



Objective One

In all patients with terminal illnesses (e.g., end-stage congestive heart failure or renal disease), use the principles of palliative care to address symptoms (i.e., do not limit the use of palliative care to cancer patients).

It may be easier to remember this point by remembering the principles of Palliative Care, the definition we like best is from the WHO:

“An approach that improves the quality of life of patients, and their families, facing life-threatening illness, through the prevention and relief of suffering by means of:

- Early identification
- Impeccable assessment and treatment of:
 - pain and other symptoms
 - Physical concerns
 - Psychosocial concerns
 - And spiritual concerns”

(Note that the WHO definition has changed terminology from “life-limiting” to “life-threatening” illness - have a look at “bow-tie” model of 21st century palliative care)

https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/For+Professionals/For+Professionals/The+Exchange/Current/The+Bow+Tie+Model+of+21st+Century+Palliative+Care.aspx

While cancer is a common life limiting illness, it is far from the only end-of-life illness. The principles of palliative care focus on providing symptom management and optimizing quality of life at end of life. It's easy to see how these principles are well leveraged and equally beneficial in both malignant, as well as non-malignant life-limiting illnesses such as end-stage COPD, Heart Failure, Dementia etc.

The primary differences between the two being differing illness trajectories, and often a different pyramid of symptoms and treatments to achieve the desired quality of life in these patients.

It is interesting to note that while a palliative approach to care can enhance quality of life, this does not necessarily come with a trade-off of shortening life, as many might believe.



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In fact, a landmark study by Temel et al. in 2010, looked at the impact of early palliative care for patients diagnosed with metastatic non-small cell lung cancer. This is in contrast to those who received palliative only near the end of life as was traditionally done.

Contrary to what some of us might intuit, the folks who had early palliative care not only had lower rates of anxiety, lower rates of depression higher quality of life scores, and also lived longer, by more than two months! <https://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678>

Summary

1. Palliative care means managing symptoms and enhancing quality of life in the face of life-threatening or life-limiting illness
2. Think beyond just cancer for palliative care
3. Early palliative care initiation increases quality of life (see below)

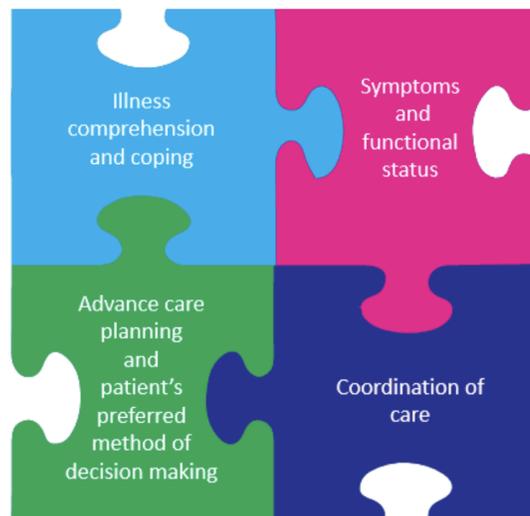
This is a picture taken from an ongoing research project from Dr. Simon (one of our palliative care staff and researchers regarding early palliative care in those with colorectal cancer - <https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guide-metastatic-colorectal-early-palliative-cancer-care.pdf>). When I think about early palliative care, I think about ensuring that patients understand these components/elements of support are coordinated. The document goes further into each component as well, which I don't think you need to go into

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detail, but just a framework!

What are the Essential Components of an Early Palliative Approach to Care?

Several recent analyses of trials integrating oncology and palliative care point towards specific key elements of an early palliative care approach that support whole person care, quality-of-life focus, and mortality acknowledgement.^{6,13,21,32} In Alberta, these have been synthesized into four components, as shown in **Figure 2**.



Objective Two

In patients requiring palliative care, provide support through self, other related disciplines, or community agencies, depending on patient needs (i.e., use a team approach when necessary).

After having a serious illness conversation and establishing your patients values and goals, it quickly becomes apparent how finite your abilities as a physician become.

