Palliative Care in Non-Cancer Illnesses: COPD, CHF

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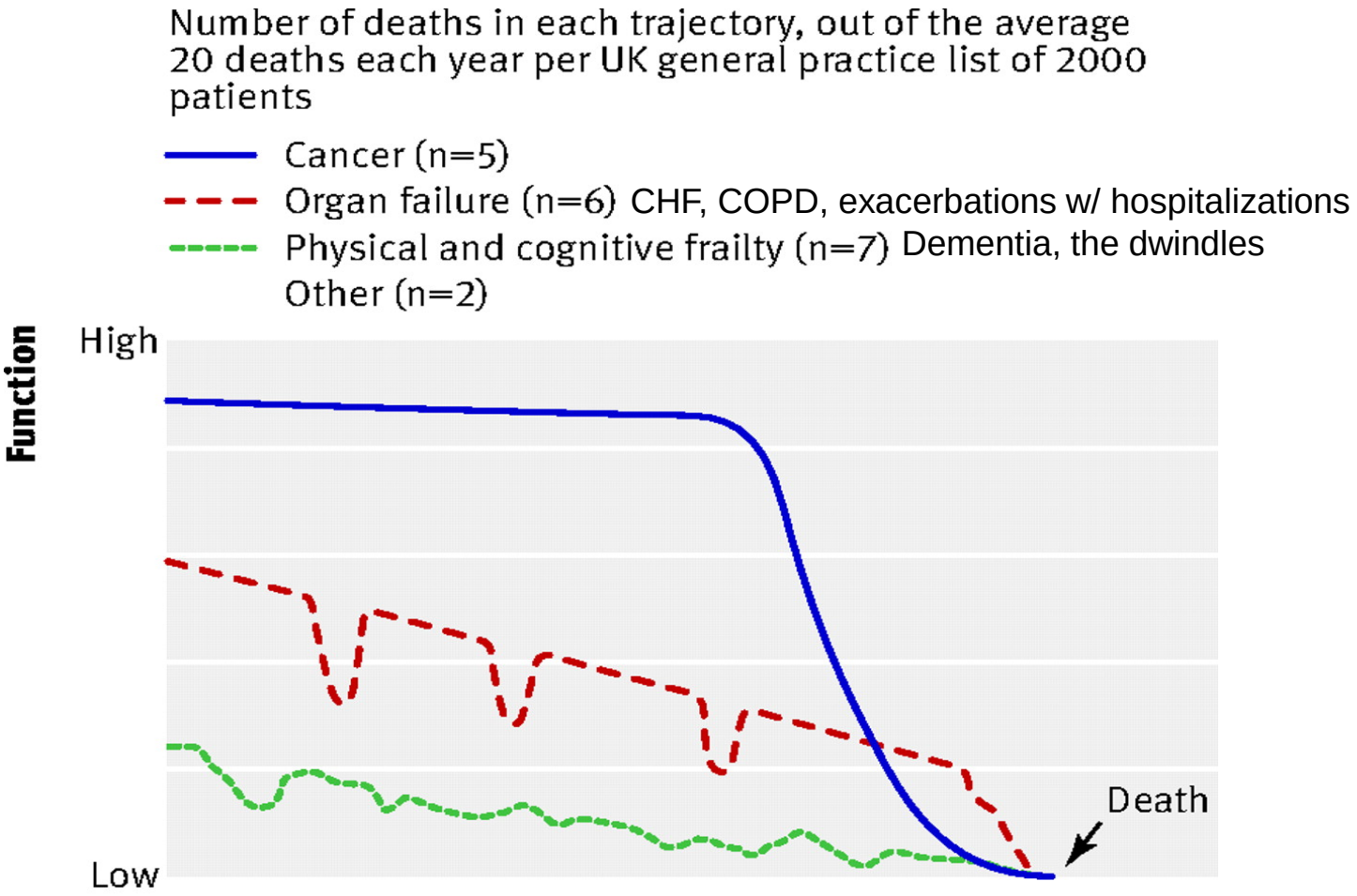
Initial Barriers:

- Worldwide only 14% of patients that need palliative care receive it – World Health Organization
- Primary/Specialist physicians often do not think of palliative care until it is very late in the course of the disease process
- Patients and families often are reluctant to consider palliative care
- Palliative care may not be available

Figure 1: The three main trajectories of decline at the end of life



Murray, S. A et al. BMJ 2008;336:958-959

Consider Palliative Care When:

- High symptom burden
- Patient/family/medical team needs help with complex decision making and determination of goals of care
- Unacceptable level of pain, dyspnea or other symptoms
- Family struggling with multiple domains of suffering
- Frequent hospital or emergency department visits
- Patient declining despite optimal therapy

What does Palliative Care offer?

