Palliative Care and the General Practitioner

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Objectives

• Have working definitions of palliative and end of life care
• Have a structure for managing common symptoms
• Know which patients might benefit from input from a specialist service
• Know which symptoms might warrant specialist advice
What is palliative care?

...the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

World Health Organization 2002

Palliative Care is EVERYBODY’S business
What does this mean in practice?

• Early identification, impeccable assessment and treatment of symptoms
• Affirms life and regards dying as normal
• Intends neither to hasten nor postpone death
• Integrates spiritual and psychosocial aspects
• Offers a support system to family including bereavement counselling
• Team approach
A brief history of dying...

• Perception of what constitutes a good death goes back thousands of years
• Accepted as part of life until 20th Century
• Carnage of 1914-1918 war turned death into something ‘shameful and forbidden’ (Aries 1976)
• Increasing tendency not to tell truth to dying, to die in hospital, alone
• unacceptability of showing emotions
Who needs palliative care?

- General vs. specialist
- ‘life threatening illness’
- You don’t have to be dying to require palliative care, and you don’t necessarily need specialist palliative care if you’re dying
What conditions do we see?

• Anyone with advanced, progressive life limiting disease
• Cancer
  – Poor prognosis
  – Curative intent
  – “Late effects”
• Degenerative neurological conditions
  – MND/ALS
  – MS
  – Parkinson’s Disease
  – CJD
  – End stage dementia
• Vascular disease
  – PVD
  – Stroke
• End stage organ failure
  – Renal
  – Heart
  – Liver
  – Lung (COPD, fibrosis, cystic fibrosis)
• Connective tissue disease
  – Systemic sclerosis
  – RA
• Sickle cell disease
• AIDS
Who don’t we see?

• Chronic, stable conditions
• People dealing with long term disability rather than death
• We do not have the skills to manage chronic pain (not enough psychological input)
• Few resources for survivors
Prognostication

The ‘Surprise’ the Question: Would I be surprised if this patient died in next year/six months/few weeks?

“Find your 1%”
General principles of symptom management

• Attitude of partnership
• Care about whole patient not only physical symptoms
• Evaluation
• Explanation
• Management
• Monitoring
• Attention to detail
Evaluation

• What is the cause of the symptom?
• What is the underlying pathological mechanism?
• What has been tried?
• What is the impact on the patient’s life?
Explanation

• Explain the underlying mechanism in simple terms
• Discuss treatment options with patient
• Explain the treatment to the family
Management

- Multimodal approach
- Correct the correctable
- Non-drug treatment
- Drug treatment
- Seek advice from others
- There’s usually something else we can try!
Monitoring

• Review, review, review
  – Old symptoms
  – Adverse effects
  – Emerging symptoms
Common symptoms

• Pain
• Nausea and vomiting
• Constipation and diarrhoea
• Fatigue
• Anorexia and cachexia
• Breathlessness
• Lymphoedema
• Anxiety and depression
Menu

- Pain
- Nausea and vomiting
- Emergencies in palliative care
- Last days of life
- That Friday afternoon feeling...
PAIN
What is pain?

• ‘Pain is what the patient says hurts’
• An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
• *Somatopsychic* phenomenon modulated by mood, morale and meaning
Physiology of pain
Schematic representation of molecular mechanisms of modulating pain neurotransmission

© Ahmedzai 2010
Psychological → TOTAL PAIN → Physical

TOTAL PAIN ← Social

TOTAL PAIN ← Spiritual
What affects the patient’s pain?

- Pain increased
- Pain decreased
What affects the patient’s pain?

• Pain increased
  – Discomfort
  – Insomnia
  – Fatigue
  – Anxiety
  – Fear
  – Anger
  – Sadness
  – Depression
  – Boredom
  – Mental isolation
  – Social abandonment

• Pain decreased
  – Relief of other symptoms
  – Sleep
  – Understanding
  – Companionship
  – Creative activity
  – Relaxation
  – Reduction in anxiety
  – Elevation of mood
At the end of the medical interview we can reflect on...

• ...the cause of the pain (cancer vs non-cancer)
• ...the mechanism of the pain (pathological vs. functional, nociceptive vs. neuropathic)
• ...the contribution of other factors
• ...the meaning of the pain to the patient
What causes pain in advanced disease?