Very often these patients will require home assessment and equipment transport and setup at their home. This is the expertise of our occupational therapist colleagues.

Many will desire keeping their strength up and remaining independent in certain functions as long as they can, which is supported by our physical therapist teammates.



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They will need medication, symptom, and assessment support while at home or in hospice which is very much the forte of our nursing or nursing specialist team members. The coordination of this home care, knowledge of specific care homes and hospice facilities is made much more efficient by your transition services colleagues in hospital if you're lucky enough to have this service.

While you can help arrange these services, have these difficult conversations with your patients, prescribe medications and monitor for changes or side effects and advise in many areas, it quickly becomes apparent how much your patient will benefit in this context by having a multidisciplinary approach to palliative care.

Summary

- Recognize the value of multidisciplinary care and leveraging team mates in enhancing the quality of life for your palliative care patients, and their families

Objective Three

In patients approaching the end of life:

a) Identify the individual issues important to the patient, including physical issues (e.g., dyspnea, pain, constipation, nausea), emotional issues, social issues (e.g., guardianship, wills, finances), and spiritual issues. Patient Centered Clinical Reasoning History

b) Attempt to address the issues identified as important to the patient.

If you have somehow gotten this far in your education and career without having seen the serious illness conversation guide, let today be the day that changes. This is a succinct guide for how to introduce the conversation, and find out what your patient truly values.

This guide was developed by the well-known surgeon Atul Gawande with Ariadne Labs, with the beneficial effects for patients later studied using the guide at Dana-Farber Cancer Institute. Two randomized cluster clinical trials looking at outcomes of the SIGC were published last year.

One, published in JAMA internal medicine found, a significant reduction in patient moderate-to-severe anxiety and depression at end of life. The second, published in JAMA Oncology, found that "This communication quality-improvement intervention



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resulted in more, earlier, better, and more accessible serious illness conversations documented in the EMR”.

Outcomes from similar Serious Illness Conversation Program were investigated in Canada as well at Hamilton General Hospital very recently this June, 2020, published in CMAJ Open. Here again they found significant increase in the overall quality of documentation of conversations about significant illness, better understanding of patient’s values and goals, and better patient understanding of their prognosis and illness as well as life-sustaining treatments.

My initial thought when I saw this conversation guide, was that it would feel too robotic and like reading from a script. However, after actually using it on Palliative care rotations I can tell you it does not. It flows really well, and the order of the questions is quite thoughtful in one building off of the last.

One of my staff in fact carries a copy in her pocket despite years of having these conversations and says she refers to it on a regular basis. If that isn’t enough to convince you, nothing will. See our ‘Bad News’ episode for a more thorough review of this.

Patients have never balked at me actually having the guide out while I am talking to them and it can be helpful early on when using it. An image of the guide are in the shownotes and we will briefly cover it here:

b) Attempt to address the issues identified as important to the patient.

This means often multiple visits with your patient to suss this out. Again, I recommend first trying these verbatim from the conversation guide.

One thing you are likely to find after identifying the patient’s goals, sources of strength etc is that many of these things are not going to be directly supported by you. This is yet another area of palliative care when the multidisciplinary team becomes critical. For many, time with family will be their primary goal.

This requires OT to assess patient and their home, home care nursing and transitions team to discuss requirements of the family at home, medication administration teaching, coordination of equipment to their home before discharge from hospital. Such planning



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and support allows to optimize a patient's ability to live comfortably and safely, minimizes caregiver burden, and avoids unnecessary admission to hospital.

Stay aware of the patient's core values and dignity, and be sure to address their psychoemotional and spiritual health. In a basic sense, spirituality can be defined as what gives one meaning in life, and while this may include faith and religion, it is not exclusive to such a domain.

If looking for a formal definition: "Spirituality is the aspect of humanity that refers to the way individuals seek and *express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.*" (Puchalski et al., 2009)

spiritual care specialists in your hospital or community are often quite adept at having these conversations, adapting to the patients beliefs.

