Palliative Care in Chronic illnesses

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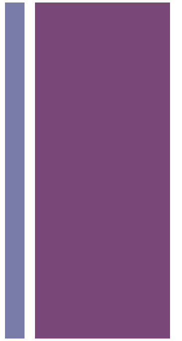
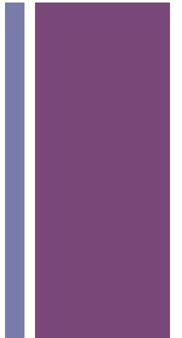
Challenges in Non-CA Palliative Care



- Viewed as more “BENIGN” than cancer
- Unpredictable trajectory of disease
- Prognostication
- Minimal conversation & No advance care plan
- Less good-quality evidence

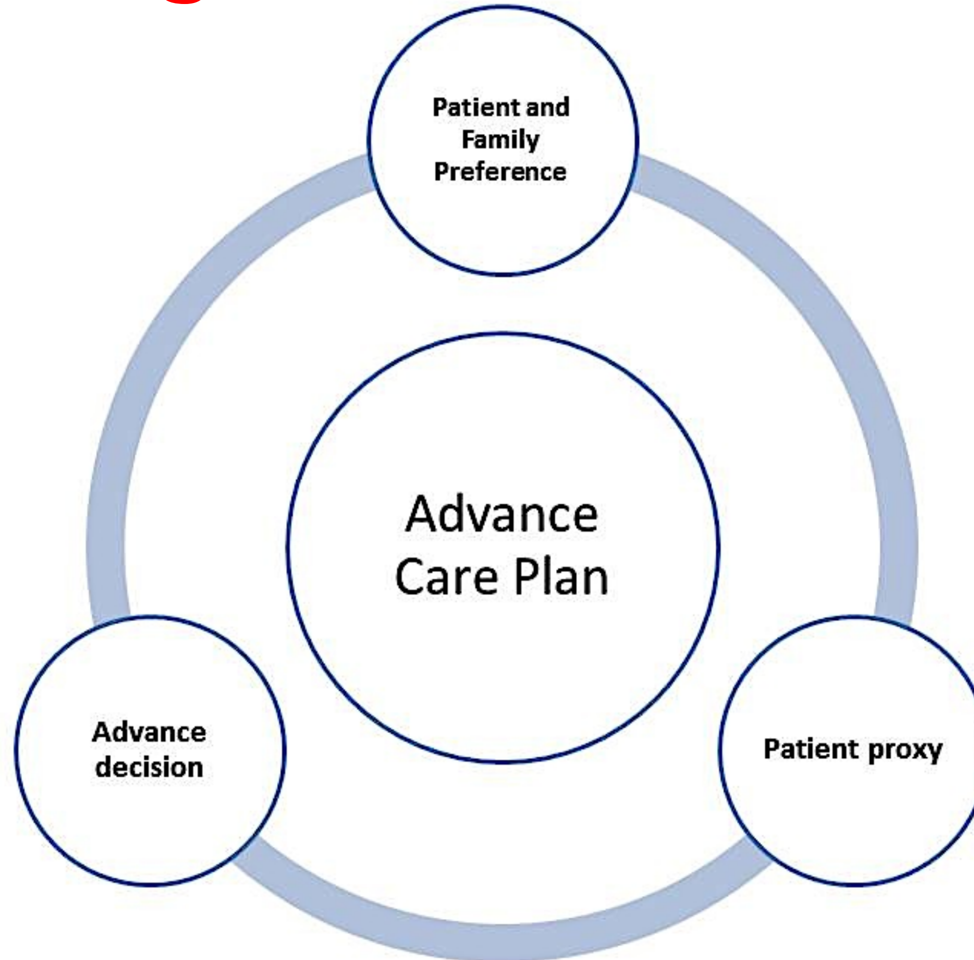
Setting

+ Barriers to Goal Setting



- Doctors and Patients want to talk about “GOOD OUTCOME”
- Miscommunication
  - “40% chance of response” ≠ “40% chance of cure”
- Focusing on “Small multiple problems” > **“BIG PICTURE”**
- Making “False Hope”
- BAD prognostication

"Formal discussion"
VS
"Ongoing informal discussion"

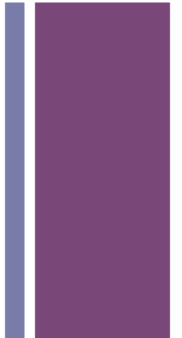


Discussion with proxy decision makers

- ก่อนหน้าจะป่วย ผู้ป่วยเป็นคนอย่างไร มีนิสัยอย่างไร
- เคยคุยกับผู้ป่วยถึงความต้องการในการดูแลหากโรคทรุดลงหรือไม่
- หากเขาสามารถความต้องการแก่เราได้ในตอนนี้ คุณคิดว่าเขาจะบอกอะไรเราบ้าง
- จากประสบการณ์ที่ผ่านมา เคยเห็นใครที่มีอาการป่วยเหมือนผู้ป่วยหรือไม่ แล้วเขาตัดสินใจเรื่องการดูแลอย่างไร

