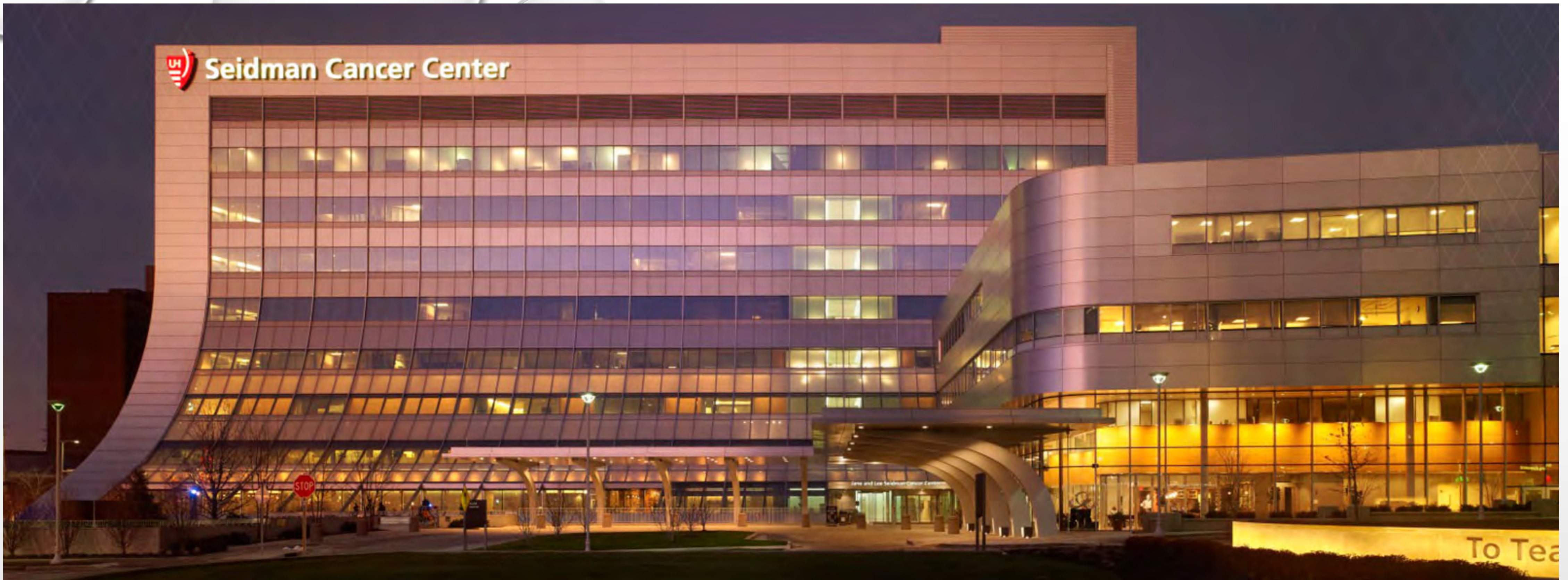


INTRODUCTION TO WEISMAN/ RATNOFF

NELROY G. JONES

OUTLINE

- GENERAL INFO
- COMMON ADMISSIONS
- TIPS AND TRICKS
- COMMUNICATION--- NURSES, SW, CARE CO-ORDINATOR
- GOC

WEISMAN/ RATNOFF

- WEISMAN- SEIDMAN 4
- RATNOFF- SEIDMAN 3
- CAPS:
  - INTERN- 8
  - INTERN + AI- 10
  - TEAM- 16-20 PATIENT'S

COMMON ADMISSIONS

- SICKLE CELL
- PAIN CONTROL, NAUSEA, VOMITING
- FAILURE TO THRIVE
- CORD COMPRESSION
- TUMOR LYSIS
- MALIGNANCY WORKUP
- HYPERCALCEMIA
- SVC SYNDROME
- CONSTIPATION
- NEUTROPENIC FEVER
- GENERAL MEDICAL PROBLEMS

