# Intro to Palliative Care

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# Objectives

Understand the goals of palliative care and how it differs from hospice

Walk through the basics of pain control and the pain ladder

Clarify the language of code status

# What is it?

“Palliative care is specialized medical care for people with serious illness. It focuses on providing relief from the symptoms and stress of serious illness. The goal is to improve quality of life for both the patient and family.”

# What is it?

Multidisciplinary team approach

Aims to relieve pain and other distressing symptoms

Provides support for both patient and family

Integrates psychological and spiritual aspects of care

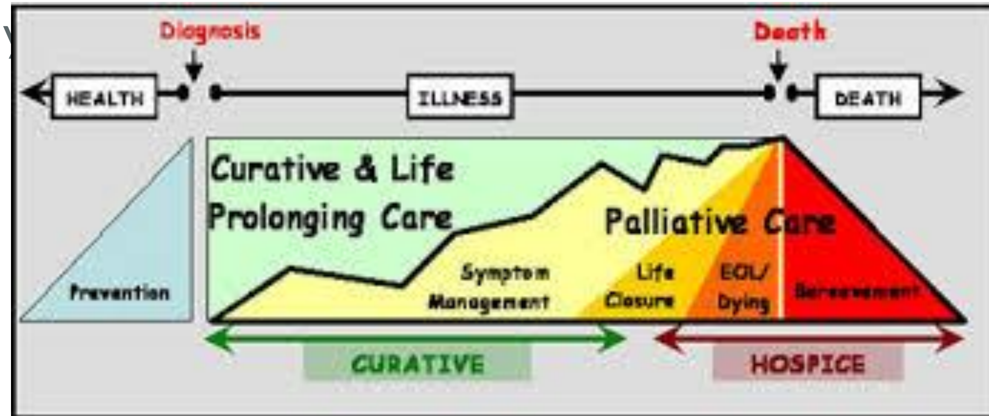
Intends neither to hasten nor postpone death

# How is hospice different than pall care?

Palliative care can be given alongside therapies with curative intent and can be given at any point during the care of a patient with a serious illness

Hospice care is reserved for patients who are estimated to be within the last 6 months of their life - focus is exclusively on patient comfort and family support.

Hospice provides famil the patient's death



# Pain

You get a page during noon conference from “41550” - Lakeside 50

“Doctor, the patient in room 52 is in pain and doesn’t have anything ordered. Can you put something in for him?”

