Symptom Management in Final Days

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Objectives

- What is Palliative Care
  - Trajectory of Decline
- Common Concerns
- Common Symptoms
  - Pain
  - Dyspnea/ Breathing patterns
  - Delirium
  - Secretions
- Symptom Management

Palliative Care

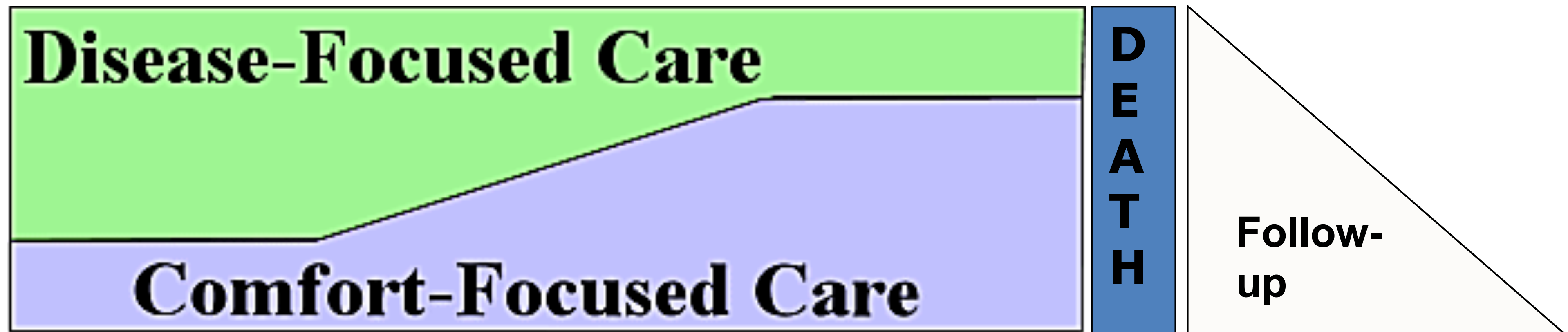
Palliative Care is:

- an **approach to care** which focuses on comfort and quality of life for those affected by life-limiting/life-threatening illness.
- is **much more than comfort in dying**;
- is about ***living***, through meticulous attention to control of pain and other symptoms, supporting emotional, spiritual, and cultural needs, and maximizing functional status.

World Health Organization, 2014

"Palliative in Parallel"

- Palliative care does not need to be exclusive of ongoing cure-focused care
- Can be involved as a parallel process, with a variable profile depending on goals of care and clinical circumstances
- Do not need to be ACP C



Trajectory of Decline

- “Momentum of decline”
- Frames goals of care
- Guides conversations
- Helps with prognostication/ recognize final days
- Variable depending on diagnosis
  - Canadian Virtual Hospice- “When Death is Near”

Commonly Voiced Concerns

- Why am I/ is mom so drowsy?
- How could this be happening so fast?
- Things were fine until that medicine was sta

- Isn't the medicine speeding this up?
- What about food and fluids?
- How much time do we have?
- How will we know when the end is near?
- What can I expect?

Why am I so tired?

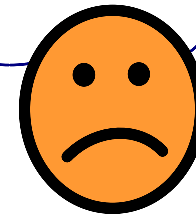
- Fatigue can be caused by many factors
- Expect to see:
  - Increased periods of sleep, which may progress to unconsciousness
- What can be done?
  - Plan activities to conserve energy
  - Suggest short visits
  - Plan rest periods
  - Some medications or treatments may trialed
  - Try to maintain hydration

How could this be happening so fast?

The Perception of the "Sudden Change"

- **When reserves are depleted, the change seems sudden and unforeseen. However, the changes *had* been happening.**

Melting ice = diminishing reserves



Day 1 Day 2 Day 3 Final

Which Came First....
The Med Changes or the Decline?