TOP 5 RATNOFF/WEISMAN

1. NEUTROPENIC FEVER
2. SICKLE CELL
3. CORD COMPRESSION
4. TUMOR LYSIS
5. PAIN MANAGEMENT

TIPS AND TRICKS-ADMISSIONS

- INCLUDE RELEVANT ONC HX ESPECIALLY TREATMENT
- KNOW THE OUTPATIENT HEME ONC ATTENDING AND EMAIL NOTIFYING THEM OF THE ADMISSION
- DOES THE PATIENT NEED TELEMETRY?
- GENERAL ADMIT ORDERS
  - ANTICOAGULATION– LOVENOX VS HEPARIN (SUB Q/ DRIP)
  - RESPIRATORY- O2 REQUIREMENTS, TRACH CARE, CPAP/ RT CONSULT
  - DIET- RESTRICTIONS, TUBE FEEDS
  - PAIN CONTROL- PO VS IV, CHRONIC VS ACUTE, CONVERSION TO MORPHINE EQUIVALENTS. OARRS
  - ADMISSION BLOOD WORK
    - LOOK FOR ADD ONS,
    - ALL ORDERS IN AT THE SAME TIME.
    - DECREASE NEEDLE STICKS
  - MED REC.
  - ORDER PT/OT

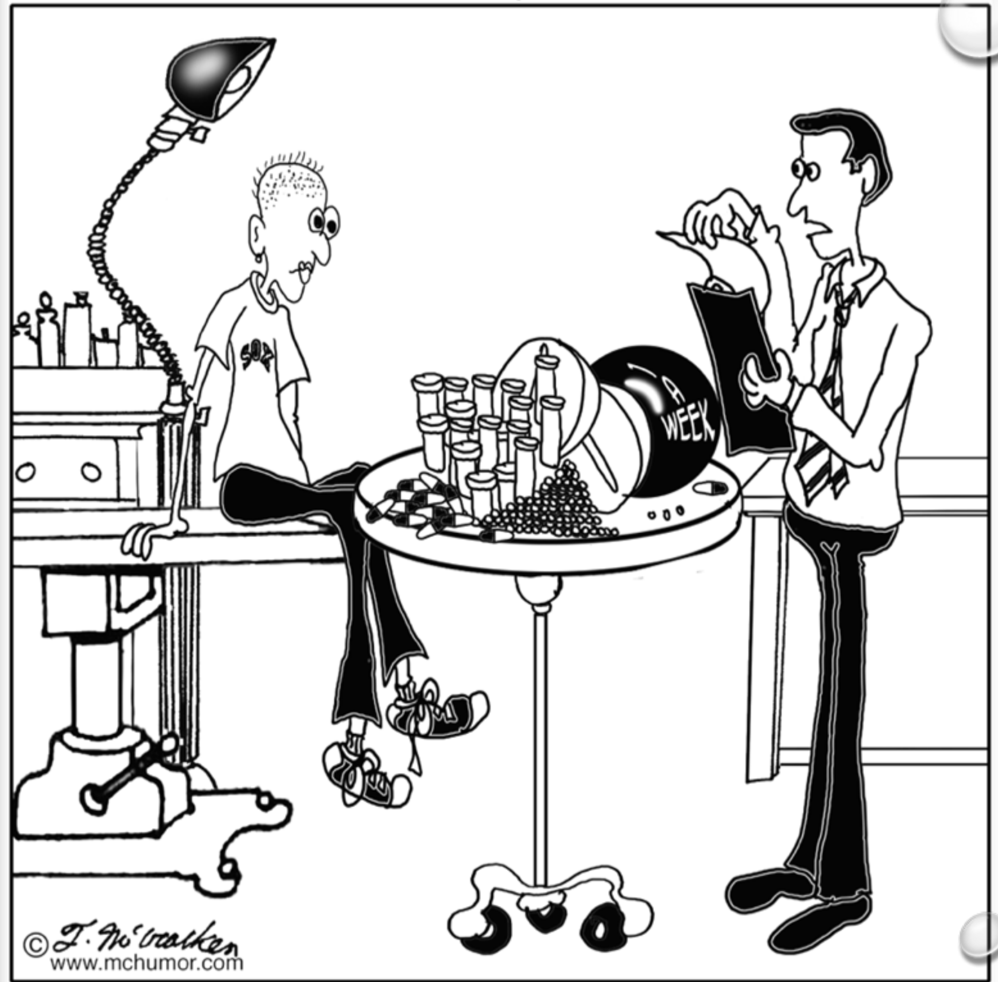
WHAT’S THE DEAL WITH THE DIET?

