Mississauga Halton
Palliative Care
Network

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Week 3

Plan & Manage – Symptom Management

SUPPORTING PALLIATIVE NEEDS EVERY STEP OF THE WAY

Learning Objectives

1. Plan/Manage: Symptom Management
    - Pharmacological

Materials:

1. Symptom Management Guidelines

A Palliative Approach to Care – Manage

1. IDENTIFY

Identify if the person would benefit from palliative care early in their illness trajectory

2. ASSESS

Assess the current and future needs and preferences of the individual and their family/caregiver across all domains of care.

3. PLAN/MANAGE

Plan and collaborate ongoing care to address needs identified during the assessment.

Symptom Management Guidelines

Follow your organization's symptom management guidelines

Pain

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage
- It is subjective
- Screen & Assess OPQRSTUV – ESAS
- Various ways to describe it (eg. ache, discomfort, annoyance, etc)
- Advise family on non-verbal cues indicating pain
- Dying in and of itself does not cause pain
- Look for reasons for possible pain – constipation, urinary retention, pressure sores, include psychological/emotional pain
- If you have ruled out a cause for the pain treat restlessness with sedatives
- **Opioids are NOT sedatives**. Too much opioid medication can cause Opioid Neurotoxicity – confusion, agitation, myoclonus, PAIN

Consider prophylactic laxatives to avoid constipation

Non-opioids	ibuprofen or other NSAID, paracetamol (acetaminophen), or aspirin
Weak opioids	codeine, tramadol, or low-dose morphine
Strong opioids	morphine, fentanyl, oxycodone, hydromorphone, buprenorphine
Adjuvants	antidepressant, anticonvulsant, antispasmodic, muscle relaxant, bisphosphonate, or corticosteroid

Combining an opioid and non-opioid is effective, but do not combine drugs of the same class.

Time doses based on drug half-life ("dose by the clock"); do not wait for pain to recur

Adapted by Treat the Pain from World Health Organization http://www.who.int/cancer/palliative/painladder/en/ (accessed 7 November 2013)

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Pain (cont’d)

- Opioids – ***GO LOW AND GO SLOW***
- Morphine 1-2.5mg, Hydromorphone 0.25-0.5mg
- May use prn or scheduled; consider long acting with breakthrough
- Short acting (eg. PRN) opioids typically last 4 hours; Q6H for elderly
- ATC dosing for consistent pain; for TID dosing Q6H is best managed
- PRN dosing – typically 10% of ATC dose Q1-2HPRN; same time as long acting if needed
- Typically given via oral administration unless unable to take medication by mouth
- Route: PO, SC (conversation by 1/2 of oral route)

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Dyspnea

Assessment

- OPQRSTUV
- Ask the patient, as with pain dyspnea is subjective

Causes

- Cardiac -- CHF
- Pulmonary – COPD
- Anemia
- Frailty
- Cancer
- Infection – pneumonia
- Pulmonary Embolism
- COVID-19

Dyspnea (cont'd)

At EOL – *is it shortness of breath OR is breathing pattern changing?*

- If patient unresponsive, doesn't feel SOB, doesn't <u>need</u> oxygen to be started
- Oxygen levels <u>have to drop</u> for <u>someone</u> to pass away
- <u>Educate</u> families on expected changes, and short prognosis
  - <u>Breathing</u> is expected to become "agonal" and "apneic"
- Can still give opioid if breathing is rapid or "looks" generally uncomfortable
  - Decreases subjective sensation of feeling SOB

Dyspnea (cont'd)

Goals of care

- Manage underlying cause
- Non Pharmacological – fan, bed position, relaxation and breathing techniques
- Pharmacological – oxygen, antibiotics, bronchodilators, steroids, diuretics
- Opioids/ Benzodiazepines (midazolam, clonazepam), Nozinan
  - Go LOW/ Go SLOW
  - ATC vs BT
  - Example: Morphine 2.5mg PO QID and Q2h PRN
- Palliative sedation if intractable

Delirium

- Disturbance in attention and reduced clarity of awareness and orientation
- Develops acutely and fluctuates
- A change in cognition

Causes

- Drugs- Opioids, benzos (ativan), antidepressants, gabapentin
- Infection (UTI, pneumonia)
- Dehydration
- Brain mets
- Hypoxiemia
- Metabolic
- Constipation/urinary retention

Types

- Hyper- Hypo -Mixed

Delirium (cont'd)

Management – treat the cause; if able

- Non-Pharmacological
  - Environment- Noise, lighting activity; reassurance, reorientation, avoid physical restraints
- Pharmacological
  - Haloperidol
  - Quetiapine (seroquel)
  - Olanzapine
  - Methotrimeprazine (Nozinan)
  - Midazolam (versed)

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Terminal Delirium

It is estimated between 25 - 85% of patients who are dying experience symptoms associated with **restlessness** before death. It is thought to be result of metabolic encephalopathy resulting from organ failure, electrolyte imbalance, nutritional abnormalities or sepsis.

Interventions – goal is to control the distress, not to correct the cause

- Gentle, repeated reassurance; Reorientation
- Reduce stimulation' Low ambient light – natural light
- Avoid restraints, Limit noise and activity around resident, visitor
- 1st line: Haldol 0.5 – 1 mg (0.1 – 0.2 mL from 5 mg /mL vial) sub cut Q 4 hr prn

GI – Nausea/constipation

- Complex symptom with many potential causes; often more than one cause
- Constipation, medications (eg. Opioids), bowel obstructions, enteral feeding, UTI
- Try to determine the cause of the nausea in addition to giving medication to treat nausea
- Can use treatment PRN or scheduled depending on the cause of the nausea

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GI – Nausea/constipation (cont'd)

- Most nausea is mediated by dopamine in the brain, so most treatments work to block dopamine from triggering nausea in the brain
  - Haloperidol 0.5mg-1mg q8h prn
  - Metoclopramide 5mg q8h prn
  - Olanzapine 2.5mg q6h prn
- Most of these medications are antipsychotic medications, but will be given in much lower doses for nausea
- Sennosides, lactulose, PEG/laxaday
- Increasing dietary fibre and hydration is important, but will not treat medication-related constipation

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Case Study # 1: Resident Jack

- 75 year old male with prostate cancer with metastases to his bone
- He is prescribed HYDROmorph contin 3 mg Q12H and 0.5 mg PO Q1HPRN
- Today he complains of worsening pain to his hip

What do you do next?

- In the last 48 hours he has used on average 5 breakthroughs in a day with some relief

What would the next step be?

Case Study # 1: Resident Jack (cont'd)

- Jack now reports he is short of breath. PPS 40%

What do you do next?

- His health continues to decline and in a week, he presents with a PPS score of 10%. His oxygen is now 66% on room air. He is having periods of gasping. His daughter at his bedside asks for oxygen therapy

What would the next step be?

Case Study # 2: Resident Jane

- Jane 80 year old female with advanced dementia.
- Her PPS score is 30%. You note that she has not been sleeping at night as she would usually.

What do you do next?

- During the day you note she is withdrawn and occasionally agitated. She did not eat her lunch today.
- By the evening, she is moaning and yelling.

What may be happening?

Changing My Practice

- ✓ Utilize symptom management guidelines in managing symptoms
- ✓ Manage symptoms at EOL and educate families about what to expect
- ✓ Call my PPSMC for support

Thank you

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