• The disease itself
• Treatments for disease eg mucositis or neuropathy from chemotherapy
• Disease-related debility eg constipation, muscle tension/spasm
• Concurrent disorder eg arthritis, chronic back pain
Managing pain 1

• Explanation
• Correct the correctible
  – Radiotherapy
  – Chemotherapy
  – Hormone therapy
  – Surgery
  – bisphosphonates
Managing pain 2 – non-drug measures

- Physical therapies
  - Heat packs, cold packs
  - TENS
- Psychological therapies
- Complementary therapies
  - Acupuncture
  - Homeopathy
  - Reiki
  - Reflexology
  - Aromatherapy
- Distraction
Managing pain 3 - analgesics

WHO Pain Ladder

Step 1

Step 2

Step 3
Managing pain 3 - analgesics

WHO Pain Ladder

Step 1

Paracetamol

+/- NSAID, adjuvants

Step 2

Paracetamol

+ weak opioid

Paracetamol

+ strong opioid

Step 3

Paracetamol

+ weak opioid

+/- NSAID, adjuvants

+/- NSAID, adjuvants

+/- NSAID, adjuvants
Which strong opioid?

- Neuro-excitatory metabolites of morphine accumulate in renal failure
- Oxycodone no active metabolites but still renally cleared
- Fentanyl safe in renal failure but takes a while to get benefit from increase
- BUT 100-150 times more potent than morphine (25 microgram patch = 90-110mg oral morphine in 24 hours)
- Methadone safe in renal and liver impairment but should not be initiated by generalists
Neuromodulatory and alternative analgesics

- Antidepressants
  - Tricyclics
  - Atypicals
    - Duloxetine
    - Mirtazepine
- Anticonvulsants
  - Gabapentin
  - Pregabalin
  - Na valproate
- Corticosteroids
- Ketamine
In the community...

-Prescribe within the bounds of your own competence
-Be familiar with a strong opioid, an anticonvulsant and a tricyclic antidepressant for pain control
-Start low and go slow with opioids
-Sensible breakthrough dose of short acting opioid is 1/6 total daily controlled release dose
-Please don’t start methadone or ketamine; definitely need specialist referral if it’s that bad
IT TAKES A TEAM TO MANAGE PAIN
NAUSEA AND VOMITING
Causes of nausea and vomiting
Causes of nausea and vomiting

• Acute gastritis
  – Infections
  – Irritants (e.g. aspirin, alcohol, other poisons)

• Central causes
  – Migraine
  – Head injury
  – Inner ear infection
  – Motion sickness
  – Vasovagal attack
  – Tumour

• Diseases of GI system
  – Gut obstruction (from oesophagus to anus)
  – Constipation
  – Gastroparesis/stasis
    • Diabetes, linitus plastica

• Treatments
  – Drugs esp. chemo agents

• Biochemical causes
  – Uraemia
  – Hypercalcaemia
Vomiting Mechanisms

Gastric Irritants
- Abdo RT
- Intestinal distension
- Chemo

Morphine/digoxin
- Ca
- Urea

Fear/Anxiety
- Na
- ICP

Movement/Vertigo

Gastric atony - Retroperistalsis - Thoracic & Abdo muscle contractions
## Four key antiemetics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Receptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyclizine</td>
<td>BLOCKS $H_1$ and $ACh_m$</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>BLOCKS $D_2$</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>BLOCKS $D_2$, STIMULATES $5HT_4$</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>BLOCKS $H_1$, $D_2$, $ACh_m$, $5HT_2$</td>
</tr>
</tbody>
</table>
Other antiemetics

- $5\text{HT}_3$ antagonists (e.g. ondansetron)
  - Specific for chemotherapy induced vomiting
  - Also licensed for post-operative nausea and vomiting
- Dexamethasone
- Hyoscine
- Olanzapine
Clinical decision making
1. Is the patient troubled mainly by vomiting?

- Large volume (+/- hiccups, early satiety)
  - *Dehydrating rapidly* consider *gastric outlet obstruction*
    - May need NG and IV
    - High dose dexamethasone
    - Consider stenting
  - *Not dehydrating* consider *gastric stasis*
    - Prokinetic – metoclopramide

- Distended stomach – brief NG suction
- Compressed stomach – as for gastric stasis
- Raised intracranial pressure – cyclizine and dexamethasone
2. Could the cause be drugs, toxins or biochemical?

- **Area postrema stimulation** (most drugs including opioids, ↑Ca, ↑Urea)
  - Reverse the reversible
  - Haloperidol 0.5-1mg nocte and titrate

- **5HT₃ receptor stimulation** (drugs especially cytotoxics)
  - Change or stop drug if possible
  - 5HT₃ antagonist e.g. ondansetron

- **GI mucosal irritation** (e.g. antibiotics, cytotoxics, iron tablets, NSAIDs)
  - Change or stop drug if possible
  - Lansoprazole or sucralfate
3. Is the nausea and vomiting worse on movement?

