Handout for LTC Rounds Presentation, 20.Apr.2022: "The Art of Palliative Care" by Dr. Katie McAleer

I DO NOT have an affiliation (financial or otherwise) with any for-profit or not-for-profit organizations (Except being a Girl Guide leader?)

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1. Take-Home Messages for Mitigating PPO Pitfalls

Nausea: Scheduled (+ PRN?)
eg. haloperidol 0.5 - 1mg SQ q12h scheduled
AND 0.5mg SQ q6h PRN, start with lowest dose

Opioids? Constipation!
Titrate opioids appropriately for pain / dyspnea
Pain: >3 PRN / day, consider increase scheduled + PRN doses
Dyspnea: anticipate 6-7 PRN / day, don't titrate until then
Need to know: which sx PRNs used for? effective?
Add instruction for PRN: "offer, may refuse"

Opioid neurotoxicity? (agitation, myoclonus)
rotate to different opioid, reduce dose by 25%, be prepared to titrate

Anticholinergic s/e can worsen
ALL THE SX we're trying to manage
Iatrogenic anticholinergics
(atropine, antipsychotics, opioids):
check the MAR for +++ PRNs, change Rx as necessary

Don't Fear Benzodiazepines

2. Consider *not* discontinuing these at End-of-Life

HF: anti-HTN + diuretics
provide symptom management
stepwise remove / taper anti-HTN
switch to SQ furosemide, same dose (may need 2 sites)

Glucocorticoids: taper +/- switch to dexamethasone SQ @ equivalent dose

Taper Antidepressants?
consider liquid, ODT

Replace anticonvulsant
phenobarbital SQ
30mg SQ q8h to start, titrate by 30mg / day
lorazepam SQ PRN

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3. Why & What to Try for constipation not responding to bowel care PPO

