

End of Life Care and Symptom Control for Pharmacists



Dr Adam Brown
Consultant in Palliative Medicine

Learning objectives

- understanding a patient's priorities for end of life care
- Working with the 5 priorities for care
- Prognostication using the SPICT tool
- ReSPECT
- Symptom control at the end of life
 - Pain Breathlessness
 - NGV Agitation
 - Secretions





What is a good death?



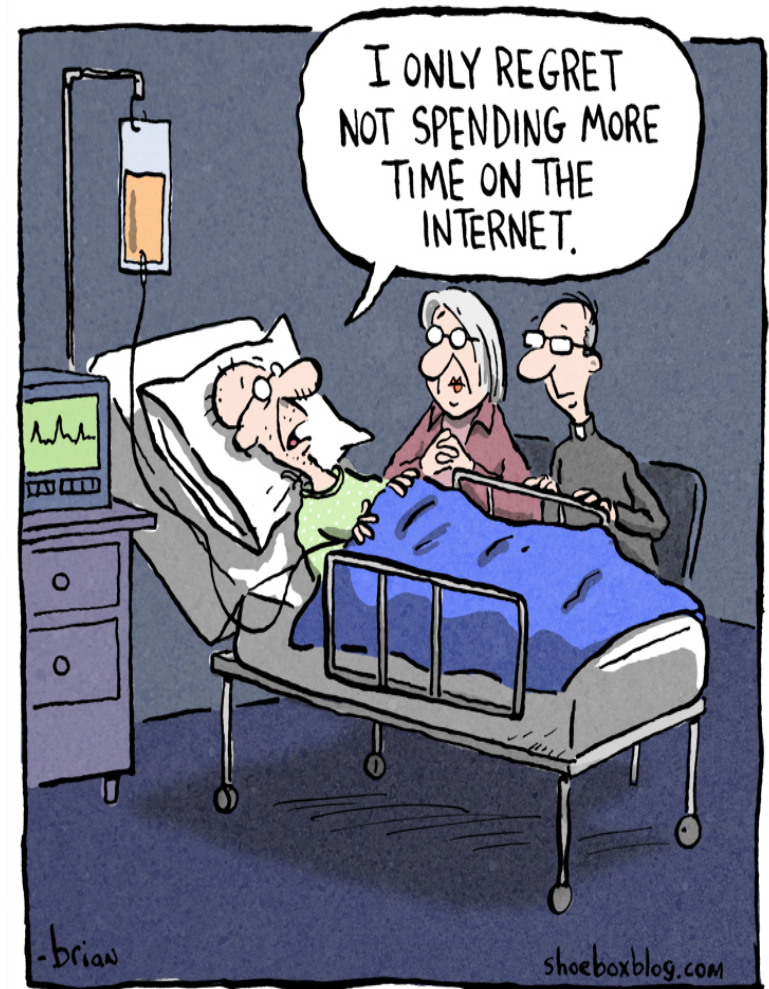
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A "Good Death"

