care to cancer patients?

a. 1 hour/week
b. 5 hours/week
c. 1 hour/month
d. 5 hours/month
e. 10 hours/month

THE TEAM APPROACH
Time, Education, Assessment, and Management

Oncologists doing PPC can achieve the same outcomes as in the RCTs of Onc/PC vs Usual Care Onc

(Bakitas, JOP, 2017)

TIME

A structured palliative care visit of at least 1 extra hour per month; repeated at regular intervals (ie, monthly); not once

EDUCATION

Structured, prospective, and recurrent discussions about symptoms, goals, and preferences for care, prognosis understanding, advance care planning, and communication with the health care team

ASSESSMENT

Formal assessments for:
- Symptoms (ESAS, MSAS-C, CAPC rounding tool)
- Spirituality (FICA, or "Are you a religious or spiritual person?")
- Distress (Distress Thermometer, others)
- Psychosocial (PHQ-2)
- Caregiver strain

MANAGEMENT

By set protocols and an interdisciplinary team (APNs, social workers, chaplains, doctors)

(See the NCCN Palliative Care Guidelines)

Primary Palliative Care Resources

EMR (eg ACP templates)
Center to Advance Palliative Care online curricula
CSU Palliative Care Institute online curricula
ASCO/AAHPM Joint STatement (Bickel, J Onc Pract, 2016)
OncoTalk/Vital Talk
Project Echo
Serious Illness Conversation Guide
NCCN Palliative Care Guideline

Case 4:

Question for the panel—

What are the key steps for oncologists to follow to be able to provide palliative care routinely?

Case 1: Palliative management of Fatigue

Key points:
- Fatigue is common in patients with cancer and with cancer treatment
- Exercise may be the most effective intervention
- Data is lacking to prove psycho-stimulants are effective, but these treatments are widely-used and often reported as effective by patients.

Case 2: Palliative management of Delirium

Key points:
- Delirium is common at the end of life
- Search for treatable causes of delirium
- The decision to use medication for delirium is complex:
  - Neuroleptics may increase mortality

Case 3: Opioids in Oncology

Key points:
- Likely more than 1% of your patients will have opioid use disorder
- Formally assess risk
- Monitor with a risk-based strategy with urine toxicology, PDMP, opioid agreements
- Ongoing reassessment of risks/benefits of opioids is key

Case 4: Primary Palliative Care in Oncology

Key points:
- Concurrent palliative and oncologic care is now standard of care for patients with advanced cancer
- Oncology teams can provide palliative care to the majority of patients
- It takes about 1 hour/month
- Following the evidence-based strategies of specialty palliative care may allow oncologists to achieve the same benefits proven in the RCTs

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Summary of Key points

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