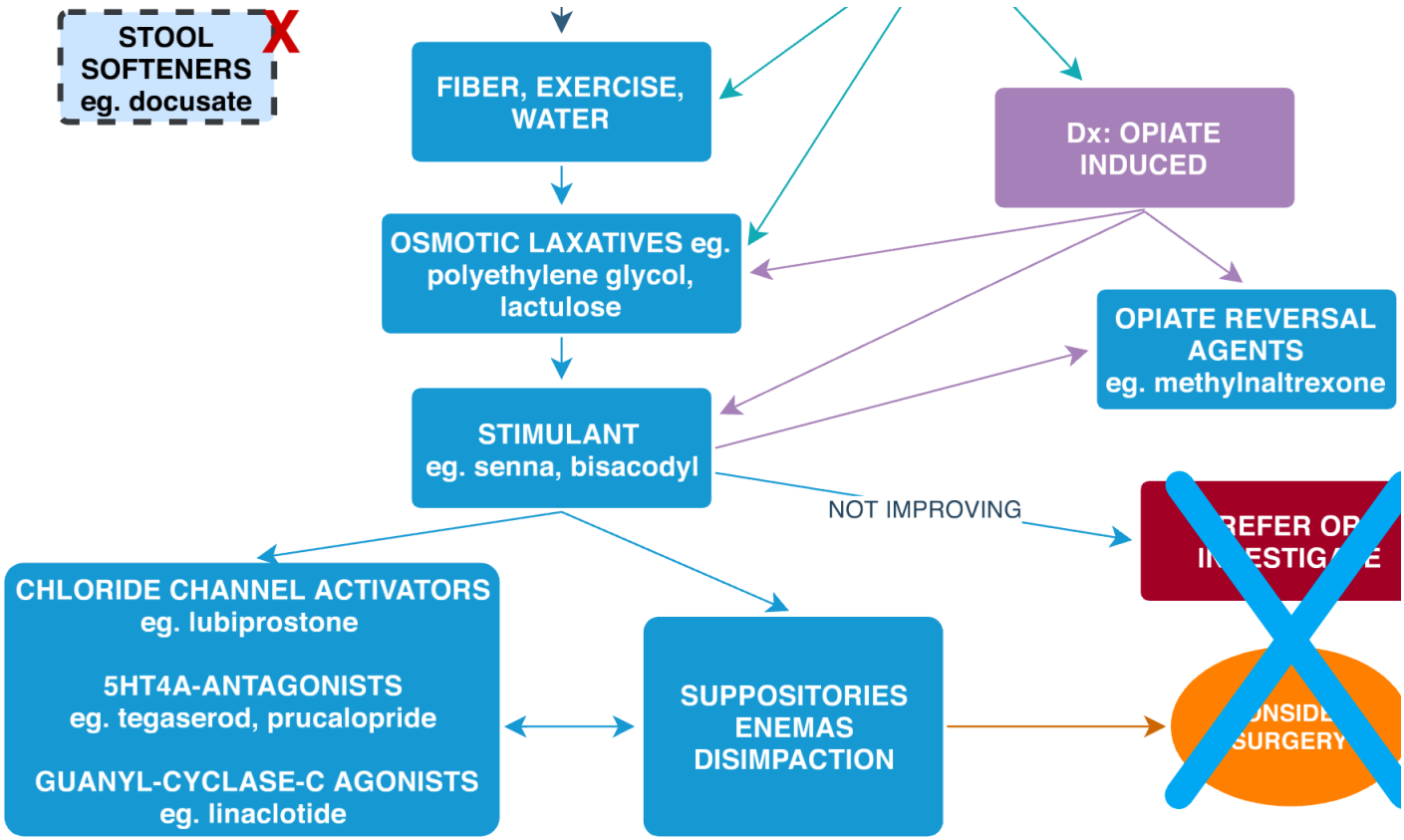
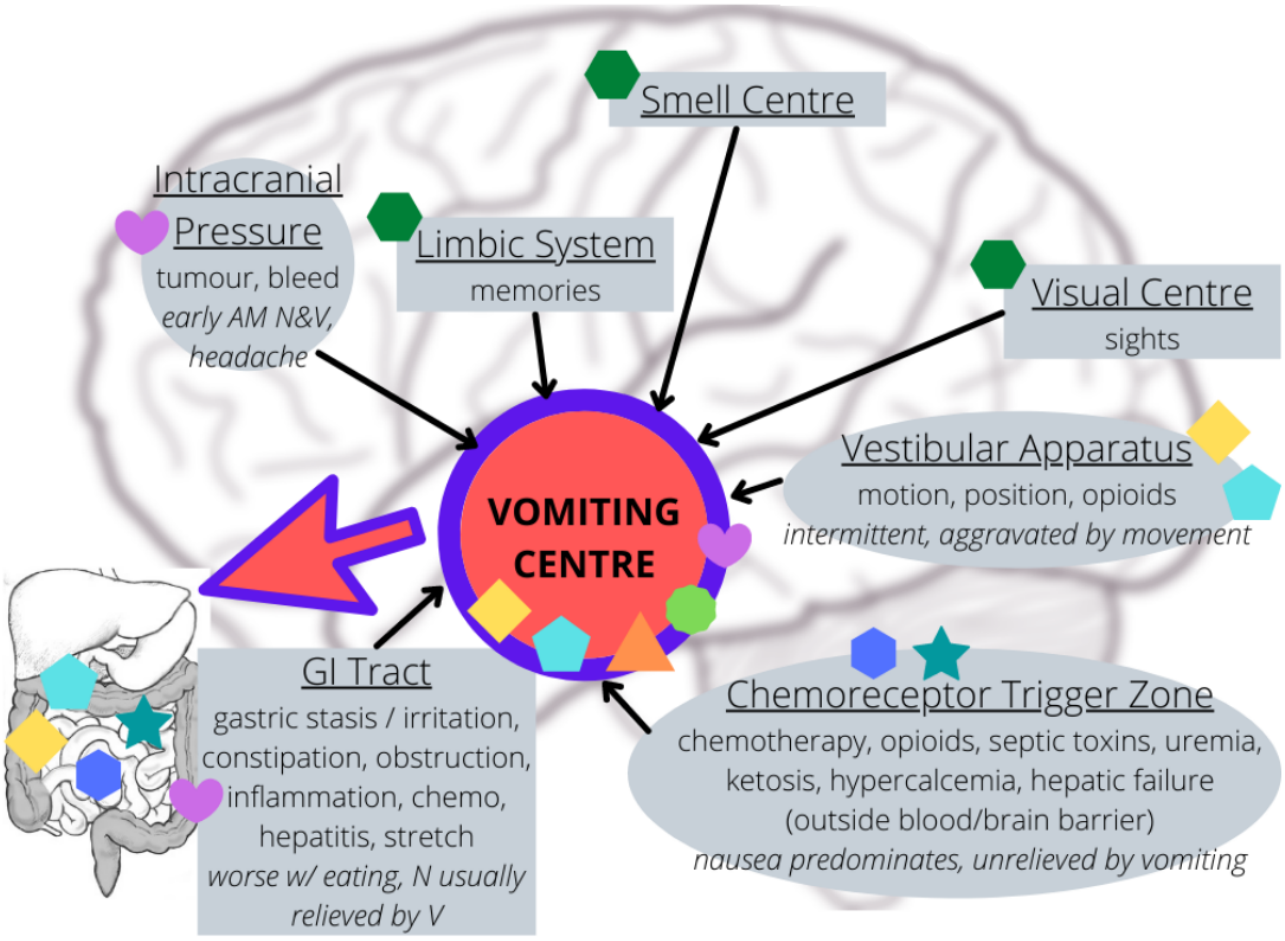