((<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1934489/pdf/bmj-335-7612-ac-00184.pdf>).

Here are a couple questions to consider using:

"What gives you purpose and meaning in your life?"

"What are the things in life that are most important to you?"

or "What should I know about you as a person to help me take the best care of you that I can?"

The loss of function, housing needs, family taking time off to care for their loved ones, can benefit from support from your social work. Whether it is assistance with housing, finances, counselling support and numerous other skills of our social worker colleagues.

Objective Four

In patients with pain, manage it (e.g., adjust dosages, change analgesics) proactively through:

- frequent reassessments
- monitoring of drug side effects (e.g., nausea, constipation, cognitive impairment)
(Pallium Canada - Via App)

I want to discuss pain in patients with palliative care needs briefly, because the approach feels quite different and also results in a unique management approach compared to what you may be accustomed to.



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This section leans heavily on the wonderful Pallium application, which also has a handbook available. In addition there are free online modules. I will put the link into this post on the website. The BC Centre for Palliative Care also has a large interactive pdf of symptom management guidelines, link to this is also on this post on the website.

One thing to remember is that generally we do not expect the pain to resolve over time with many of these conditions, and so the focus has to be on getting AHEAD of the pain early.

Briefly, the general outline does commonly reference the WHO analgesic pain ladder, which we will give a quick overview of now.

- Adjuvants such as radiotherapy, surgery, psychosocial needs and management of other comorbid symptoms underlie the entire ladder and so should be considered for any pain.
- Mild pain generally can be dealt with using non-opioids, such as acetaminophen and/or NSAIDs
 - Of course caution with NSAID if:
 - Significant renal disease
 - History of upper GI bleeds
- Moderate pain is considered the moderate pain step and refers to 'weak opioids' such as Tramadol or Codeine (note that low doses of "strong" opioids can be used as an alternative here)
 - Continue to use non-opioids alongside these and of course consider adjuvants that would be helpful
- Severe Pain and significant functional loss due to pain is where we get into opioids such as Morphine, Hydromorphone, Oxycodone
 - 2nd line is considered fentanyl if the above cause adverse effect or prove ineffective
 - 3rd line, methadone can also be considered, particularly if the neuropathic analgesic characteristics of this opioid may be beneficial.

Common 'Strong Opioid' Dosing

For each, consider halving the initial dose, and decreasing the frequency for particularly frail patients. Of course, also take into account whether or not they are opioid naïve.

Morphine:

note: despite a cultural shift toward hydromorphone over morphine, there is no data-driven rationale for using HM over morphine, unless apparent medical contraindication (for example, hydromorphone is considered safer in those with renal failure)



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- Reasonable starting dose is 2.5-5mg PO q4h
 - with 2.5-5mg q1h PO prn
 - Never forget to write for breakthrough prns,

Hydromorphone:

- 0.5-1mg q4h PO
 - with 0.5-1mg q1h PO prn

Manage Your Opioid Regimen

Once you have titrated your patient's dosing to a manageable pain level with short acting dosing.

1. Calculate their total 24h dose as morphine equivalents
2. Split this b.i.d. as long-acting contin dosing
3. Use 10% of this 24h dose as their new short-acting prn q1h breakthrough dosing
4. If they require four or more breakthrough doses on a regular basis, consider adding this to their 24h dosing and re-do the above calculations

To me, one of the nice things about palliative service is the ability to focus on applying appropriate therapies based on the nuance of the type of pain and it's likely aetiology. This enables more reasoned analgesia selection. There are three main types to consider: nociceptive, neuropathic and total pain.

