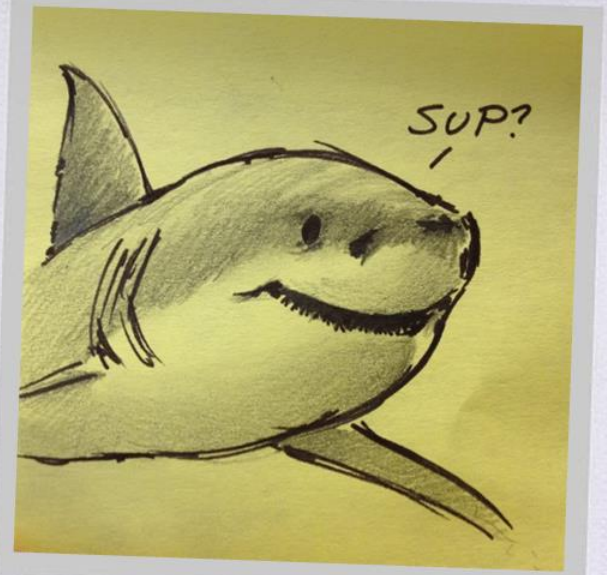
FPON Webinar - Feb 15, 2018
Dr Julia Ridley - PSMPC VC

BC CANCER

Disclosures:

I am prey to the whims of my 3 year old

I have no affiliations with any commercial organizations



Objectives:

Describe and practice approaches to **5 common symptoms** in patients with palliative cancer diagnoses:

- **Nausea/vomiting**
- **Constipation**
- **Fatigue**
- **Dyspnea**
- **Delirium**

BC Centre for Palliative Care

Utilize 2017 Guidelines from BC-CPC Available Online (PDF)

Google search
BCCPC Guidelines (1st link)

http://www.bc-cpc.ca/cpc/symptom-management-guidelines/


SYMPTOMS TO EXPLORE
PAIN
FATIGUE
PRURITUS
SEVERE BLEEDING
CONSTIPATION
NAUSEA & VOMITING
DYSPHAGIA
ANOREXIA
DEHYDRATION
RESPIRATORY CONGESTION
DYSPNEA
COUGH
HICCOUGHS
TWITCHING/ MYOCLONUS/SEIZURES
DELIRIUM
OTHER SYMPTOMS
B.C. INTER-PROFESSIONAL PALLIATIVE SYMPTOM MANAGEMENT GUIDELINES
BC Centre for Palliative Care
CONTRIBUTING PARTNERS
fraserhealth
Interior Health
First Nations Health Authority
Health through wellness
island health
Providence HEALTH CARE
Vancouver CoastalHealth
northern health

Goals of care conversation:

- The first step
- Determine disease state, progression
- Discuss **goals/fears** & acceptable interventions to the patient

1.

Nausea & Vomiting

Worse than Pain?

N/V in advanced malignancy

Prevalence

40-60%

Impact

- ✗ Decreased quality of life
- ✗ Delayed & declined treatments
- ✗ Weight loss
- ✗ Dehydration
- ✗ Electrolyte abnormalities…

Assessment

Needed!!

PQRST+

Mnemonic Letter	Assessment Questions *Whenever possible, ask the patient directly. Involve family as appropriate and desired by the patient.*
Onset	When did it begin? How long does it last? How often does it occur?
Provoking /Palliating	What brings it on? What makes it better? What makes it worse?
Quality	What does it feel like? Can you describe it? Do you vomit or just feel nauseated? Does it change when you change position?
Region/Radiation	Not applicable
Severity	How severe is this symptom? What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)? Right now? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
Treatment	What medications and treatments are you currently using? Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? How effective are these? Do you have any side effects from the medications and treatments? What have you tried in the past? Do you have concerns about side effects or cost of treatments?
Understanding	What do you believe is causing this symptom? How is it affecting you and/or your family? What is most concerning to you?
Values	What overall goals do we need to keep in mind as we manage this symptom? What is your acceptable level for this symptom (0-10)? Are there any beliefs, views or feelings about this symptom that are important to you and your family?