Image snipped from Therapeutics Initiative presentation, "Everyone Poops" by Dr. Jessica Otte, 10.Mar.2020 available at https://www.ti.ubc.ca/2020/03/10/webinar-constipation/

4. Why & What to Try for Nausea & Vomiting (infographics created by Dr. Katie McAleer for this presentation)



antimuscarinics
dry, dilated pupils
scopolamine (C)
hydroxyzine (P)

antihistamines
sedating
dimenhydrinate(C)
hydroxyzine (C)
methotrimeprazine
promethazine (C,P)

antiserotonin (5HT2)
methotrimeprazine

antiserotonin (5HT3)
prokinetic:
metoclopramide
constipating:
ondansetron *($$$)*

steroids
insomnia, mania
other long-term
dexamethasone

antidopamine
sedation, akathisia
avoid in Parkinson Dsx
metoclopramide (C,P)
methotrimeprazine (C)
haloperidol (C)
domperidone (P)
olanzapine (C)

cannabinoids
variable
nabilone
sativex
other products

benzodiazepines
sedating
lorazepam
diazepam
midazolam

Non-Rx: oral hygiene, fluids, sights / sounds / smells, polypharmacy?
*****MANAGE CONSTIPATION*****

Is **GERD** contributing?
Multiple non-Rx or PO options, or injectable famotidine 10-20mg SQ BID

Good choice for multifactorial N & V, to **replace** haloperidol if max dose not working:
methotrimeprazine 5-15mg PO / SQ q12h scheduled *AND* q6h PRN,
start with lowest dose, call MD if >25mg used in 24h
Can also be used PRN agitation / delirium -> potentially fewer Rx overall.
Watch for anticholinergic effects. PO & SQ: same dose

Good choice if likely low GI motility (eg. 2' opioids / constipation), to **replace** haloperidol:
metoclopramide 5-10mg PO or SQ QID; preferably 30 minutes before meals, and at HS
Primarily prokinetic, watch for dyskinesia, some patients get paradoxic nausea. PO & SQ: same dose

If symptoms not resolved +/- other systemic symptoms (pain, fever), **add** this to current Rx:
dexamethasone pulse + taper: 4-8mg PO or SQ qAM daily x 14d,
decrease by 2mg every 7d, from 2mg decrease to 1mg x 7d, then discontinue.
If symptoms resume, go back up to lowest effective dose.
May allow decrease / discontinue other medications. Watch for insomnia, psychosis. Consider gastroprotection.
No need to divide dose: long half-life, give full dose in AM. PO & SQ: same dose