- ANOREXIA
- DYSGEUSIA –HYPOGEUSIA VS AGEUSIA
- FAMILY TEND TO ASK ABOUT DIET MORE THAN ANYTHING ELSE. WHY?
  - ONE AREA THEY CAN UNDERSTAND AND/OR CONTROL.
  - FOOD = LOVE

COMMUNICATE, COMMUNICATE, COMMUNICATE

- COMPLEX PATIENT = INCREASED PROBABILITY OF THINGS BEING OVERLOOKED
- UPDATE NURSES ON GENERAL PLAN OF CARE FOR PATIENT.
- UPDATE FAMILY ON PROGRESS OF PATIENT.
- SOCIAL WORK AND CARE CO-ORDINATORS MEET WITH SENIORS AND WILL GET UPDATED THEN

THE PATIENT



CANCER PATIENT

- NEW OR RECURRENT MALIGNANCY-
  - WHAT IS THE BEST IMAGING MODALITY TO DETERMINE LOCATION AND SPREAD?
  - CAN WE BIOPSY? HOW?
- TYPE OF CANCER
  - CHEMO SENSITIVE VS RT VS COMBINATION THERAPY
  - METASTASIS
  - PROGNOSIS
- UNDERGOING TREATMENT?
  - IS THIS A SIDE EFFECT FROM TREATMENT OR PROGRESSION OF MALIGNANCY?
- TREAT SYMPTOMS

A 37-YEAR-OLD WOMAN IS EVALUATED IN THE EMERGENCY DEPARTMENT FOR FEVER AND RIGORS OF 4 HOURS' DURATION. MEDICAL HISTORY IS SIGNIFICANT FOR ACUTE LYMPHOBLASTIC LEUKEMIA FOR WHICH SHE COMPLETED MULTIAGENT CHEMOTHERAPY 10 DAYS AGO. HER MEDICAL HISTORY IS OTHERWISE NONCONTRIBUTORY, AND SHE TAKES NO OTHER MEDICATIONS.

ON PHYSICAL EXAMINATION, TEMPERATURE IS 38.8, BLOOD PRESSURE IS 110/60 MM HG, PULSE RATE IS 100/MIN, AND RESPIRATION RATE IS 16/MIN. ON PULMONARY EXAMINATION, THE LUNGS ARE CLEAR. THE REMAINDER OF THE PHYSICAL EXAMINATION IS UNREMARKABLE. LABORATORY STUDIES INDICATE A LEUKOCYTE COUNT OF 0.3 L WITH 0 NEUTROPHILS. THE REMAINING LABORATORY STUDIES ARE NORMAL.

A CHEST RADIOGRAPH IS NORMAL. BLOOD AND URINE CULTURES ARE OBTAINED.

WHICH OF THE FOLLOWING IS THE MOST APPROPRIATE NEXT STEP IN MANAGEMENT?

A. ADMINISTER GRANULOCYTE-MACROPHATE COLONY-STIMULATING FACTOR

B. AWAIT CULTURE RESULTS BEFORE STARTING ANTIMICROBIAL THERAPY

C. BEGIN PIPERACILLIN-TAZOBACTAM

D. BEGIN VANCOMYCIN

NEUTROPENIC FEVER

- NEUTROPENIA: ANC <1500 CELLS/UL; RISK OF INFECTION RISES WITH ANC <500 CELLS/UL
- INFECTIOUS ETIOLOGY IDENTIFIED IN 20-30% OF EPISODES
- COMMON ORGANISMS: S. EPIDERMIDIS, S. AUREUS, PSEUDOMONAS AND OTHER GRAM NEGATIVES

NEUTROPENIC FEVER: MANAGEMENT

- 2 SETS OF BLOOD CULTURES
- CULTURES FROM OTHER SITES IF CLINICAL SUSPICION
- CXR IF RESPIRATORY SX
- INITIAL MONOTHERAPY WITH ZOSYN, CEFEPIME, OR MEROPENEM
- VANCOMYCIN FOR SOME INDICATIONS
- TREATMENT IS TYPICALLY CONTINUED AT LEAST UNTIL ANC > 500
- ADDING ANTIFUNGALS

AG Freifeld et al. Clinical practic guideline for the use of antimicrobial agents in neutropenic patients with cancer: 2010 update by the infectious diseases society of america. *Clinical Infectious Diseases*. 2011. 52(4): 56-93.