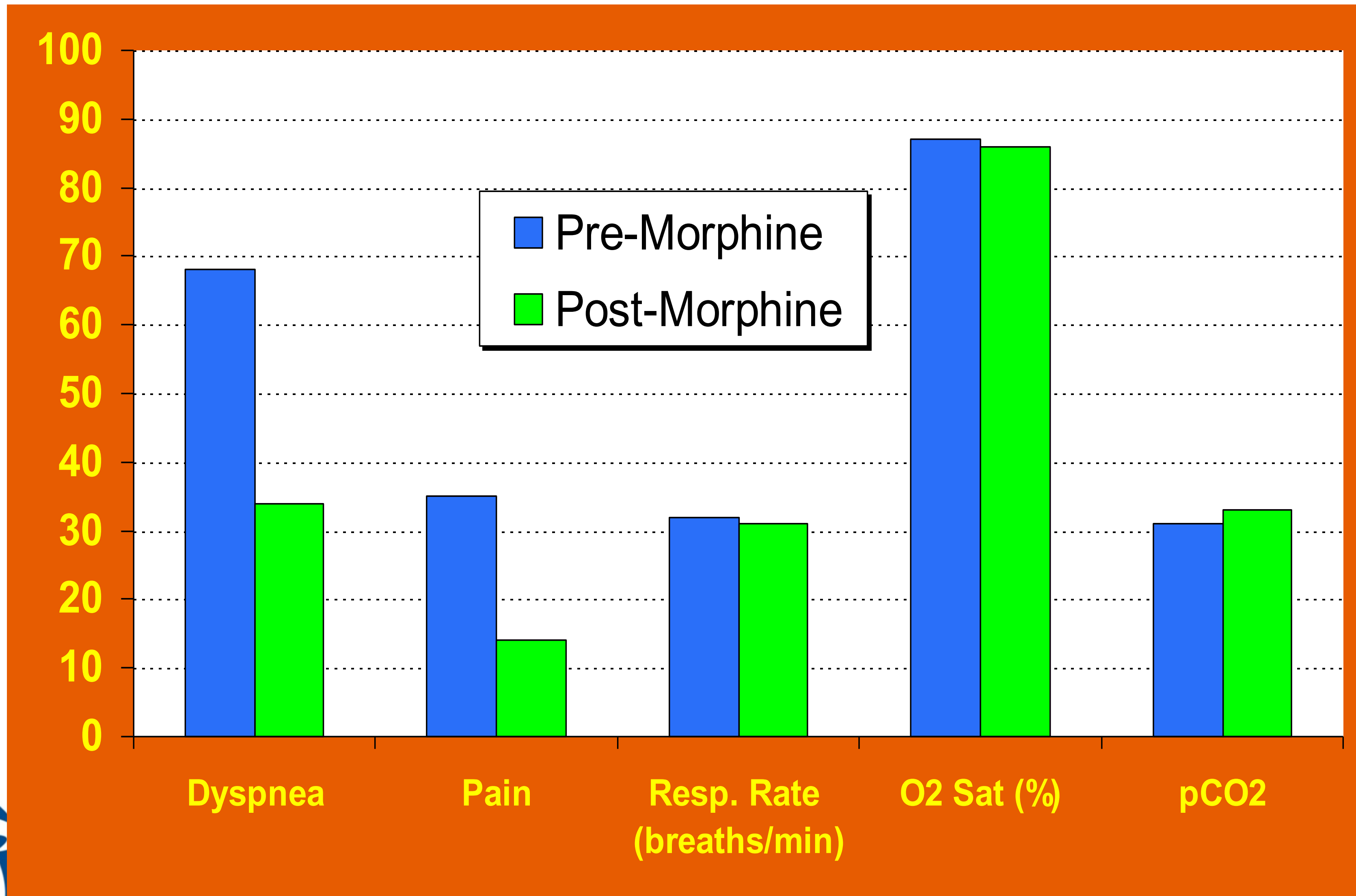
Steady decline

Accelerated deterioration begins, medications changed

Rapid decline due to illness progression with diminished reserves

Medications questioned or blamed

Is the medicine speeding things up?