- Motion sickness
  - Hyoscine hydrobromide (‘Kwells’)
- Other causes (e.g. middle/inner ear infection, cerebellar tumour)
  - Cyclizine
4. Could anxiety or fear be contributing?

- Anticipatory prior to chemotherapy
  - Try lorazepam prior to treatment
  - Hypnosis or behavioural therapy
- Anticipatory prior to meals
  - Lorazepam
5. Is the nausea and vomiting persisting?

- Call the specialist palliative care team!
- Consider levomepromazine
- Consider trial of steroids
Last thoughts on anti-emetics

• Metoclopramide and cyclizine antagonise each other so should not be co-prescribed
• 5HT₃ antagonists (e.g. ondansetron) may completely block the effect of paracetamol and partially block the analgesic effect of tramadol

PALLIATIVE CARE EMERGENCIES
What’s an emergency?

• Haematological
  – massive haemorrhage
  – Superior vena caval obstruction
• Anaphylaxis
• Respiratory
  – Stridor
  – acute breathlessness
• Sudden acute pain
• Neurological – metastatic spinal cord compression
• Biochemical - hypercalcaemia
• Psychiatric
• Infection – neutropenic sepsis
SPINAL CORD COMPRESSION
Some facts and figures

- Occurs in 3-5% of patients with advanced cancer (5-10% post-mortem)
- Cancers of breast, bronchus and prostate account for >50%
- Majority occur in the thoracic vertebrae
- Compression at more than one level in 17%
- 1/3 patients survive at least a year after symptoms develop with median survival of 4 months
- Early recognition vital; once paraplegia develops is irreversible and expensive
Clinical features

- **Pain** 95%
  - Bone
  - Radicular/funicular

- **Weakness** 85%
  - May be subjective i.e. no demonstrable neurology

- **Sensory symptoms** 50%
  - Paraesthesiae, decreased sensation, numbness

- **Sphincter dysfunction** 40%
  - LATE

- >66% are in thoracic spine, 6-7% in cervical spine
Investigations

• Bone scan and x-ray poor sensitivity for showing up bone metastases

• MRI investigation of choice (CT if contraindicated – discuss with oncology)
  – If symptoms suspicious of spinal mets, admit, speak to spinal cord co-ordinator within 24 hours, MRI within 1 week
  – If neurological symptoms or signs too then phone co-ordinator IMMEDIATELY. MRI within 24 hours (or sooner)

NICE guidance 2008
Management

• Corticosteroids - high dose dexamethasone 16mg daily
• Surgery
• Radiotherapy
• Chemotherapy
• Percutaneous vertebroplasty
Superior Vena Cava Obstruction
Superior Vena Cava Obstruction

- Caused by extrinsic compression
- Mostly caused by lung cancer (80%)
- May have acute onset with venous thrombosis
Symptoms and signs
Symptoms and signs

**Symptoms**
- Dyspnoea
- Neck and facial swelling
- Trunk/arm swelling
- Feeling of fullness in head/neck
- Choking sensation
- Other potential symptoms:
  - Chest pain
  - Cough
  - Dysphagia
  - Cognitive dysfunction
  - Hallucinations
  - Seizures

**Signs**
- Thoracic and neck vein distension
- Facial oedema
- Tachypnoea
- Facial plethora
- Cyanosis
- Arm oedema
- Vocal cord paralysis
- Horner’s syndrome

If severe:
- Laryngeal stridor
- Coma
- Death
Management

*SVCO with severe symptoms is an emergency*

- Corticosteroids (no evidence)
- Specific oncological management
- Stent
- Anticoagulation/thrombolysis
Neutropenic sepsis

- Definition = neutrophil count $< 1.0 \times 10^9/L$
Who is at risk of neutropenia?

• Any cancer/haematology patient who has received high dose chemo in the last year
• Patients with bone marrow failure e.g. due to haematological malignancy, tumour infiltration
• Patients on immunosuppressant agents e.g. ciclosporin, tacrolimus
• Idiosyncratic reaction to other drugs e.g. Na valproate, carbimazole, mirtazapine
• Those with autoimmune disease e.g. rheumatoid arthritis, SLE
• HIV
Neutropenic sepsis post-chemotherapy

• Nadir tends to be 7 – 10 days post chemo
• PATIENTS WITH NEUTROPENIC SEPSIS CAN BE CRITICALLY ILL WITH MINIMAL SIGNS
• May just present feeling generally unwell
• May not be pyrexial (especially if on regular paracetamol/NSAIDs)
• Look for
  – Pallor
  – Mottled skin
  – Tachycardia/tachypnoea
  – Altered mental state/anxiety
Management