A 29-YEAR-OLD MAN IS EVALUATED IN THE EMERGENCY DEPARTMENT FOR DYSPNEA AND DIFFUSE SEVERE PAIN IN THE ARMS, LEGS, BACK, AND CHEST OF 2 DAYS' DURATION. HE HAS SICKLE CELL ANEMIA AND EXPERIENCES PAINFUL EPISODES ONE TO TWO TIMES PER YEAR. HE ALSO HAS A HISTORY OF ACUTE CHEST SYNDROME AND HAS KNOWN ERYTHROCYTE ALLOANTIBIODIES. IN ADDITION TO INCREASED FLUID INTAKE AT HOME, HE HAS BEEN TAKING ORAL MORPHINE SULFATE, 30MG TWICE DAILY, WITH NO RELIEF. HE ALSO TAKES FOLIC ACID.

ON PHYSICAL EXAMINATION, TEMPERATURE IS 36.8, BLOOD PRESSURE IS 153/65 MM HG, PULSE RATE IS 108/MIN, AND RESPIRATION RATE IS 20/MIN. OXYGEN SATURATION IS 98% WITH THE PATIENT BREATHING AMBIENT AIR. THE PATIENT IS HUNCHED OVER IN PAIN, AND HE IS DIFFUSELY TENDER TO TOUCH. CARDIOPULMONARY, ABDOMINAL, AND NEUROLOGIC EXAMINATIONS ARE NORMAL.

LABORATORY STUDIES SHOW HEMOGLOBIN 7.2 G/DL, LEUKOCYTE COUNT 11,900/ L WITH A NORMAL DIFFERENTIAL, PLATELET COUNT OF 199,000/ L, RETICULOCYTE COUNT 5.4%, AND LACTATE DEHYDROGENASE OF 420 UNITS/L. THE PATIENT HAS ALLOANTIBODIES TO ANTIGENS C, E, AND K ON BLOOD TYPING AND SCREENING.

IN ADDITION TO INTRAVENOUS HYDRATION AND INCENTIVE SPIROMETRY, WHICH OF THE FOLLOWING IS THE MOST APPROPRIATE INITIAL TREATMENT?

A. ERYTHROCYTE EXCHANGE TRANSFUSION

B. ERYTHROCYTE TRANSFUSION

C. INTRAVENOUS MEPERIDINE

D. INTRAVENOUS MORPHINE

SICKLE CELL PATIENT

- SICKLE CRISIS
  - PAIN EPISODES
  - STROKE
  - MI
  - ACUTE CHEST SYNDROME,
  - PRIAPISM
  - VTE
  - LIVER DISEASE
  - SPLENIC SEQUESTRATION
  - LEG ULCERS
  - OSTEONECROSIS/ AVN
  - RETINOPATHY
  - INFECTION,

MANAGING A VASO-OCCLUSIVE CRISIS

- LABS: CBC, RETIC, LDH, CMP, CRP, UA, T&S
- PAIN CONTROL AND FLUID RESUSCITATION.
  - WHAT ARE HOME PAIN MEDS? → OARRS
  - DO THEY HAVE A CARE PATH? → PORTAL OR PREVIOUS ADMISSIONS
  - DR. LITTLE RECOMMENDS D5/1/2 NS AS IV FLUID
  - CONTACT SANTINA AND SICKLE CELL TEAM
- WHAT IS PATIENT'S BASELINE HGB?
- INCENTIVE SPIROMETRY DECREASES ACS
- SUPPLEMENTAL OXYGEN
- DON'T FORGET INFECTION. THEY ARE FUNCTIONALLY ASPLENIC (MAY BE ON ABX PPX)

PAIN MANAGEMENT

- PAIN AFFECTS 70-80% OF PATIENTS WITH ADVANCED MALIGNANCY
- PAIN IS OFTEN UNDERTREATED
- CAN BE RELATED TO THE MALIGNANCY OR THE TREATMENT
- PAIN ASSESSMENT
  - HISTORY
  - PAIN SYNDROME
  - PATHOPHYSIOLOGY AND ETIOLOGY OF PAIN
  - EXTENT OF MALIGNANCY AND PLAN FOR FURTHER TREATMENT
  - GOALS OF CARE
  - RELATED SYMPTOMS

A Caraceni et al. Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC. *The Lancet: Clinical Oncology*. 2012. 13:2 (58-68).