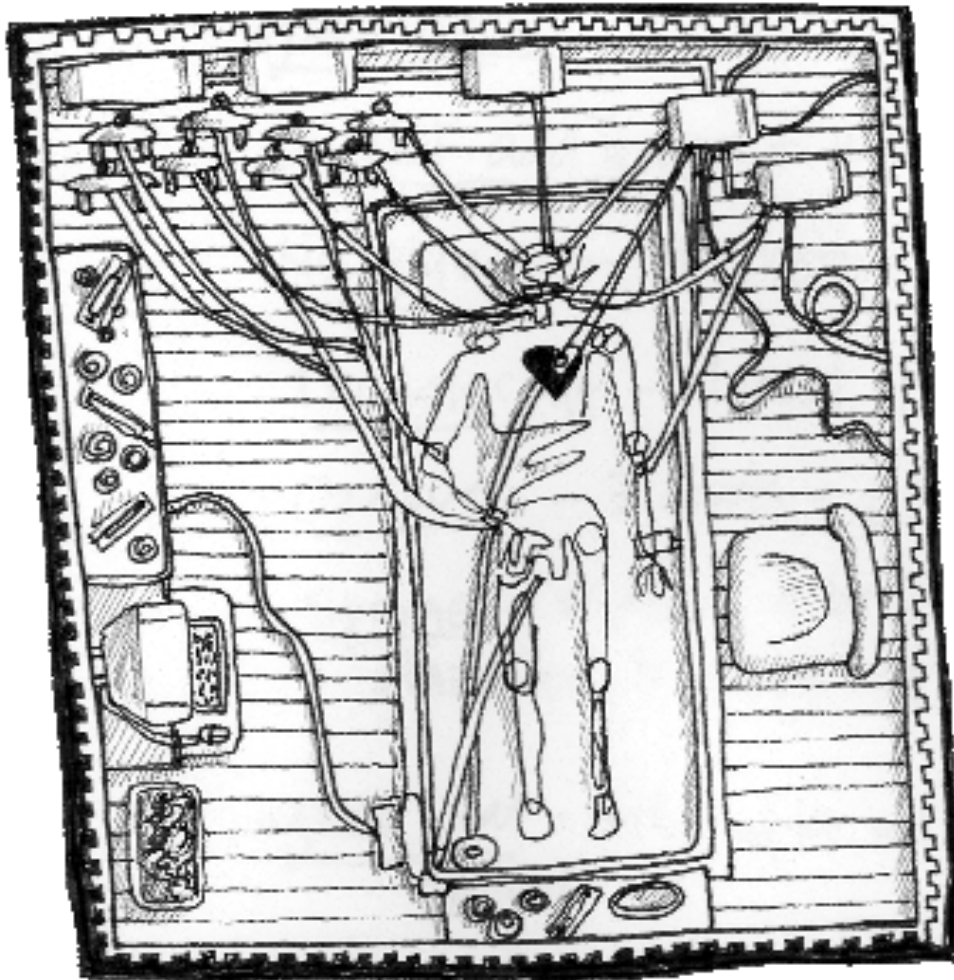
- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and friends



Preferred place of care

- Most people want to die at home if asked
but...
- Patients top priorities are:
 - Pain and symptom management
 - Not being a burden
- Not automatic that home is the best option
- Need to ensure we are acting in accordance with the patient's priorities
 - Have we asked them?

The reality at present...



- Not dying in a place they would choose to
- Poor care in place of death
- Unnecessary pain and other symptoms
- Not being treated with dignity and respect

Quality of life?



“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”



5 Priorities for Care

- Guidance developed after the decision to phase out the LCP
- Patient “may” die
- Doesn't require stopping active treatment – use of a “dual approach”
- Can also offer the opportunity to stop and focus on quality of life or discharge

ONE CHANCE TO GET IT RIGHT

Improving people's experience of care
in the last few days and hours of life.

Published June 2014 by the
Leadership Alliance for the Care of Dying People

Publications Gateway Reference 01509

5 Priorities for Care

- When it is thought that a person *may* die in the next few days or hours...

Recognise:	This <i>possibility is recognised</i> and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
Communicate:	Sensitive <i>communication</i> takes place between staff and the dying person, and those identified as important to them.
Involve:	The dying person, and those identified as important to them, are <i>involved in decisions</i> about treatment and care to the extent that the dying person wants.
Support:	The <i>needs of families</i> and others identified as important to the dying person are actively explored, respected and met as far as possible.
Plan and do:	An <i>individual plan of care</i> , which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.



SPICCT tool



Supportive and Palliative Care Indicators Tool (SPICCT™)



The SPICCT™ is a guide to identifying people at risk of deteriorating and dying. Assess these people for unmet supportive and palliative care needs.

Look for general indicators of deteriorating health.

- Unplanned hospital admissions.
- Performance status is poor or deteriorating, with limited reversibility; (person is in bed or a chair for 50% or more of the day).
- Dependent on others for care due to physical and/or mental health problems.
- More support for the person's carer is needed.
- Significant weight loss over the past 3-6 months, and/ or a low body mass index.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- Person or family ask for palliative care, treatment withdrawal/limitation or a focus on quality of life.

Look for clinical indicators of one or more advanced conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; swallowing difficulties.

Urinary and faecal incontinence. No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/ or progressive swallowing difficulties.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Deteriorating and at risk of dying with any other condition or complication that is not reversible.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Review current care and care planning.