# Pain "PPQRST"

**Provocation - what makes it worse?**

**Palliation - what makes it better?**

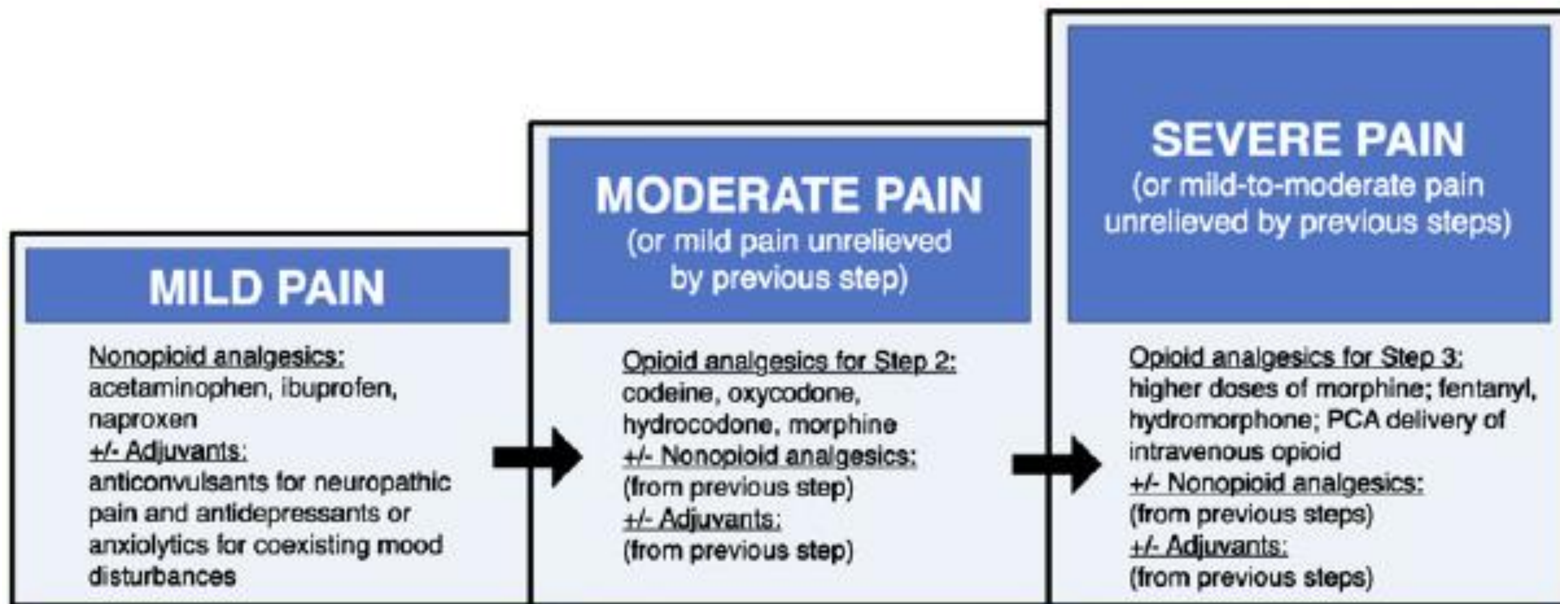
**Quality - stabbing? dull? cra**

Radiation

**Severity - pain scale**

Timing

# WHO Pain Ladder




*Proposed specifically for cancer pain
*Chronic non-cancer pain should NOT be managed long term with opiates

# Non-opioids

Acetaminophen
- 650mg PO q4h  (can do PRN or scheduled)
- Daily max; 3-4g per day
- Caution in liver patients - daily limit of 2g
- IV tylenol available at VA

NSAIDS
- Ibuprofen 400-800mg PO q6h
- Toradol (ketorolac) 15-30mg IV q6, stop after 5 days
- Caution in cardiac patients, GI bleed, renal patients, contraindicated in pregnancy

# Opioids

**Oral:** Tramadol, Morphine, Oxycodone, Dilaudid, Methadone
**IV:** Morphine, Dilaudid
**Transdermal:** Fentanyl

Moderate pain - start with oral opioids

- Tramadol 50mg PO q6h or q12h (max 200mg/day)
- Morphine 5-10mg PO q4h
- Oxycodone 5mg PO q4-6 hours

Severe pain - can use IV opioids

- Dilaudid 0.2mg IV q3h
- Morphine 2mg IV q3-4h

# A quick word on PCAs

Most often used in sickle cell crisis, post-op, or severe unrelenting pain not responsive to intermittently dosed opiates

**Demand dose** - the amount a patient receives when he/she presses the button for pain relief (typically start at 0.2mg with a 6-minute lockout)

**Bolus dose** - larger doses that can be nurse-administered if patient is still in pain despite using their demand doses (typically 0.6mg q1h PRN)

**Basal Rate** - typically we do NOT use this feature; this would provide a continuous dose of opiate at all times whether the patient rated that he/she was in pain or not

# Case

You are on Night Float and are covering the Seidman teams. You receive a call from a nurse on Seidman 4 that one of the Ratnoff patients has become increasingly altered and somnolent over the course of the last hour. She has a history of stage IV cancer and is admitted with severe intractable pain. You review her medications and see that she is on a dilaudid PCA and the demand dose and bolus dosing had just been increased earlier in the day. She also just received two extra boluses from the nurse due to severe pain. You assess her and she is only responsive to sternal rub. You count her respirations at 9. Her pulse ox is stable and she is still protecting her airway. What are your options?