TREATMENT OF PAIN

- CAN INCLUDE DISEASE-MODIFYING THERAPIES AND SYMPTOMATIC TREATMENT
- OPIOID ANALGESICS
- NON-OPIOID ANALGESICS
- ADJUVANT ANALGESICS
- NON-PHARMACOLOGIC TREATMENT

OPIOID ANALGESIA

- START WITH SHORT ACTING
  - TRAMADOL
  - OXYCODONE
  - HYDROMORPHONE
- PATIENT CONTROLLED ANALGESIA
- TRANSITION TO A LONG ACTING AGENT
- PALLIATIVE CARE CONSULT

OTHER ISSUES IN PAIN MANAGEMENT

- ADJUVANT THERAPY
  - ANTICONVULSANTS (GABAPENTIN)
  - ANTIDEPRESSANTS (DESIPRAMINE AND NORTRIPTYLINE)
  - CORTICOSTEROIDS
- OPIATE SIDE-EFFECTS
  - CONSTIPATION
  - NAUSEA
  - ITCHING

E Bruera and HN Kim. Cancer Pain. *JAMA*. 2003. 290:18 (2476-2479).

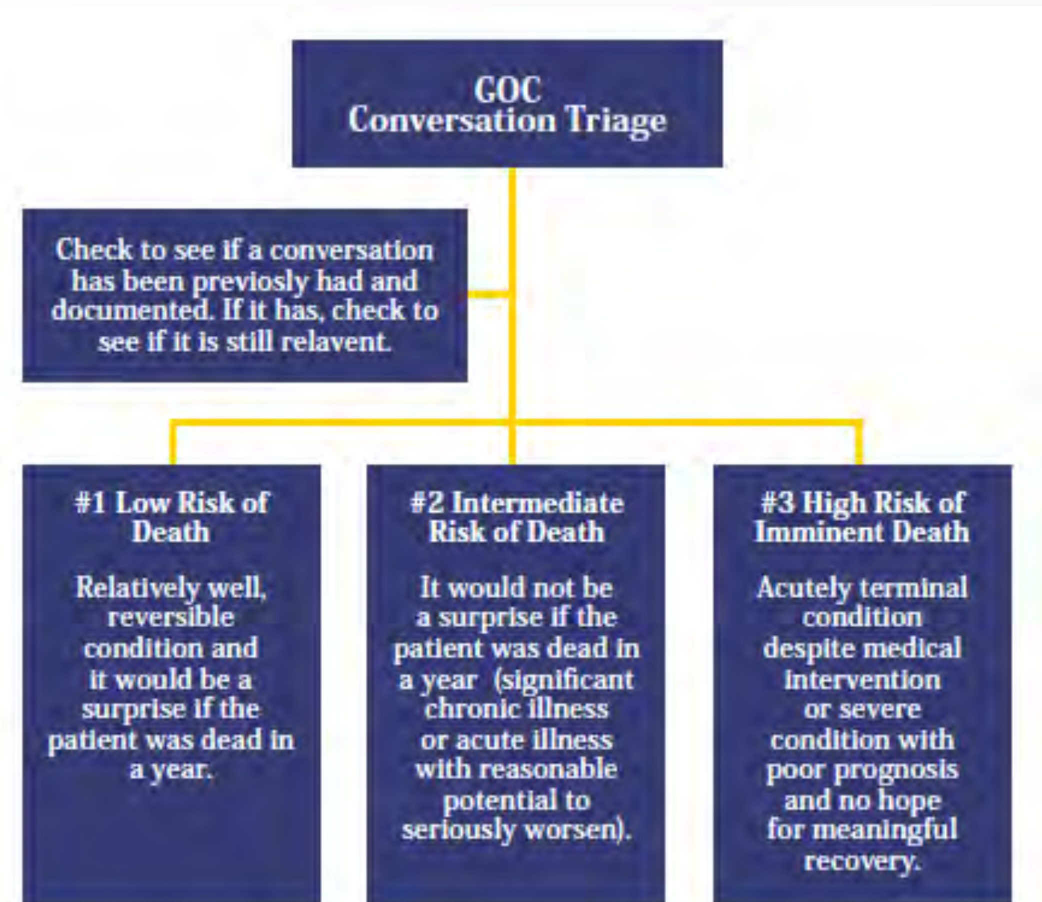
GOALS OF CARE

- Different from Advanced Care Planning - where people plan for a time when they cannot make decisions for themselves. Living wills, HC POA etc.

- ACP - reflection on and determination of a person's values and wishes or preferences for care at the end of life

- GOC discussions are aimed on applying ACP to current situation based on the patient's goals.
    - Focused on current clinical situation.
    - Has the situation changed?
    - How has it changed?