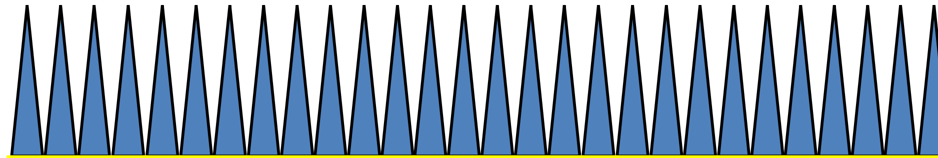


Bruera et al. *JPSM* 1990; 5:341-344

Expected Breathing in the Final Hours

Cheyne-Stokes

Rapid, shallow

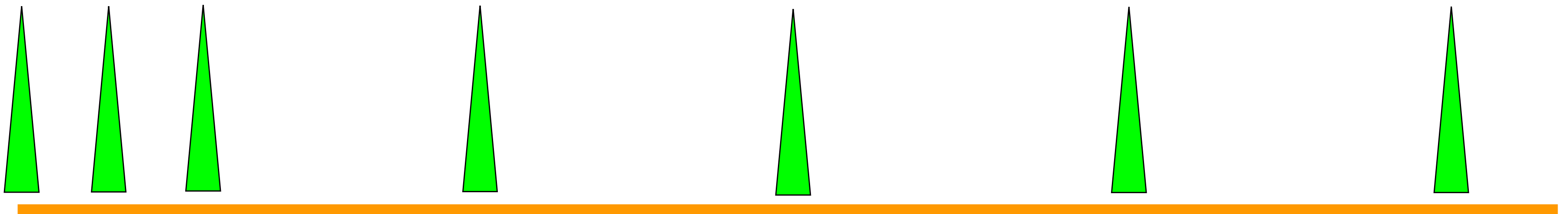


“Agonal” /Ataxic

Treatment often not required

Typically, **too much** opioid causes:

- **pinpoint pupils**
- **gradual slowing of the respiratory rate**
- **breathing is deep (may be shallow) and *regular***



Intervention with Narcan (naloxone) recommended

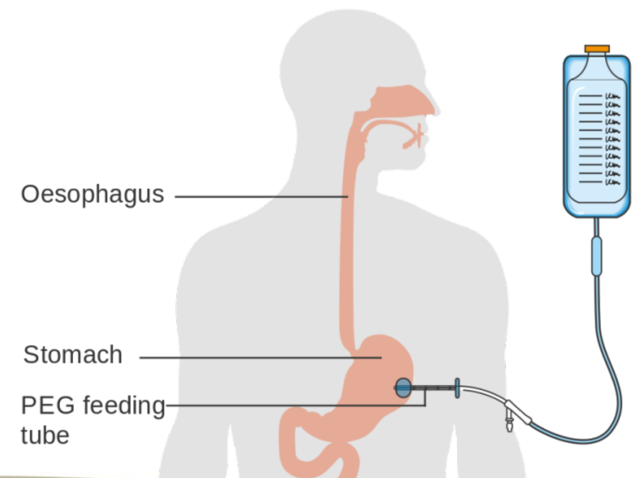
What about food and fluids?

- **Decreased hunger and intake at end of life is normal**
  - The body may not be metabolizing food appropriately
  - Anorexia – loss of appetite
  - Cachexia – muscle wasting
  - Cancer Anorexia Cachexia Syndrome (CACS)

- **Feeding can be a very contentious issue**
  - Feeding = Loving
  - Most difficult for families and care providers to accept
  - Food preferences can change
  - ***Support and education essential***

Should we consider tube feeding?

- **Enteral Feeding** (Feeding tube):
  - Typically not initiated in the face of advanced illness
  - Can be used if person unable to swallow due to obstruction or underlying disease process (and if client and family can manage)
  - Does not improve strength or prolong life in someone who is in the final weeks of life
  - Intervention is assessed on individual basis



Consider Concerns About Food And Fluids Separately

Food Intake

Strong evidence base that there is no benefit in terminal phase

Fluid Intake

Conflicting evidence regarding effect on thirst in terminal phase;
cannot be dogmatic in discouraging artificial fluids in all situations

How long do we have?

- Most difficult question
- Attempts to estimate prognosis are a "best guess"
  - Need to be cautious
- Some diseases are easier to predict than others
  - Still difficult to be specific
- Several Apps/ Tools
  - Not very reliable
- "Momentum of Decline"

What can I expect near the end?

- Address with permission
- Review common symptoms and management
- Review available resources

- **Reassure:**
  - Will work to maintain comfort to best of ability
  - Will provide support of physical and emotional symptoms (to client and family)
  - Will provide care consistent with goals of care
  - Will support maintaining dignity
  - Will not abandon

Questions so far…?

Symptom Management

Diabetes

Cancer

Discontinued Dialysis

Stroke

End-Stage Lung Disease

Dementia

Neuro-Degenerative

Bedridden

↓

Can't clear secretions

↓

Pneumonia

↓

Lethargy, Congestion, Delirium

Common EOL Symptoms

- Weakness
- Fatigue
- Pain
- Dyspnea
- Poor oral intake
- Nausea
- Upper airway secretions
- Restlessness/ delirium

Pain

- Subjective experience; greatest fear
- Dying itself is not painful?
- Causes are multi-factorial
  - Disease, injury
  - Anxiety, metabolic factors,
  - Constipation
  - Immobility
- Different types
  - Affects medication choices*
  - ***Incident pain- pre-treat***

Pain Management

Non-pharmacological

- Positioning
- Toileting (skin)
- Seat cushions
- Diet
- Bowel regime
  - ***constipation***
- Calm approach
- Adequate sleep
- Distraction
  - Music; lack of chaos; volunteer