Focused **physical** exam:

- Neurological exam (? ↑ICP)
- Vitals (fluid status, ?infection)
- Abdominal exam +/- DRE
- Oral exam

Investigations:

- CBC, electrolytes, renal/liver function, calcium, glucose
- Urine culture +/- others
- Abdominal, CNS imaging
- ?Endoscopy

causes:

chemical
- opioids/drugs
- toxins
- electrolytes
- hormones
- cytokines / infection

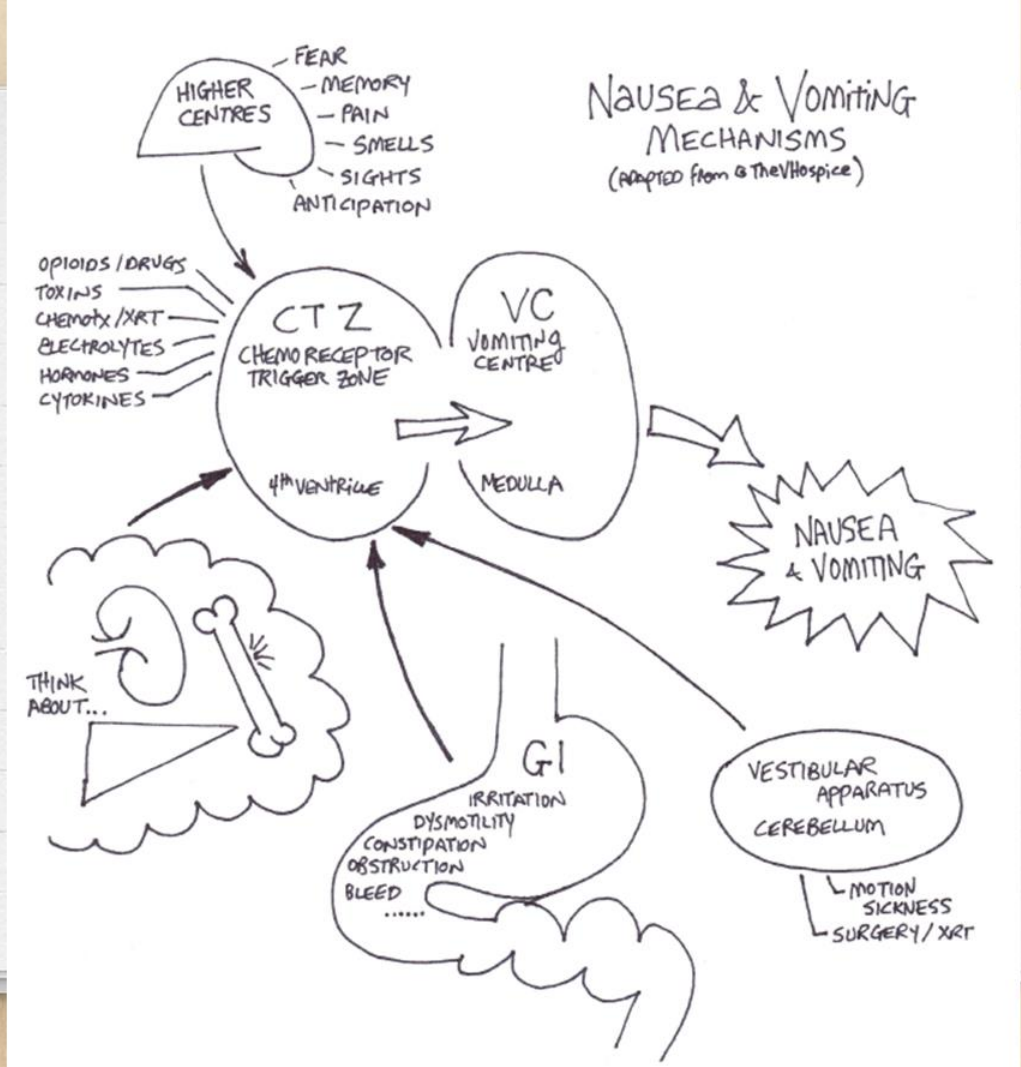
cortical
- fear/memory
- anxiety
- pain
- smells