# Narcan

Initial dose: 0.4-2mg IV

Can repeat every 2-3 minutes if desired response is not achieved

Effects last about 30 minutes to 1 hour

Can produce severe rebound pain

# Risks of opioids

- Significant potential for addiction and abuse (MUST CHECK OARRS PRIOR TO PRESCRIBING AS AN OUTPATIENT)
- Constipation - ALWAYS ORDER A BOWEL REGIMEN
- Sedation/Respiratory depression
- Nausea
- Itching

# How do I convert between Opioids?

Opioid conversion calculator - I use globalrph.com

Should reduce dose for cross-tolerance when changing between opiates

To convert from short acting to long acting: dose of long acting should be ~50-75% of total daily requirement

**OPIOID ANALGESIC CONVERSION CHART**

| Opioid | IV (mg) | PO (mg) | Interval/ Duration (hr) | Onset (min) | Peak (min) | Comments |
|---|---|---|---|---|---|---|
| **Morphine (MSIR)** | 10 | 30 | 3–4 | IM 15–30<br>IV < 5<br>PO 15–60<br>PR 10–20<br>SC 5–10 | 30–60<br>10–20<br>60<br>20–60<br>50–90 | Injection: 2,4,8,10,15 mg/mL syringes<br>Oral IR: 10,15,30 mg tablets<br>Oral soln: 10mg/5mL, 20mg/mL<br>Suppositories: 5,10,20,30 mg |
| **Morphine SR (MS Contin®, Kadian®, Avinza®)** | | | 8–12 | 20 – 40 | 60 | MS Contin (q12h): 15,30,60,100,200 mg tabs,<br>Kadian (q12h): 20,30,50,60,80,100 mg caps,<br>Avinza (q24h):30,60,90,120 mg caps |
| **Hydromorphone (Dilaudid)** | 1.5 | 7.5 | 3–4 | IM 15–30, IV < 5, PO 15–30 | 30–90<br>10–20<br>30–90 | Injection: 1,2,3,4,10 mg/mL;<br>Tablets: 1,2,3,4,8 mg; Oral Soln: 1mg/mL |
| **Fentanyl inj. (Sublimaze)** | | | IV: 0.5–1<br>PO: 1–2 | IV 1–2 | 3–5<br>10–30 | Injection: 50 mcg/mL |
| **Fentanyl tab/loz. (Actiq, Fentora, Onsolis, Abstral)** | 0.1–0.2 | 0.2–0.4 | Buccal: 1–2 | Buccal 5–15 | | Bioavailability different for each product<br>Dosing individual for each product |
| **Fentanyl patch (Duragesic)** | | | 72 | 8 – 12 hr | 24 – 36 hr | 25mcg patch = 60mg oral morphine/day<br>Patches: 12, 25, 50, 75, 100 mcg/hr |
| **Methadone** | See comments | | 6-12 | IV 10–20<br>PO 30–60 | 30–60 | PO morphine:methadone ratio (mg/day):<br>< 90 mg (4:1); 90–300mg (8:1); > 300 (12:1) |
| **Oxycodone (Oxycontin (CR), OxyIR)** | | 20 | IR 3-4<br>CR 12 | PO 10–15 | 30–60 | morphine:oxycodone ratio: 3:2<br>25% will require q8hr dosing with Oxycodone CR |
| **Hydrocodone** | | 30 | 3–4 | PO 10–20 | 30–60 | Lortab, Norco: 5,7.5,10mg (500,325mg) |

# Opioid Conversion - Case

You are on Weisman and you are working on optimizing your patient’s pain regimen. He has metastatic prostate cancer with bony metastases that cause him significant discomfort. He has completed a course of palliative radiation but still has a lot of pain. You are a few days away from discharge and need to start thinking about how to control his pain at home.

Currently,  he is getting oxycodone 15mg q4H PRN moderate pain, and has dilaudid 0.8mg q3H for severe pain.  You look back in the EMR and he got 6 total doses of oxycodone over the past 24 hours (essentially scheduled), and he got 3 doses of IV dilaudid for breakthrough pain. Your attending suggests starting a long-acting agent for pain control. How do you do this???