- How do you have this conversation?



SPIKES

- **STEP 1: S—SETTING UP THE INTERVIEW**
  - **ARRANGE FOR PRIVACY**
  - **ENSURE THAT ALL MEDICAL PERSONNEL ARE ON THE SAME PAGE**
  - **ENSURE STAKEHOLDERS ARE PRESENT- FAMILY, SO, SW, PALLIATIVE CARE, OTHER TEAMS**
  - **SIT DOWN**
  - **CONNECT WITH PATIENT**
  - **MANAGE ANY TIME CONSTRAINTS AND INTERRUPTIONS**
- **STEP 2: P—ASSESSING THE PATIENT'S PERCEPTION**
  - **ASK BEFORE YOU TELL--- WHAT HAVE YOU BEEN TOLD OF YOUR MEDICAL SITUATION SO FAR?**
  - **ARE THEY IN DENIAL/ HAVE UNREALISTIC EXPECTATIONS**
- **STEP 3: I—OBTAINING THE PATIENT'S INVITATION**
  - **WHAT WOULD THEY LIKE TO KNOW? WHAT WOULD THEY LIKE YOU TO FOCUS ON?**

Table 2. Examples of empathic, exploratory, and validating responses

Empathic statements	Exploratory questions	Validating responses
"I can see how upsetting this is to you."	"How do you mean?"	"I can understand how you felt that way."
"I can tell you weren't expecting to hear this."	"Tell me more about it."	"I guess anyone might have that same reaction."
"I know this is not good news for you."	"Could you explain what you mean?"	"You were perfectly correct to think that way."
"I'm sorry to have to tell you this."	"You said it frightened you?"	"Yes, your understanding of the reason for the tests is very good."
"This is very difficult for me also."	"Could you tell me what you're worried about?"	"It appears that you've thought things through very well."
"I was also hoping for a better result."	"Now, you said you were concerned about your children. Tell me more."	"Many other patients have had a similar experience."

- **STEP 5: E—ADDRESSING THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES**
- **STEP 6: S—STRATEGY AND SUMMARY**
- **REVIEW & REVISE PERIODICALLY PRN**
  - **REMAP**

SPIKES PRACTICE

PATIENT IS A 65 YO MAN WITH PMHX SIGNIFICANT FOR PANCREATIC CANCER WHICH WAS RESECTED WITH WHIPPLE PROCEDURE 5 YEARS AGO, COMING IN WITH NEW ONSET ABDOMINAL PAIN AND SOB. CT SCAN SHOWS MULTIPLE LIVER MASSES AND LUNG MASSES.

- BREAK UP INTO PAIRS
- PERSON WITH LARGER SHOE SIZE IS THE HEALTH CARE PROVIDER FIRST.
- PRACTICE SPIKES.

DON'T FORGET THE CAREGIVER

- PROVIDING CARE TO A CANCER PATIENT IS A FULL TIME JOB. CAREGIVERS TAKE ON THE RESPONSIBILITIES OF CANCER PATIENT AND THE HOUSEHOLD IN ADDITION TO THEIR OWN.
- THIS LEADS TO CAREGIVER BURDEN:
  - "MULTIDIMENSIONAL BIOPSYCHOSOCIAL REACTION RESULTING FROM AN IMBALANCE OF CARE DEMANDS RELATIVE TO CAREGIVERS' PERSONAL TIME, SOCIAL ROLES, PHYSICAL AND EMOTIONAL STATES, FINANCIAL RESOURCES, AND FORMAL CARE RESOURCES GIVEN THE OTHER MULTIPLE ROLES THEY FULFILL" (AS CITED IN GIVEN ET AL., 2001B).
- MOST CAREGIVERS ARE UNPREPARED TO PROVIDE CARE NEEDED BY CANCER PATIENT
  - REMIND THEM THAT SELF-CARE MAKES THEM MORE EFFECTIVE
  - HAVE SW OFFER RESOURCES
    - EX. THE GATHERING PLACE

LAST WORD

- DON'T FORGET TO USE YOUR RESOURCES
  - PALLIATIVE CARE
- IF YOU RUN INTO ANY ISSUES OR PUSH BACK **ALWAYS** FRAME ISSUE IN TERMS OF PATIENT AND PATIENT CARE.
- IF IN DOUBT ASK SOMEONE

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