cranial
- ICP
- CNS XRT
- meningeal irritation

vestibular
- tumor
- motion
- OR/XRT

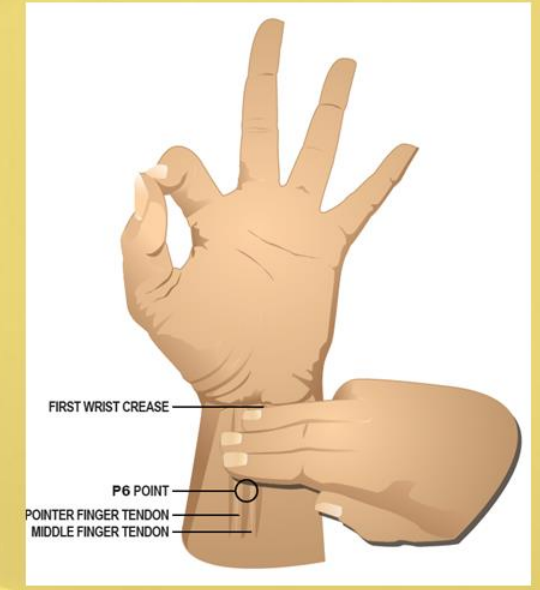
visceral/serosal
- obstruction
- constipation
- dysmotility
- bleed
- irritation

gastric stasis


Nausea & Vomiting Mechanisms
(adapted from @TheVHospice)
HIGHER CENTRES
FEAR
MEMORY
PAIN
SMELLS
SIGHTS
ANTICIPATION
OPIOIDS / DRUGS
TOXINS
CHEMOTX / XRT
ELECTROLYTES
HORMONES
CYTOKINES
CTZ
CHEMORECEPTOR TRIGGER ZONE
4th VENTRICLE
VC
VOMITING CENTRE
MEDULLA
NAUSEA & VOMITING
THINK ABOUT...
GI
IRRITATION
DYSMOTILITY
CONSTIPATION
OBSTRUCTION
BLEED
.....
VESTIBULAR APPARATUS
CEREBELLUM
MOTION SICKNESS
SURGERY / XRT

non-pharmacologic

- ✗ Decrease smells
- ✗ Hydration
- ✗ Peppermint
- ✗ Ginger
- ✗ Citrus
- ✗ Cold, lightly carbonated drinks
- ✗ P6 pressure point



Treatments

- Target the **cause**
  - ICP
  - Bowel obstruction/constipation
  - Hypercalcemia
- Choose by **mechanism**
  - Gastric stasis
  - Motion-induced
  - Chemotx
- Avoid overlapping mechanisms