Some specific illnesses

Advanced heart failure

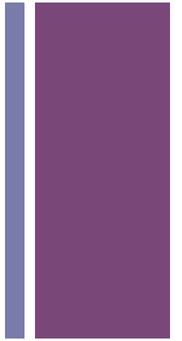


- ในปี พ.ศ.2556 มีผู้เสียชีวิตด้วยโรคหัวใจและหลอดเลือด จานวน 54,530 คน เฉลี่ยเสียชีวิตวันละ 150 คนหรือ**เฉลี่ยชั่วโมงละ 6 คน**

Table 1. Incidence of and Number of Deaths Due to Heart Failure Compared With Other Common Causes of Death in the United States

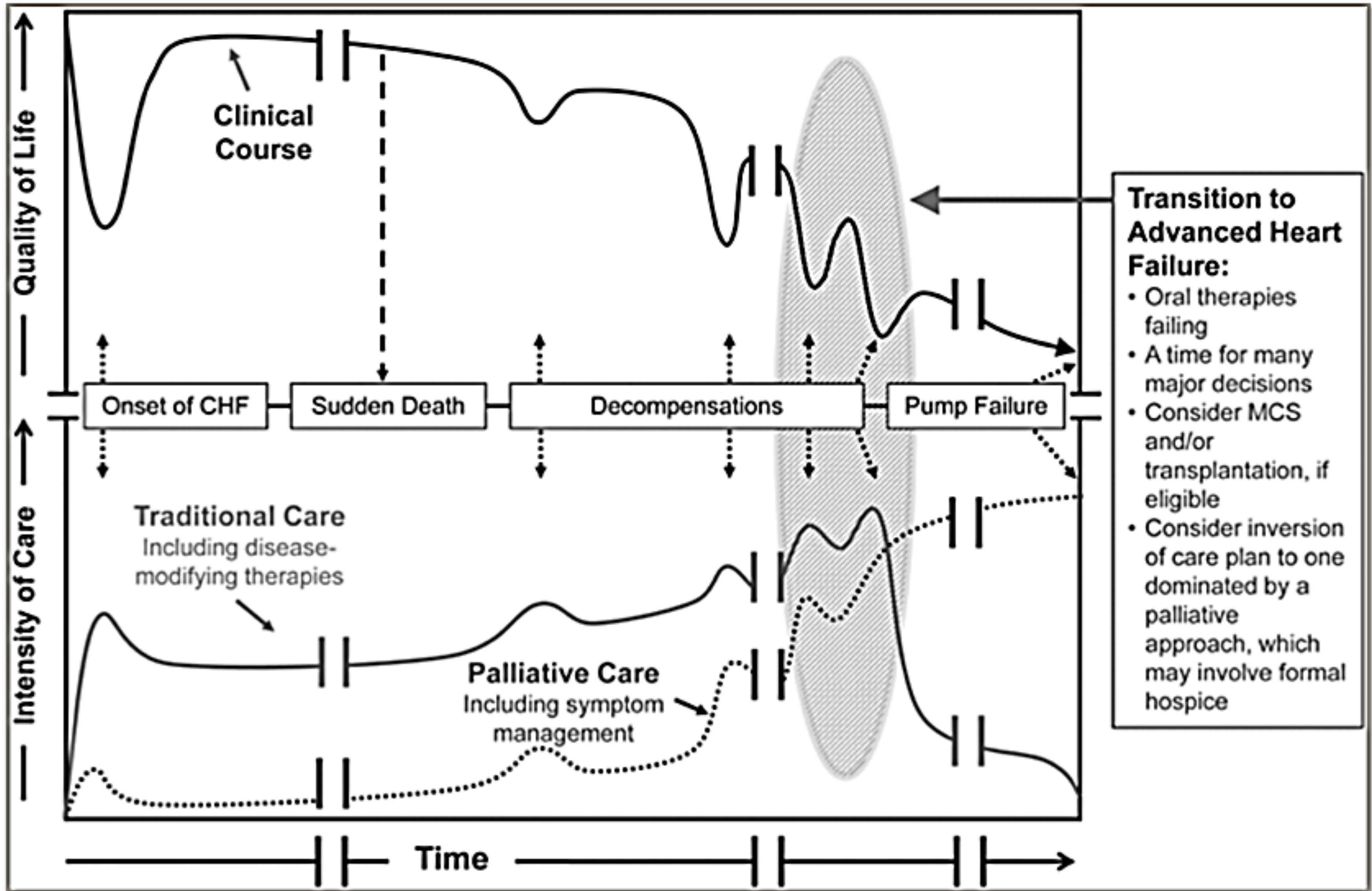
Cause of Death	Incidence	Deaths
Heart failure[3]	≈500 000	284 365
Lung cancer[4]	196 252	158 006
Breast cancer[4]	188 587	41 316
Prostate cancer[4]	189 075	29 002
HIV/AIDS[5]	37 726	16 395