Add Rx from another drug class?
benzodiazepine if anxiety component, antihistamine, anti-serotonin

Is it bowel obstruction??
++N&V, nothing in rectum, no flatus (+/- bowel sounds is non-diagnostic)
Medical management: stop prokinetics + laxatives, NPO,
dexamethasone 8mg SQ qAM + octreotide 100mcg SQ TID
+ analgesia +/- benzodiazepine

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5. What to Try for Respiratory Distress

move air across face
eg. handheld fan

trial of O2 (if available / Rx private pay?)
*no evidence unless hypoxemic *but**
strong placebo effect (may be 2' air movement across face)

HF? try SQ furosemide eg. x 3 days
same dose SQ as PO, may need multiple SQ sites (that's OK)

ensure opioid dose is adequate & being *offered*
anticipate 6-7 PRN doses / day

consider rapid-acting opioids
eg. buccal fentanyl or sufentanil
high potential for error;
commercial products available but $$$,
limited doses available

add methotrimeprazine 6.25-12.5mg SQ q2h PRN
keep opioid as 1st-line; watch for anticholinergic s/e!

if 2' neoplasm: dexamethasone 2mg SQ qAM

add benzodiazepines PRN
Helps diminish anxiety / dyspnea cycle; don't stop opioids

If unmanaged despite maximal medical therapy, consider Palliative Sedation *(see below under “Agitation”)*

6. Why & What to Try for Agitation & Seizures; also, how to initiate Palliative Sedation

Agitation	**Seizures** *consider writing "crisis" seizure orders when start Actively Dying PPO*
etiology often multifactorial, may be irreversible / terminal, but good to consider potentially reversible & treat accordingly	
Medication s/e? *(review anticholinergics / PRNs / opioid neurotoxicity?)* Constipation? Urinary retention? Unmanaged pain / sx? Central neuro signs? *(not likely able to tx but can help explain)* Glucose +/-? *(2' dexamethasone? consider insulin / dextrose PRN hypoglyc)* HyperCa++? *(disease-congruent? consider Xgeva x i, calcitonin)* Hypoxemia? Anemia? Sepsis? *(don't necessarily treat)*	Medication s/e? *(antipsychotic Rx can lower seizure threshold / check for ++ PRNs / opioid neurotoxicity?)* Prior diagnosis? *(currently undertreated?)* Central neuro signs? *(not likely treatable but can help explain)* Hypoxemia? Anemia? Sepsis? *(don't necessarily treat)*
What to try if irreversible / not meaningfully reversible / while awaiting tx of any reversible	
1st line: antipsychotic **haloperidol / methotrimeprazine** **as per Actively Dying PPO** *start low, go slow, maximize;* *goal is "treat / reverse", sedation is s/e*	1st line: benzodiazepine **lorazepam *OR* midazolam 0.5-2mg SQ q15min PRN** **until seizure stops** *can continue intermittent / PRN tx* *if seizures infrequent / non-distressing*
2nd line, low threshold to add: benzodiazepine* **lorazepam 0.5-4mg SL q2h PRN,** **titrate dose to achieve ~q8-12h dosing** *OR* **midazolam 0.5-10mg SQ q30min PRN,** **titrate dose to achieve ~q4-8h dosing** *goal is mild / moderate sedation,* *can then decrease / discontinue antipsychotic* **This dosing strategy can also be used to initiate Palliative Sedation, which should be considered for unmanaged symptoms despite maximal medical therapy eg. for respiratory distress, agitation*	2nd line, if multiple distressing seizures: scheduled benzodiazepine or sedative **lorazepam 0.5-4mg SL q2h PRN,** **titrate dose to achieve ~q8-12h dosing** *OR* **midazolam 0.5-10mg SQ q30min PRN,** **titrate dose to achieve ~q4-8h dosing** *OR* **phenobarbital 30mg SQ q8h,** **titrate by 30mg / day to achieve no seizures** *goal is no seizures, may require mild / moderate sedation*
while using sedation: continue all previous symptom management	

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