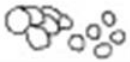
Drug	Mechanism	Dosing (starting→typical standing dose)	Indications	Side effects
Metoclopramide (=Maxeran)	DA_2 antagonist Prokinetic	10mg q6hr PRN → 10mg sc/iv/po TID or 30mins before meals & at hs	Opioid induced, GI dysmotility,	CTZ / ↑QTc, diarrhea, EPS, may increase appetite *renal excretion, start with 5mg per dose if low GFR **Black box warning due to ↑QTc, max 40mg/day
Domperidone	Prokinetic	10mg q6hr PRN → 10mg po TID (AC meals)	Opioid induced, GI dysmotility	↑QTc, diarrhea, minimal EPS risk **Black box warning due to ↑QTc, max 40mg/day
Haloperidol (=Haldol)	DA_2 antagonist Mild prokinetic	0.5mg sc/po q4h PRN → 1mg sc/po BID	Opioid induced, CTZ	↑QTc, EPS
Prochlorperazine (=Stemitil)	DA_2 antagonist	10mg iv/po q6h (usually used just PRN)	Opioid induced, CTZ	↑QTc, EPS
Methotrimeprazine (=Nozinan)	DA_2 antagonist Anticholinergic (mild)	5mg sc/po qhs PRN → titrate to required dose, max 75mg/day	Opioid induced, CTZ, anxiety, insomnia	↑QTc, EPS, paroxysmal delirium in ~5%, sedation
Olanzapine (=Zyprexa)	DA_2 antagonist, $5HT_2$ antagonist	2.5mg sc/po q4hr PRN → 2.5mg qAM, 5mg qhs	Opioid induced, CTZ, anxiety	↑QTc (mild), EPS (mild), some sedation, increases appetite
Ondansetron (=Zofran)	$5HT_3$ antagonist	4-8mg po/iv/sc q8hr PRN → 8mg po/iv BID	Chemo/Radiation therapy induced, resistant n/v, CTZ	↑QTc, constipation, headache
Granisetron (=Kytril)	$5HT_3$ antagonist	1mg po/iv/sc q8hr PRN → 1mg po/iv BID	Chemo/Radiation therapy induced, resistant n/v, CTZ	↑QTc, constipation, headache
Dimenhydrinate (=Gravol)	Anti-histamine Anticholinergic DA_2 antagonist	25-50mg sc/iv/pr/po	Acute symptoms, sedation desirable	Sedation, delerium
Scopolamine (=Transderm V patch)	Anticholinergic	1 patch q3 days	Motion induced nausea	Anticholinergic (postural hypotension, delirium, dry mouth etc)
Dexamethasone (=Decadron)	Anti-inflammatory	4-12mg in single or divided dose po/sc	Bowel obstruction, intracranial disease, resistant nausea/vomiting	Corticosteroid 'shopping list' if used long term (high sugars, edema, muscle wasting, AVN, etc)
Nabilone (=Cesamet)	Cannabinoid	1mg po BID	Chemotherapy induced, in combination for resistant n/v	Confusion, sedation, euphoria, increased appetite
Medical Marijuana	Cannabinoid	?? Usually Rx is for 1-3 grams/day	Chemotherapy induced, in combination for resistant n/v	Confusion, sedation, euphoria, increased appetite
Octreotide (=Sandostatin)	Somatostatin analogue	100-300mcg SC TID	Bowel obstruction, diarrhea (chemo, not infection induced)	Decreased bowel motility
Aprepitant/ Fosaprepitant (=Emend po/iv)	NK-1 Antagonist	PO = 125mg or 80mg OD IV = 150 or 115mg OD	Highly emitogenic chemotherapy	Fatigue, hypotension, constipation

CTZ = Chemosensitive trigger zone; NK-1 = Natural Killer receptor; 5-HT = Serotonin; DA2 = Dopamine receptor


2.
CONSTIPATION
THIS POO SHALL PASS

assessment

- **normal** bowel habit
- current frequency and bps
- medications
- hydration
- gi tract status

- 4	- 3	- 2	- 1	BPS Score 0	+ 1	+ 2	+ 3	+ 4
← Constipation						Diarrhea →		
Impacted or Obstructed ± small leakage 	Formed Hard with pellets 	Formed Hard 	Formed Solid 	**Characteristics** Formed Soft 	Unformed Soft 	Unformed Loose or Paste-like 	Unformed Liquid ± mucus 	Unformed Liquid ± mucus 
No stool produced	Delayed ≥3 days	Delayed ≥3 days	Pt's Usual	**Pattern** Pt's Usual	Pt's Usual	Usual or Frequent	Frequent	Frequent
Unable to defecate despite maximal effort or straining	Major effort or straining required to defecate	Moderate effort or straining required to defecate	Minimal or no effort required to defecate	**Control** Minimal or no effort to defecate	Minimal or no effort required to control urgency	Moderate effort required to control urgency	Very difficult to control urgency and may be explosive	Incontinent or explosive — unable to control or unaware

Downing, Watson, Carter (© Victoria Hospice Society)

Opioid-Induced (OIC)