• Remember, mortality is up to 30% (and this is from something doctors have done to them!)
• Have high index of suspicion
• ABCDE; Early Warning Score System
• Resuscitate as necessary
• Take FBC, cultures, U&E, LFT, clotting screen, CRP
• DO NOT WAIT FOR ABOVE RESULTS TO GIVE ANTIBIOTICS
• Seek senior oncological advice: RHH for haematology, WPH for oncology (acute oncology service 9am – 5pm seven days 07949 021449 but don’t wait if OOH)
Hypercalcaemia
Clinical features

• Drowsiness alone is common

• The severity of symptoms is not related to severity of hypercalcaemia

• Symptoms are insidious and mimic symptoms seen in dying patients so it is often missed or undertreated
Some facts and figures

• Can occur in any cancer (Incidence 10-20%)
• Particularly common in
  – Myeloma (50%)
  – Squamous cell lung carcinomas (25%)
  – Breast cancer (20%)
• 80% will have skeletal metastases
• Paraneoplastic phenomenon
• Survival often <3 months even with treatment (20% alive after 12 months)
Management 1

NB: are you justified in correcting a potentially fatal complication in a moribund patient?

• A Ca >4mmol/l is generally fatal if untreated due to renal failure and arrhythmias

• Indications for treatment:
  – Corrected Ca >2.8mmol/l
  – Symptoms attributable to ↑Ca
  – First episode or long interval since previous one
  – Previous good quality of life
  – Patient willing to have IV/blood tests
Management 2

• Admit
• IV rehydration if necessary – normal saline (reduces Ca by only 0.2-0.4mmol/L)
• IV bisphosphonate – zoledronate 4mg
• SC clodronate 1500mg over 6-12h
• Octreotide in neuro-endocrine tumours
THE LAST DAYS OF LIFE
Diagnosing dying

• In patients with advanced malignancy
  – Gradual deterioration in functional status
  – Becomes bedbound
  – Is semi-comatose
  – Able only to take sips of fluid
  – No longer able to take oral drugs

• In patients with heart failure imminent death is difficult to predict but
  – Previous admissions with worsening failure
  – No identifiable reversible precipitant
  – Receiving optimal tolerated conventional drugs
  – Deteriorating renal function

• NB important to reverse the reversible if appropriate (e.g. constipation, hypercalcaemia)
Barriers to diagnosing dying

- Hope that the patient may get better
- No definite diagnosis
- Continuing to pursue futile interventions
- Disagreement about patient’s condition
- Failure to recognise key symptoms & signs
- Lack of knowledge about how to prescribe
- Poor ability to communicate with family and patient
- Concerns about withdrawing or withholding treatment
- Fear of foreshortening life
- Concerns about resuscitation
- Cultural and spiritual barriers
Where do people want to die?

• Majority would like to die at home, as long as not a burden to family
• Majority would NOT want to die in hospital
The reality
Where did people die in the borough in 2011?

<table>
<thead>
<tr>
<th>Place of death</th>
<th>All causes (%)</th>
<th>Malignant neoplasm (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>22.2</td>
<td>35.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>53.2</td>
<td>36.8</td>
</tr>
<tr>
<td>Mount Vernon Hospital</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Nursing home</td>
<td>16.4</td>
<td>10.4</td>
</tr>
<tr>
<td>Hospice</td>
<td>3.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Management

• Preferred place of care
• Rationalise medications
• Alternative route
  – Subcutaneous
  – Syringe driver
• Discussion with patient and family about course of illness
• Discussion about eating and drinking
• Last days of life pathway
• DNACPR
Pre-emptive prescribing

• Pain
  – sc opioid of choice, dose depending on background (morphine significantly cheaper than diamorphine sc)

• Breathlessness
  – sc opioid
  – Midazolam

• Agitation
  – Midazolam
  – Levomepromazine

• Secretions
  – Hyoscine butylbromide (Buscopan)

• Nausea
  – Haloperidol
THAT FRIDAY AFTERNOON FEELING
Over to you!
Specialist Palliative Care in Barnsley

• Hospital Team
• Community Macmillan Team
• Hospice
  – Inpatient Unit
  – Limes Support and Therapy Centre
  – Medical Outpatient Clinic
  – Lymphoedema Clinic
  – Complementary therapy
  – Counselling
  – Advice for professionals 24 hours
In summary...

• You don’t need to be imminently dying to need specialist palliative care but you don’t necessarily need specialist palliative care if you’re dying

• Opioids are not the panacea for all pains

• You don’t have to have neurological signs to have spinal cord compression

• We are always happy to discuss patients, do joint visits, participate in palliative care MDTs, run education sessions etc. Just ask!