Symptom Management at End-of-Life

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Objectives

To Discuss:

- General principles of palliative medicine
- General principles of symptom management
- Management of specific symptoms
Principles of Palliative Medicine

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of assessment and treatment of pain and other problems, physical, psychosocial, or spiritual.
Suffering is not Pain

- Pain
  - Physical distress or discomfort caused by illness or injury

- Suffering
  - “Total” pain
    - Physical
    - Psychological
    - Social
    - Spiritual
Individuals are not Symptoms

Systems

Individual

Situations
Principles of Symptom Management

- Pain: 60-90%
- Nausea and vomiting: 20-60%
- Constipation: 30-70%
- Shortness of Breath: 30-90%
- Depression: 15-30%
- Anorexia: 30-100%
- Delirium: 15-90%
Principles of Symptom Management

- Symptoms can be controlled
- One size does not fit all
- Look for reversible causes
- Scheduled vs. prn
- Kill two birds with one stone
- Discontinue meds that are not effective
Management of specific symptoms

Mr. Jones is a 67 year old man with metastatic lung cancer and COPD. He has severe mid-back pain and comes to you for management.

What do you do?
Pain

• Assessment
  – **Nociceptive**
    • Damage
      – Sharp, aching, throbbing
  – **Neuropathic**
    • Disorder function
      – Burning, tingling, numbness, shooting
  – **Degree**
    • Mild, moderate, severe
Pain

- Management
  - **WHO 3-Step Model** for Analgesic Dosing
    - Step 1 (mild)
      - Tylenol/NSAIDS
      - Adjuvants
    - Step 2 (moderate)
      - Combination meds
      - Adjuvants
    - Step 3 (Severe)
      - Opiates
      - Adjuvants
  - *Opiates do work for neuropathic pain*
Pain

- **Opiates**
  - “Equivalent”
    - Cost, ease, etc. vs. effectiveness
  - **Dosing**
    - Can always go up
  - **Titration**
    - Prn becomes ATC
    - Mild to moderate
      - 25-50%
    - Moderate to severe
      - 50-100%
    - Maximum based on side effects
His pain is much better. However, he develops nausea and vomiting.

What do you do?
Nausea and Vomiting

• Assessment
  – *Central*
    • Chemoreceptor Zone
    • Vestibular
    • Cortex
  – *Gastric*
Nausea and Vomiting

- Plan for this when starting opiates
- Management—focus on neurotransmitters
  - **Central**
    - Chemoreceptor Zone
      - Dopamine (most frequent)—halol, phenergan, compazine
      - All four receptors
    - Vestibular
      - Acetylcholine—scopolamine, glycopyrolate
      - Histamine—diphenhydramine
  - Cortex
    - “Anticipatory”
  - **Gastric**
    - Serotonin—ondansetron
His nausea resolves but Mr. Jones has not had a bowel movement in 5 days.

What do you do?
Constipation

• Assessment
  - Opiates?
  - Other
    • Decreased food intake?
    • Decreased liquid intake?
    • Decreased ambulation?
    • Pain?
    • Other medications?
Constipation

- Plan for this when starting opiates
- Management
  - **Stimulants**
    - Senna, bisacodyl
  - **Osmotics**
    - Magnesium salts, lactulose, sorbitol, miralax
  - **Prokinetic**
    - Consider when refractory—metoclopramide
  - **Enemas**
    - Avoid if possible
  - **Methylnaltrexone**
You have cared for Mr. Jones for months. His pain, n/v, and constipation are well controlled. However, he is getting progressively more short of breath.

What do you do?
Dyspnea

• Assessment
  – Tachypnea vs. dyspnea
  – People become “used to it”
    • “I’m doing the same” vs. “I feel good”
Dyspnea

- Management
  - Opiates are very effective
  - Opiates are very safe
  - Don’t jump to oxygen
Mr. Jones states he is feeling more “down” recently.

What do you do?
Depression

• Assessment
  – *Depression is inevitable—a myth!*

  – *Are you depressed?*
    • Ahedonia
    • Hopelessness
Depression

Management

- *Take longevity into account*
  - Expected mortality *days/weeks*
    - Methylphenidate
    - Dexamethasone (effect wears off)
  - Expected mortality *months*
    - SSRI
    - SNRI
    - Be careful with TCAs
Mr. Jones’ family is worried that he is not eating and is newly confused.

What do you do?
Late-Stage Symptoms

• Assessment
  – Anorexia
    • Is patient/family worried about it?
  – Delirium
    • Fluctuating: with acute onset (staff/family are best informants)
    • Attention: Difficulty focusing, easily distracted
    • Thinking: Disorganized thinking, rambling, illogical
    • Consciousness: Hyperarousal, hypoarousal, mixed
Late-Stage Symptoms

• Management
  – Anorexia
    • Take longevity into account
      – Dexamethasone
  •Depressed?
    – Mirtazipine
    •No contraindications (ICP, clots)
      – Megesterol
  –Generally not effective
    • Starvation vs. “giving up” vs. dying
Late-Stage Symptoms

- **Delirium**
  - Drugs (prescription, OTC, illicit)
  - Endocrine (hyper-, hypoglycemia, thyroid, or adrenal dysfunction)
  - Lung Disease (hypoxia, COPD, sleep apnea)
  - Infection (Encephalitis/meningitis, HIV, UTI, pneumonia)
  - Injury (Concussion, brain tumor, raised ICP, subdural/epidural hemorrhage)
  - Renal (acute and chronic renal disease)
  - Intestinal (obstruction, ileus)
  - Unstable circulation (arrhythmias, hypoperfusion)
  - Metabolic (hyponatremia, hypokalemia, renal/liver failure, dehydration)
Late-Stage Symptoms

• Delirium

• Management
  
  – *Education*
    • Often a preterminal event
    • “Because of the morphine”
    • Very distressing to families

  – *Haloperidol*
    • Not benzodiazepines