- Up to 90% of patients on opioids endure constipation
- More likely with other risk factors:
  - Older
  - Reduced PO intake
  - Immobility
  - Anticholinergics

Treatment

- Review medications and comorbidities
- Get things moving …then… keep them going
- Lactulose, enema, opioid antagonist … then … senna, PEG routinely
- Educate patient and family

TIPS & TRICKS

- ★ IF ON OPIOIDS, AVOID BULKERS AND SOFTENERS AS FIRST LINE AGENTS -
  - STIMULATE!
  - **senna**!
- ★ RULE OUT OBSTRUCTION - CLINICALLY (AND RADIOLOGICALLY IF INDICATED)
- ★ PEG IS GREAT BUT NOT COVERED...
- ★ CONSIDER METHYLNALTREXONE/NALOXEGOL

3.
Fatigue

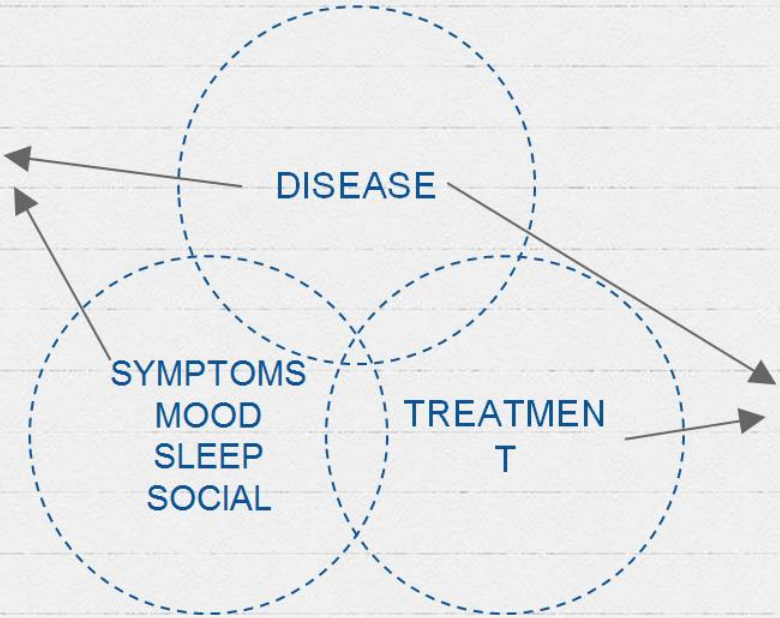
Beyond sleep hygiene

Fatigue

- Up to 90% of those with cancer
- Most **common** symptom
- Most **debilitating** symptom
- Easy tiring, impaired concentration, generalized weakness, reduced endurance - often poor memory and emotional lability
- **Expected as disease advances**

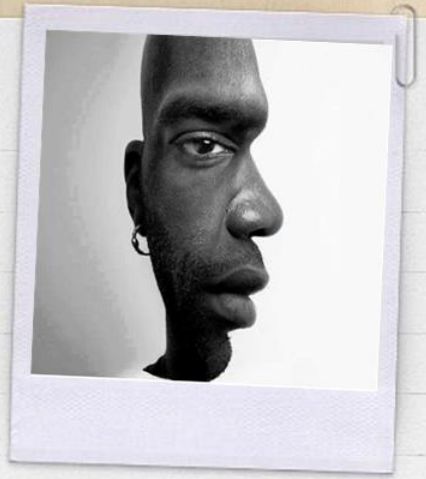
Fatigue

Education
Support
Pacing
Sx mgmt



Review meds
B/W: Hb, 'lytes,
blood sugar, renal
fcn, liver fcn, TSH
& R/O infection

Pharmacological Tx



- **Corticosteroids**
  - Dexamethasone 2-4mg/day
  - Methylprednisolone 16mg BID
  - Short term benefit (<2/52)
- **Methylphenidate**
  - For opioid-induced or dep'n related fatigue
  - Avoid if tachyarrhythmia
  - 5mg OD start (max 20mg/day)
- **Modafinil**
  - Benefit in those with severe fatigue (<7/10)
  - 200mg OD (not covered!)