- Nociceptive (caused by damage or disease affecting body tissue that isn't a nerve). can be visceral or somatic.
 - Generally your opioid regimen is going to serve well here.
 - For visceral pain,
 - particularly if due to hepatic mets, you can find benefit from Dexamethasone, 2-8mg per day
 - Colicky abdominal pain, may benefit from an anticholinergic such as: Hyoscine or Scopolamine
 - Can also consider a trial of steroid for colicky pain in addition
 - Bone Pain
 - can be awful and can often be helped with a few management options:
 - NSAIDs, though this have been falling out of favour of late due to risk of bleeding/renal concerns/combo with steroids
 - Steroids are more often used first instead
 - Radiation therapy, depending on feasibility of location. Quite often vertebral mets, for example, lend themselves well to this



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- Note that this can initially cause the pain to worsen, with pain reduction often seen 1-2 weeks later. A cycle of steroids can help during this initial post-treatment period
- Surgical removal may be feasible as well. On service I did see a few instances recently of arthroplasties with removal of the local bone mets to both eliminate the source as well as maintain function in the associated joint
- For bone pain, bisphosphonates can be considered as an adjunct, however the evidence of benefit is more toward reducing risk of pathologic fractures rather than any benefit from a pain perspective.
- Neuropathic (caused by damage or disease affecting the somatosensory nervous system) may look like radiculopathy or more of a glove and stocking distribution such as in diabetes or other systemic causes. Listen for patient descriptors such as 'lightning', 'burning' or 'tingling'
 - 1st line: gabapentin, 100-300mg tid initially with titration to effect
 - Caution in renal dysfunction
 - 1st line: pregabalin, 25-50mg daily, titrating up to 150-225mg daily
 - Also renal function risk
 - Another thing to consider is that pregabalin is often not covered and so can be very expensive for your patient compared to Gabapentin
 - 2nd line: Tricyclic antidepressants, *desipramine or nortriptyline*
 - 2nd line: Duloxetine(SNRI), initially 30mg daily, often 30-60mg daily
 - Often the side effects mean these are trialed before the TCAs
 - Adjunctive methadone is also an option, with a recent paper out of Calgary showing benefit even at microdosing starting at 1mg per day

Remember that pain is a multidimensional experience

Total Pain do NOT forget that an important component of pain is the patient's perception of the pain. This can augment or attenuate the physiologic pain that they are experiencing. Management might look like

- Acknowledging their pain
- Admitting the difficulty in helping it
- Careful discussion around psychosocial factors, anxiety and other stressors
- Offering counselling and support for psychosocial factors impacting them
- Continue to assess for these factors and reaffirming your commitment to the patient



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One of the primary medications that is ubiquitous in palliative care are opioids. They are so common in this patient population because they work. Of course we most often use them for their desirable analgesic effects, however they are also very useful for palliative symptoms such as dyspnoea.

However, just like any other medication or intervention, there are unintended side effects that need to be addressed.

Opioid Side Effects

Here it is useful to recognize two different sets of side effects.

There are the persistent side effects, that often need management and continuous monitoring. Then there are common immediate side effects that relate to the **initiation** of the opioids. These side effects, fortunately, most commonly will pass spontaneously usually in 3-5 days as the patient develops initial tolerance. These immediate effects include:

- Nausea
 - Expected to pass in 3-5 days, but can consider metoclopramide or domperidone prn with opioid prescription
- Somnolence
 - Can also expect this to pass in 3-5 days
 - If outpatient, advise no driving until pain controlled and somnolence has resolved

A non-transient side effect of opioids is Constipation (primary mechanism through which opioids cause constipation is by reducing bowel motility, and secondarily by reducing intestinal secretions).