Pharmacological

(WHO Pain Ladder)

- Non- opioids
- Opioids
  - Morphine
  - Hydromorphone
- Neuropathic agents
  - Ketamine, Methadone*
- Adjuvant medications
  - Decadron
- Anxiety medications
  - Olanzepine
  - Lorazepam

Pain

Fentanyl patches

- Not for opioid naïve
- 12 mcg patch ~ 30 to 45 mg morphine~ 6 to 9 mg hydromorphone

Opioid Neurotoxicity (OIN)

- Result of rapid escalation of doses and/ or renal failure
- Call the palliative care program

<u>OIN</u>

- Myoclonus
- Sedation
- Delirium
- Hyperalgesia

Methadone

- MD needs special prescribing license
- Variable long half-life
- Would suggest consult to PC Program to assist with pain management if attending MD does not have a license

Dyspnea Management

- **Subjective experience**

- Multiple causes
  - Lung cancer
  - COPD
  - Heart failure
  - Renal failure
  - Anxiety
  - PE
  - Surgeries
  - Bronchial obstruction
  - Constipation
  - Others…..

Often O2 sats are normal…

Dyspnea

Non-pharmacological

- Depends on cause
- Increase HOB
- Positioning
- Fan in room
- Calm approach
- Try not to leave alone if more aware and symptoms severe

Pharmacological

- Depends on cause
- Opioids
  - Hydromorphone
  - Fentanyl
- Steroids
  - Decadron
- Anti-anxiety meds
  - Olanzepine
  - Lorazepam*
- Oxygen

Delirium

Acute change in behavior or level of consciousness

- Sleep disturbances
- Hypo- or hyperactive

Causes are multi-factorial

- Underlying disease
- General functional decline
- Renal decline
- Encephalopathy (liver failure)
- Medications
- Infections
- Metabolic changes (Hypercalcemia, SIADH)
- Opioid Neurotoxicity (OIN)

- Common at EOL (> 80%)
- Goals of care important factor in management
- Separate condition from dementia

Delirium

- Treat underlying cause if reversible and congruent with goals of care
  - Antibiotics
  - Modify medications
  - Fluids

- Treat Symptoms
  - Discuss with resident / family in advance
  - ***Haldol***- low dose; prn and/or scheduled; subling or subcut
  - ***Olanzepine***; low dose at hs regularly and/or prn
  - ***Nozinan***- prn and/or scheduled; more sedating than haldol;
  - ***Benzodiazepines- rebound effect possible***

Upper Airway Secretions

- Common at EOL (up to 80%)
- "Death rattle" result of general weakness and inability to swallow secretions
- Treat if believe it is uncomfortable for the resident

- Medications:
  - **Glyccopyrolate**- subcut; prn
  - **Scopolamine**- subcut or gel; prn
    - Can use patch but only if secretions quite excessive and requiring frequent prn doses
    - Crosses blood- brain barrier
    - more sedating and may cause increased confusion and agitation in the elderly so use cautiously

Questions about symptoms?

Considering individuality

- Unique cultural beliefs
- Unique religious spiritual beliefs
- Necessary to ask:

"Are there ceremonies, rituals or aspects of care that are important to you in your care?"

"How can we support you and your families in meeting your cultural care needs?"

" What do I need to know about you/ your loved one to provide you with the best care?"

Resources: Canadian Virtual Hospice

- Patients, Families and You
- Topics Articles
- Asked and Answered
- Practice Guidelines
- Medications
- Ask a Professional
- Research
- Clinical, Psychosocial and Spiritual care
- Adults and pediatrics

- **LivingMyCulture.ca**
  - Indigenous Voices (First Nations, Metis, Inuit)
  - Iranian, Somali, Indian, Italian, Chinese, Ethiopian, Filipino, Chinese, Pakistani

- **MyGrief.ca**
  - Online bereavement support

Other Resources

- **WRHA Palliative Care Program**
  - Physician consultant (MD to MD) 24/ 7 via St. Boniface Hospital paging (204-237-2053)

- **Canadian Virtual Hospice**
  - www.virtualhospice.ca
  - Topics, Asked and Answered, national grief resources, talking with kids, care planning, communication, Ask a Professional

- **Palliative Manitoba** (formerly Hospice and Palliative Care Manitoba)
  - www.palliativemanitoba.ca
  - Support groups, visiting volunteers, compassionate care courses

- **Palliative Care website** (by Dr. Harlos)
  - www.palliativeinfo.org
  - PowerPoints, links to professional groups

Thank you