- Review current treatment and medication so the person receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the person and their family.
- Plan ahead if the person is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Please register on the SPICCT website (www.spicct.org.uk) for information and updates.

SPICCT™, April 2016

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ReSPECT

- New national form and process
 - Alternative process for discussing, making and recording recommendations about future emergency care and treatment, including CPR
 - Focuses on treatments to be considered as well as those that are not wanted or would not work
- Replaces DNACPR form
- Introduces element of advance care planning into discussions, especially around emergency treatment
- Planned for introduction across all providers in Lincolnshire on 4th February



Common symptoms at end of life

- Remarkably similar despite diagnosis
 - Pain
 - Shortness of breath
 - Agitation
 - Nausea and vomiting
 - Excess secretions
 - Fatigue
 - Dry mouth
 - Urinary or bowel problems
 - Skin care issues

Anticipatory prescribing

- Ensure medications available to the patient to manage the symptoms likely to occur
 - Opioid Pain/SOB
 - Midazolam Agitation/SOB
 - Levomepromazine NGV/Agitation
 - Hyoscine Butylbromide Secretions
- All subcutaneous, up to 2 hourly
- All need to be available on the ward/at home
- If patient in the community, will need to be supplied and written up on CD1 form
 - Home/NH/Community Hospital



Pain

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Analgesic options

- Correct the correctible
- Non-drug measures
- Analgesic ladder
 - Paracetamol
 - NSAIDs
 - Weak/Strong Opioids
- Adjuvants
 - Gabapentin
 - Amitriptyline
- Steroids
- Benzodiazepines
- Bisphosphonates
- Radiotherapy
- Nerve blocks
- Opioid switching
- Methadone
- Ketamine
- Sedation

Morphine

- Oral morphine is the strong opioid of choice
- μ opioid receptor agonist (inhibitory)
- Oral bioavailability 30%
- 2 main active metabolites
 - Morphine-3-glucuronide (not analgesic)
 - Morphine-6-glucuronide (potent analgesic)
- Half-life of morphine-6 trebles in renal failure
 - Leads to toxicity, with sedation and respiratory depression
- Hyperexcitability at high doses due to accumulation of morphine-3

Side effects of morphine

- Common initial:
 - Drowsiness
 - Nausea and vomiting
 - Unsteadiness
 - Delirium
- Common ongoing:
 - Constipation
 - Nausea and vomiting

Side effects of morphine

- Occasional:
 - Dry mouth
 - Sweating
 - Pruritus
 - Hallucinations
 - Hyperexcitability (myoclonus, allodynia, hyperalgesia)
 - Urinary retention
- Rare:
 - Respiratory depression
 - Psychological dependence

Opioid-induced hyperalgesia

- Individuals taking opioids can develop an increasing sensitivity to noxious stimuli
 - Allodynia
 - Hyperalgesia
- Increasing dose aggravates the paradoxical pain problem
 - Effective way to overcome tolerance
 - In OIH may worsen the patient's condition by increasing sensitivity to pain while escalating physical dependence
- Need to dose-reduce and consider alternatives
 - Ask for specialist advice

Morphine myths

- Does not usually cause significant respiratory depression in patients in pain
- Psychological dependence is rare
- Physical dependence does not prevent dose reduction if pain improves
- Tolerance is not a practical problem
- Therapeutic ratio is large
- Naloxone is rarely needed

Oxycodone

- Synthetic opioid, acts on κ opioid receptors
 - Similar properties to morphine
 - Side effect profile may vary
- Approximately twice the price of morphine
- Bioavailability 75% - much higher than morphine
- Indicated for patients with intolerable side effects from morphine
 - Causes less sedation, delirium, vomiting and pruritus
 - May cause more constipation

Fentanyl

- Acts on μ opioid receptors
- Transdermal bioavailability 100%
- Highly lipophilic
 - Forms reservoir in body fats (including CNS white matter)
 - Reduced tendency to cause constipation
- 100-150 times more potent than morphine
 - 25 mcg/hr Fentanyl Patch \equiv MST 30mg bd – 45mg bd
- Elimination plasma half-life 24 hours

Methadone

- For pain unresponsive to other opioids
- Excellent oral absorption and no active metabolites
- Low development of tolerance
- Use limited by difficult pharmacology
 - Long and unpredictable half-life
 - Potential for delayed toxicity
 - Limited knowledge of conversion ratios and administration intervals, even amongst palliative care specialists
- Specialist use only