- This is a big one, and very common. One good tidbit is “the hand that writes the opioid order, also writes the laxative order”
- Best bet here is daily PEG ‘polyethylene glycol’ 17g, which essentially acts as a non-absorbable sugar and causes osmotic effect to draw water out into the GI tract
 - Many folks on chronic opioids adjust this on their own and will adapt as needed to get to q2day bowel movements
- Second line Sennoside also works well as its primary mechanism is to speed peristalsis, which is counter to the opioid effect of slowing peristalsis
- Depending on practitioner preference, Senna may be considered a first line agent



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- Lactulose can also be considered, but is very sweet and sometimes not well loved by patients. Has the potential to cause a lot of bloating!
- Docusate is useless for this application. (Proven in RCT to be no more beneficial when added to senna, in comparison to using senna alone)
- If your patient remains refractory to this regimen, and is not obstructed but you really need to get their bowels moving, last line you can consider methylnaltrexone, which is an opioid antagonist, but acts preferentially on the gut (i.e it does not cross the blood brain barrier so will not reverse analgesic effect of the opioid).
- Less common, but important side effects to watch for
 - Dry mouth
 - Pruritis
 - Sweating
- Respiratory depression

(If you have the time, Consider talking about opioid side-effect (related to parent chemical) vs. neurotoxicity (related to opioid metabolite)).

To Summarize

- With end-of-life pain, get ahead of the pain or you will always be playing catch up
- Use your 0-10 pain scale and the WHO ladder for the basics of when to step up your interventions
- Know your starting doses for common opioids and consider reducing these for frail patients
- Know how to initiate an opioid regimen and transition to long-acting background forms
- Carefully assess your patient's pain in each anatomical area affected to clarify the type: somatic, visceral, neuropathic, or total. Do NOT forget total pain factors.
- The hand that writes the opioid Rx, writes the laxative Rx
- Recognize and anticipate opioid side effects and manage them proactively

Objective Five

In patients diagnosed with a terminal illness, identify and repeatedly clarify wishes about end-of-life issues (e.g., wishes for treatment of infections, intubation, dying at home)



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It is very important that your first conversation with them at diagnosis or hospital admission is not the last time you have this discussion.

Once you have identified their wishes at the initial visit, their mentation can change. The more often you review their desires while they are able to express them, the more up to date these wishes can be, before they lose the ability to speak for themselves.

Further to this, patients are, understandably, overwhelmed at first with all of the information. Particularly when suddenly learning of their life-limiting illness. Give them time to digest and reflect.

Additionally, their circumstances can change and their priorities may evolve throughout their disease trajectory. . For example, through their course at hospital, they may develop an infection of the lung, and now we need to have a discussion surrounding this item to uncover their desires.

- Milestones that could prompt discussions - after hospital admission, family events -

As a family physician, this becomes important as well as your patient may be discharged from hospital and have a period of increased strength and function. It is easy to forget during clinic visits to reassess their needs as they appear so well. However, this is an excellent opportunity to reassess their goals, and wishes should their health deteriorate further.

- **Can also give reading material prior to discussion - see below -**
 - <https://myhealth.alberta.ca/Alberta/AlbertaDocuments/conversations-matter-guide-english.pdf> (AHS has this in several languages)
 - <https://www.advancecareplanning.ca/>

Clinical Pearls

Thanks so much for your time in helping with this episode and sharing your experience with us. I guess what we would all really like to know is, if you had three things that you wanted all Family Medicine residents, medical students and even currently practicing General Practitioners to know about Palliative Care, and how to contribute effectively to Palliative care, what would they be?



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- Palliative Care is active care. It aims to optimize quality of life of those living with advanced illness through holistic and multidimensional approach to health. It is applicable early in the course of an illness, can include aggressive intervention, and be provided in conjunction with other therapies intended to prolong life. We often describe ourselves as an “added layer of support” to be provided based on patient’s NEEDS, and not necessarily prognosis.
- **Family physicians are uniquely positioned through their** longitudinal relationships of trust with patients. This relationship provides a tremendous opportunity for you to support your patients as they journey through their illnesses, and facilitate advance care planning in an effective and meaningful way.
 - Remember, these conversations take time and practice. It is like a surgical skill, practice practice practice
- Be mindful of the challenges encountered when caring for **patients with palliative care needs - cases can be heavy, emotional, bring up emotions in yourself.**
 - Self reflection and wellness throughout your career
 - **Don’t be afraid to ask for help from your team or local palliative care consultant!**

Referenced Sources

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