TIPS & TRICKS

- ★ Check for reversible causes but **warn** patients/families that fatigue is often disease related and expected
- ★ Pacing
- ★ Allow rest
- ★ Community support services, equipment
- ★ Consider pharmacologic trial

4.

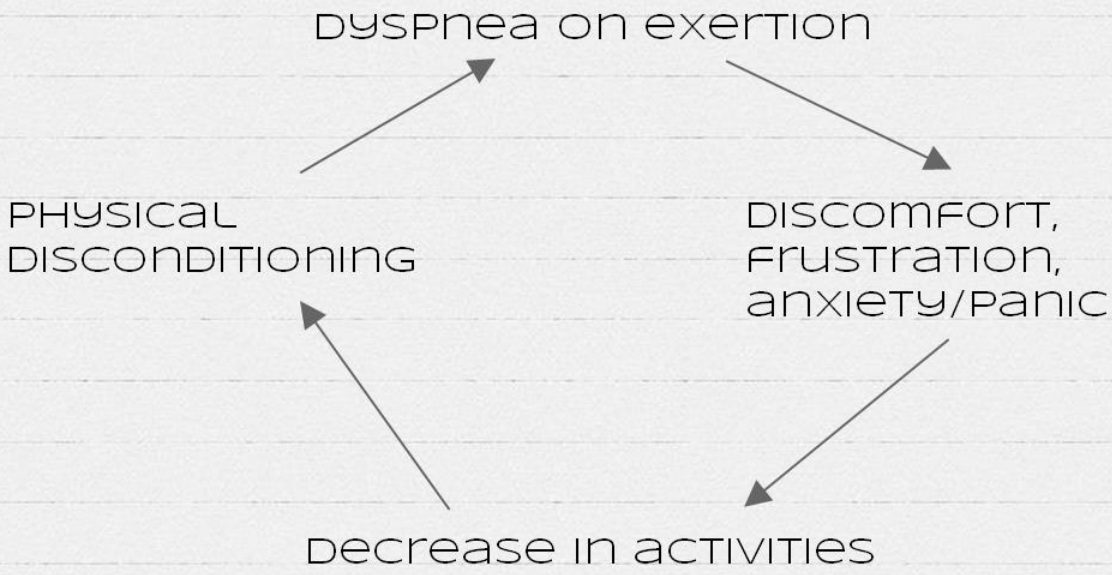
Dyspnea

NOT JUST O_2

Dyspnea

- **Subjective**
- Impacts quality of life, functional status
- Distinguish dyspnea from hypoxia esp. on exertion
- Consider progressive course (?rapid onset)

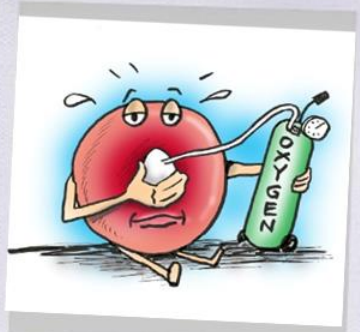
Dyspnea


Dyspnea on exertion
Discomfort, frustration, anxiety/panic
Decrease in activities
Physical deconditioning

Possible causes:

- Pulmonary
- Cardiac
- Neuromuscular
- Psychological
- Fluid

Consider bloodwork and imaging

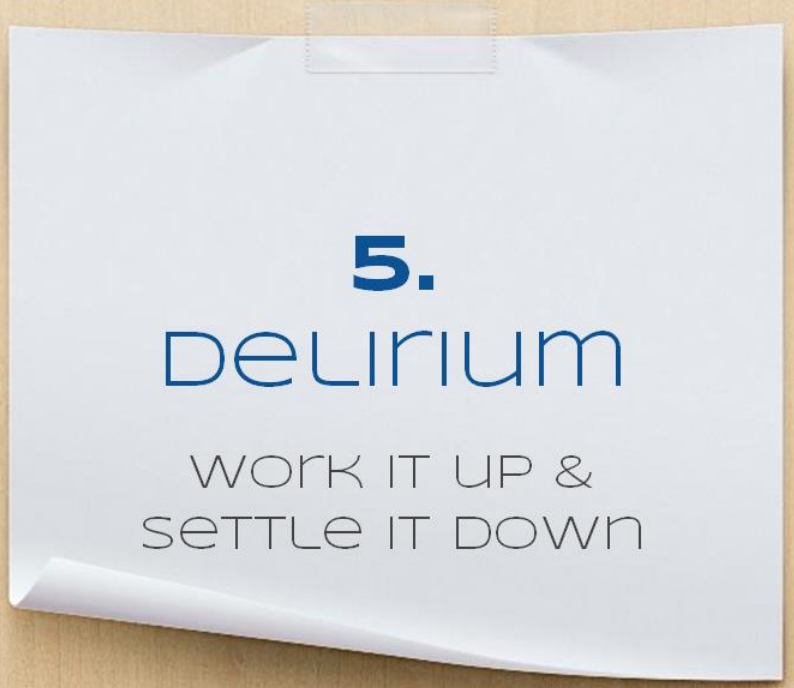


Treatment

- Pacing, Breath controls (eg pursed lip)
- Positioning & equipment
- Relaxation techniques
- Cool blown air
- **Opioids** (low dose vs pain)
- **Corticosteroid** (trial)
- **Benzodiazepine** (with caution)

TIPS & TRICKS

- ★ OXYGEN ONLY AVAILABLE IF SAO2 <88%
- ★ FORCED AIR AS BENEFICIAL IF NOT HYPOXIC
- ★ PARENTERAL OPIOIDS MAY BE BEST BENEFIT, USED PREEMPTIVELY
- ★ CORTICOSTEROIDS SOMETIMES HELPFUL
- ★ MOST **common reason** FOR PALLIATIVE SEDATION


5.
Delirium
work it up &
settle it down

Delirium

- Hyperactive: 30%
- Hypoactive: 48%
- Mixed: 22%

- Terminal Delirium
  - Huge impact to family experience & memories

Risk Factors

- Older
- Dementia
- Decreased Hearing or Visual Acuity
- Immobility
- Malnutrition
- Substance Use
- Polypharmacy
- Comorbidities
- Hospitalization
- **Restraints**

Workup

Disease trajectory
- reversibility?
- burden of workup/treatments

Drugs - review, minimize, rotate

Infection - UTI*, pneumonia, cultures/imaging

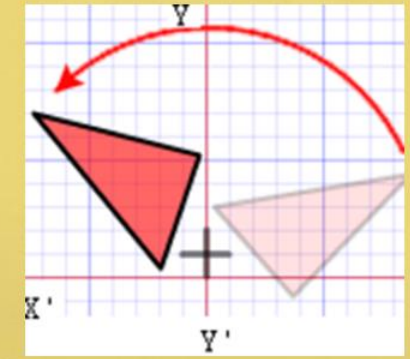
Metabolic - renal, electrolytes, liver, calcium*

Structural change - examine-->image

Consider other changes in status

Opioid rotation

- Consider fentanyl, methadone
- Methadone exemption for analgesia in palliative care:
  methadone4pain.ca
- Free, takes ~1hr, CPD accredited!



Treatments

- Daylight
- Reminders of self
- Companionship
- Reorienting
- Circadian rhythm

Treatments

- Avoid antipsychotics, opioids
- Consider methylphenydate, trazodone, melatonin
- Avoid benzodiazepines unless goal is sedation
- If patient, family or caregivers **at risk/distressed** consider haldol (low dose), methotrimeprazine, midazolam
- May need to consider sedation

Tips & Tricks

- Consider and discuss that delirium may be terminal
- Workup as appropriate
- Treat during workup if moderate/severe
- Consult if needed for severe cases, sedation

Thank you!

Questions?

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