Other strong opiates

- Buprenorphine
 - SL tablet (Temgesic), or TD patch (Transtec)
 - Similar profile to morphine
 - Contraindicated for uncontrolled pain
- Alfentanyl
 - used in syringe drivers for severe renal impairment
 - Short acting – PRNs may be needed more frequently
- Transmucosal fentanyl products
 - Abstral, Effentora, Instanyl, PecFent
 - Short-acting and rapid onset – breakthrough cancer pain



Breathlessness

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Correct the correctible

- Direct cancer effects
 - Pleural effusion/ascites
 - Airway obstruction/SVCO
 - Lymphangitis carcinomatosa
- Indirect cancer effects
 - Anaemia
 - Pulmonary emboli
 - Infection
- Unrelated to cancer
 - COPD/Asthma
 - Heart failure

Non-drug treatment

- Explore perception of patient and family
 - Inform patient that breathlessness itself is not damaging or life-threatening
 - Reassure that they will not die during an acute episode
- Maximizing feeling of control over breathlessness
 - Plan of action for acute episodes, with written step-by-step plan
- Additional measures
 - Open window/fan
 - Complimentary therapies

Oxygen

- Increases alveolar O_2 concentration
- Reduces work of breathing
- Cannot predict response from O_2 sats
- Can vary concentration
 - High flow ($\geq 60\%$) in Type 1 respiratory failure
 - Controlled (24-28%) in Type 2 resp. failure
- Can vary method of administration
 - Nasal cannulae do not interfere with communication (up to 4L/min)
 - Short-burst therapy after exertion
- Air flow may be as effective as oxygen

Morphine

- μ opioid receptor agonist (inhibitory)
 - Reduces stimulatory effects of excitatory glutamate system
 - Reduces response to hypercapnia/hypoxia
 - Reduces tidal volume and respiratory rate
- More beneficial in patients breathless at rest
 - Exertional breathlessness often settled by the time opiates administered and absorbed
- Give low doses in the opioid-naïve
 - 2.5-5mg PO prn
- If on opioids for pain already, use 25-100% of usual 4 hourly analgesic dose

Anxiolytics

- Strong association between breathlessness and anxiety
- Oral diazepam or SL lorazepam can be used regularly and/or prn
- SSRIs may be helpful if panic occurs during exacerbations
- Neuroleptics have an anxiolytic as well as an antipsychotic effect
 - Haloperidol is drug of choice (without marked respiratory depressant effect)
 - Levomepromazine helpful if more sedation required

Terminal breathlessness

- Patients often fear suffocating to death
- Positive approach is important
 - No patient should die with distressing breathlessness
 - Failure to relieve terminal breathlessness implies inadequate drug treatment
- Drugs can be given by CSCI and prn
 - Morphine/Diamorphine
 - Midazolam
 - Haloperidol (or Levomepromazine) if agitated
- Sedation not primary aim of treatment
 - May need to balance comfort and drowsiness



Agitation

Delirium and agitation

- Restlessness or agitation occurs in 42% of hospice inpatients
- Terminal agitation shares early symptoms with delirium
 - Prodromal symptoms
 - » Restlessness Anxiety
 - » Sleep disturbance Irritability
 - Disorientation in time/place/person
 - Memory impairment and poor concentration
 - Affective symptoms
 - » Emotional lability Sadness/euphoria
 - Altered perceptions/delusions

Terminal agitation

- Becomes apparent over time, as patients become more agitated as they deteriorate
- Still important to consider possible reversible causes
 - Pain
 - Urinary retention
 - Constipation
 - Steroids
 - Benzodiazepine withdrawal
 - Hypercalcaemia
 - Psychological

Terminal agitation

- May be difficult to treat
 - Sometimes requires significant sedation
- Use step-wise approach to treatment
 - Treat reversible causes
 - Non-drug measures (lighting, involve family etc.)
 - Haloperidol
 - Haloperidol + benzodiazepine
 - Levomepromazine +/- benzodiazepine
 - Phenobarbital or Propofol (profound sedation)
- Ask for help if symptoms remain poorly controlled