- Management of symptoms: dyspnea, pain, nausea, fatigue, anorexia
- Communication with the patient and family regarding goals of care and treatment options
- Coordinate care with the medical and social support services

Tools to measure symptoms:

- Edmonton Symptom Assessment Scale (ESAS)
- http://npcrc.org/files/news/edmonton_symptom_assessment_scale.pdf

- Memorial Symptom Assessment Scale (MSAS)
- http://npcrc.org/files/news/memorial_symptom_assessment_scale.pdf

- Needs at the End-of-Life Screening Tool (NEST)
- http://npcrc.org/files/news/needs_end_of_life_screening_NEST.pdf

Prepare for the Future

- Establish goals and treatment options
- Educate the patient and family on what to expect as the disease progresses
- Establish who they want as a surrogate decision maker and obtain the appropriate documents
- Do they have peace with God?
- What are their preferences regarding resuscitation?

Dyspnea/Breathlessness

- Beta adrenergic agonist (long and short acting) in COPD
- Muscarinic antagonist/anticholinergics (long and short acting) in COPD

Dyspnea

- Immediate release morphine effective for Cancer and COPD
- Immediate release morphine probably effective for CHF
- Benzodiazepines effective
- Benzodiazepine + opioid may be most effective

What about nebulized meds?

- Nebulized furosemide
- Nebulized morphine
- Nebulized fentanyl
- All have reported success in case reports but needs more study

Dyspnea

- Oxygen
- Fan
- Non invasive positive pressure ventilation
- Corticosteroids more for COPD
- Diuretics

Anorexia and Weight Loss

- Nutritional counseling, encourage favorite foods
- Education-explain that forcing patient to eat will not likely help
- May have dyspnea with eating
- Early satiety- metoclopramide
- Constipation-laxatives, stool softeners
- Appetite stimulants-megestrol, brief course of corticosteroids, cannabinoids/dronabinol
- Antidepressants such as mirtazapine

Fatigue

- Exercise program but the patient may need to conserve energy
- Treat underlying problems such as pain, depression
- Short course of corticosteroids
- Psychostimulants such as methylphenidate 5 mg in am
- If anemic consider transfusion
- Rearrange room to remove impediments to activity
- Tailor treatment to the illness trajectory

Bibliography

- American Academy of Hospice and Palliative Medicine Packet Guide to Hospice and Palliative Medicine
- Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care. 1991 Summer;7(2):6-9
- Bruera E, Sala R, Spruyt O, et al. Nebulized vs Subcutaneous Morphine for Patients with Cancer Dyspnea: A Preliminary Study.J Pain and Symptom Manage 2005;29(6):613-618.
- Emanuel LL, Alpert HR, Emanuel EE. Concise screening questions for clinical assessments of terminal care: the needs near the end-of-life care screening tool. J Palliat Med 2001; 4:465-74
- Emanuel LL, Alpert HR, Baldwin DC, Emanuel EJ: What terminally ill patients care about: toward a validated construct of patients' perspectives. Journal of Palliative Medicine 2000, 3:419-431
- Gifford AH[1], Mahler DA, Waterman LA, et al. Neuromodulatory effect of endogenous opioids on the intensity and unpleasantness of breathlessness during resistive load breathing in COPD. COPD. 2011 Jun;8(3):160-6.
- GomutbutraP, O'Riordan DL, Pantilat SZ. Management of Moderate-to-Severe Dyspnea in Hospitalized Patients Receiveing Palliative Care.J Pain and Symptom Manage 2013;45(5):885-891.
- Hospice and Palliative Nurses Association Dyspnea Task Force

Bibliography

- Janssen DJA, Spruit MA, Uszko-Lencer NH, et al. Symptoms, Comorbidities, and Health Care in Advanced Chronic Obstructive Pulmonary Disease and Chronic Heart Failure. J Palliat Med 2010:14(6):735-743.
- Navigante AH,Castro M, Cerchietti LC. Morphine verses Midozolam as Upfront Therapy to Control Dyspnea Perception in Cancer Patients While Its Underlying Cause is Sought and Treated. J Pain and Symptom Manage 2010;39(5):820-830.
- Oxberry SG, Torgerson D J, Bland JM, et al. Short Term Opioids for Breathlessness in Stable Chronic Heart Failure: A randomized controlled trial. Eur J Heart Fail 2011;13(9):1006-1002.
- Portenoy RK, Thaler HT, Kornblith AB, Lepore JM, Friedlander Klar H, Kiyasu E, Sobel K, Coyle N, Kemeny N, Norton L, et al. The Memorial Symptom Assessment Scale: an instrument for the evaluation of symptom prevalence, characteristics and distress. Eur J Cancer 1994; 30A: 1326-36