# Case continued

Start by converting all his pain medicines back to PO morphine equivalent

Oxycodone 15mg x 6 doses = 90mg PO oxycodone

$$90\text{mg PO oxy} \times \frac{30\text{mg PO morph}}{20\text{mg PO oxy}} = 135 \text{ mg PO Morphine}$$

Dilaudid 0.8mg x 3 doses = 2.4mg IV dilaudid

$$2.4\text{mg IV dilaudid} \times \frac{10\text{mg IV morphine}}{1.5\text{mg IV dilaudid}} \times \frac{30\text{mg PO Morphine}}{10\text{mg IV morphine}} = 48 \text{ mg PO morpine}$$

# Case continued

So, our PO morphine equivalent for the last 24 hours is 135 +48 = 183mg

Now, we will take half of that and convert to long acting

183/2 = ~90mg PO morphine

90/2 = 45mg PO morphine BID

Can start with 45mg long-acting morphine BID, and continue oxycodone 15mg q4h PRN

# What are adjuvants?

Gabapentin/pregabalin - neuropathic pain

SNRIs - neuropathic pain

Flexeril (cyclobenzaprine) - muscle relaxants can significantly reduce pain related to muscle spasms. (others include baclofen and zanaflex)

Benzodiazepines - anxiety can manifest as pain (also with addictive potential)

Lidoderm patch - topical treatment can be helpful for muscular pain/local pain

# Code Status

Many of the terms we use are confusing to patients and can even be confusing to healthcare providers

DNAR - ?

DNR-CCA - ??

DNR-CC - ???

DNR/DNI - ????

# Code Status

Many of the terms we use are confusing to patients and can even be confusing to healthcare providers

**DNAR - Do not attempt resuscitation**

**DNR-CCA - “comfort care arrest”  - same as plain old DNAR**

**DNR-CC - “comfort care” - hospice**

**DNR/DNI - do not attempt resuscitation AND do not perform elective intubation**

# Code Status

You are on geriatrics and are admitting an 85 year old woman from the ED with a UTI. She has baseline dementia (AOx2 usually) and on your current exam she is only answering yes/no questions and appears confused. You need to discuss code status - what do you do?!?

# Code Status

- Call family
- Ask if patient has a medical Power of Attorney (different than a financial power of attorney)
- Ask if patient has a living will (and if they do, ask them to bring in a copy!)
- If no appointed POA, there is an established chain of decision makers
    - Spouse → majority of adult children → parents → "other family members" (aunts/uncles/cousins/grandchildren)
- Call ethics if you aren't sure!

# Code Status

Make it a habit to reconfirm code status with patients admitted overnight

**Do not be afraid to re-address code status throughout a patient's hospital stay as the clinical picture changes**

"Hope for the best, prepare for the worst"

# Code Status - Statistics

AHA data from 2012:

- 24% of adults with in-hospital arrest survived to discharge
- If initial recorded rhythm was VF or pulseless VT, that number increased to 43%
- >200,000 in-hospital arrests per year in the US

Portenders of poor outcome in the event of cardiac arrest: hepatic insufficiency, acute stroke, renal failure/dialysis, metastatic cancer, poor functional status

**The more comorbidities the patient has, the less likely they are to survive a cardiac arrest**

# Palliative Care and Ethics

Pall care -35614

- If consult is for pain, know their recent pain regimen
- Be prepared to arrange family meeting  and palliative care will assist

Ethics - 33298

- Can be called by anyone on the team at anytime

# Thank you!!

# Goals of Care and Giving Bad News

# SPIKES

1. Set the stage for the interview

- Practice what you will say and try to anticipate difficult questions
- Arrange for privacy
- Ensure that family members are present if patient desires
- SIT DOWN
- Hand off your pager if possible!

# SPIKES

2. Assess the patient's Perception

-Gauge what the patient understands

-Before you tell, ask

-"What is your understanding of the reason we did the MRI?"

# SPIKES

3. Obtaining the patient's Invitation

-Asking how much a patient would like to know

-Some patients prefer to focus on a treatment plan rather than to specifically hear exactly what is wrong

# SPIKES

4. Giving Knowledge and information to the patient

-Give a "warning shot" (ex: "I'm sorry to tell you that…")

-Use common vocabulary

-Give information in small chunks, checking for understanding

-Avoid the phrase "there is nothing more we can do for you"

# SPIKES

5. Addressing patient's Emotions with empathy

-Allow for silence and time for patient to express themselves after receiving the bad news

-Recognize which emotion is being expressed

-Name the emotion

-Show your support of them with empathy. "I know this isn't what you wanted to hear", "I was also hoping for a better result"

# SPIKES

## 6. Strategy and Summary

- Having a clear plan for the future can reduce anxiety surrounding bad news
- Reassure patient that you will not abandon them in their time of need
- Be available for questions that patients may have in the future