Palliative sedation

- Intention is symptom relief, not euthanasia
 - used for terminal agitation, breathlessness and pain
- Step-by-step approach
 - Initially p.r.n. sedation ("time out")
 - Titrate doses gradually to find lowest effective dose
 - Continuous deep sedation occasionally necessary
- Need to involve patients (if possible) and families in decision-making process



Nausea and Vomiting

Assessment

- History
 - Pattern of nausea and vomiting
 - Volume and content of vomitus
 - Triggers
 - Previous treatment and whether successful
- Examination
 - To help establish cause
 - Condition of mouth
- Investigations
 - If necessary, to find/exclude reversible cause

Correct the correctible

● Drug side effect	→	Review medication
● Hypercalcaemia	→	Fluids/bisphosphonates
● Constipation	→	Laxatives
● Infection	→	Antibiotics
● Ascites	→	Paracentesis
● Renal failure	→	Fluids/dialysis/stents
● Bowel obstruction	→	Surgery/stent
● Raised ICP	→	Steroids
● Pain	→	Analgesia
● Emotional	→	Support

Non-drug measures

- Small meals (eat little and often)
- Avoid fatty foods
- Avoid cooking smells
- Control of odours (fungating tumour/colostomy)
- Distraction
- Complimentary therapies
- Emotional/psychological support
- Education of family members (not pushing unwanted foods/supplements)

Drug measures

- Predictive prescribing
- Match antiemetic to likely cause
- Consider route
 - Syringe driver if not absorbing
- Be aware of potential side effects
- If it is not working:
 - Reconsider cause of vomiting
 - Is the drug being absorbed?
 - Consider adding in second antiemetic
 - Ensure not using 2 drugs with opposing actions
 - » Metoclopramide/cyclizine or metoclopramide/hyoscine

Drugs

- Example: Metoclopramide
- Class: Prokinetic
- Site of action: Peripheral
D₂ antagonist
5HT₄ agonist
- Side effects: Colic
Diarrhoea
Extrapyramidal effects
- Use for: Delayed gastric emptying

Drugs

- Example: Cyclizine
- Class: Antihistamine
- Site of action: Vomiting centre
H₁ antagonist
Muscarinic antagonist
- Side effects: Anticholinergic effects
Sedation
- Use for: Gastric irritation
Constipation
Raised ICP

Drugs

- Example: Haloperídol
- Class: Anti-dopamínergic antipsychotic
- Site of action: Chemoreceptor trigger zone
D₂ antagonist
- Side effects: Extrapyramidal effects
Sedation
- Use for: Hypercalcaemia
Renal failure

Drugs

- Example: Levomepromazine
- Class: Phenothiazine antipsychotic
- Site of action: Broad spectrum
D2, H1, 5HT2 antagonist
Muscarinic antagonist
- Side effects: Sedation
Extrapyramidal effects
Anticholinergic effects
- Use for: Bowel obstruction
2nd line antiemetic

Drugs

- Example: Hyoscine Butylbromide
- Class: Anticholinergic
- Site of action: Peripheral
Muscarinic antagonist
- Side effects: Anticholinergic effects
Dry mouth
Constipation
- Use for: Bowel obstruction

Drugs

- Example: Ondansetron
- Class: Anti-serotonergic
- Site of action: Chemoreceptor trigger zone
5HT₃ antagonist
- Side effects: Constipation
Headache
- Use for: Chemotherapy/radiotherapy-induced nausea
Post-surgery



Secretions

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Excess secretions

- Retained secretions in the upper airway
 - Pooling of saliva
 - Bronchial secretions due to infection or oedema
 - Excess IV fluids
- Usually more distressing to relatives and ourselves than to the patient
 - Often seen in patients unconscious and close to death
- May also have noisy tachypnoea or Cheyne-Stokes respiration

Management

- Good explanation to relatives
 - Rattle reflects the patient's level of consciousness
 - Not usually distressing
- Position semi-prone to encourage postural drainage
- Oropharyngeal suction
- Antimuscarinic drugs
 - Hyoscine Butylbromide (Buscopan)
 - Glycopyrronium
 - usually effective in around 50% of patients



Help and advice

St Barnabas Hospice
24 hour advice line
01522 511566