Some facts about HF



- ผู้ป่วยโรคหัวใจวายมีโอกาสเสียชีวิตสูงกว่าโรคมะเร็งหลายชนิด
- มีการดำเนินโรคและการพยากรณ์โรคที่ไม่แน่นอน โดยเฉพาะในระยะแรกๆ
- การดูแลแบบประคับประคองควบคู่ไปกับการดูแลเฉพาะโรคนั้นสามารถทำให้ผู้ป่วยด้วยโรคหัวใจวายมีคุณภาพชีวิตที่ดีและชีวิตยืนยาวมากขึ้น

Stage 1 Stage 2 Stage 3 Stage 4 Stage 5

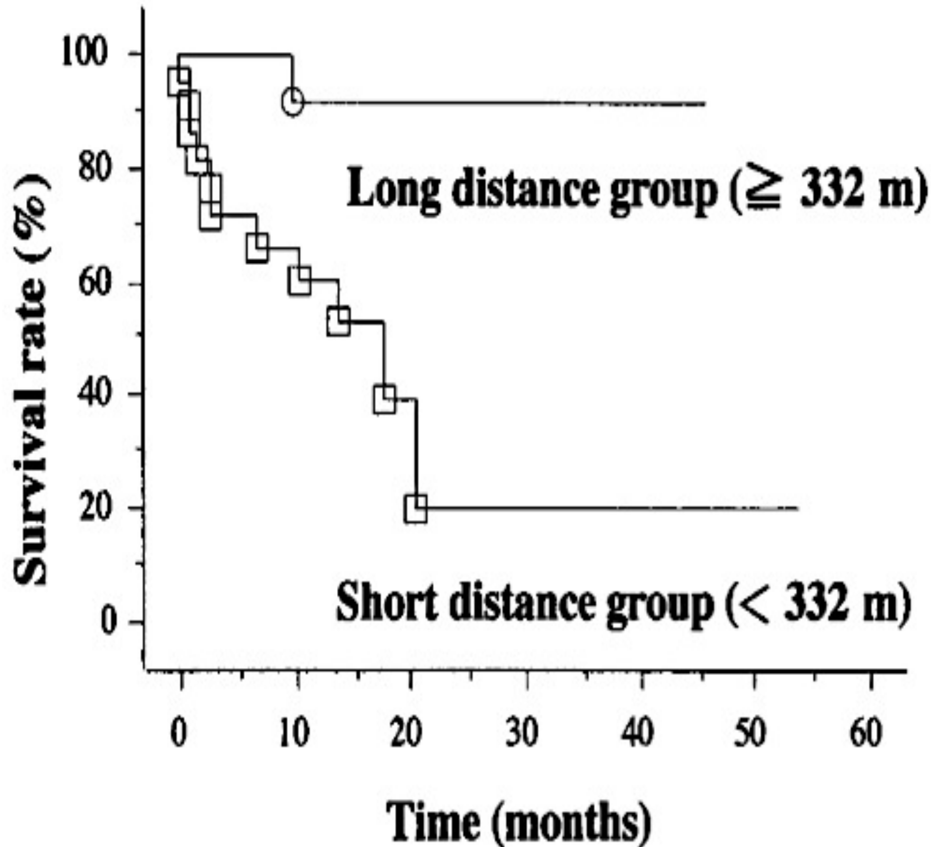


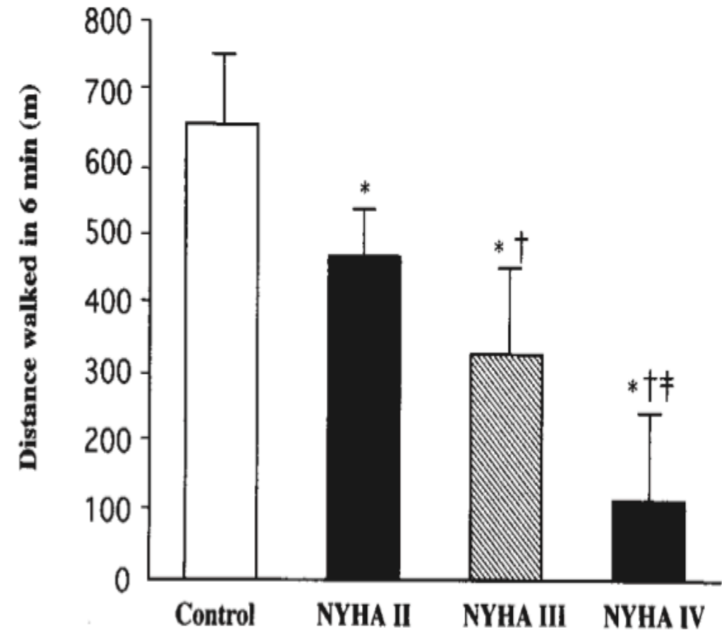
Allen L A et al. Circulation. 2012;125:1928-1952

Poor Prognostic Factors for advanced HF

- Frequent admissions
- Greater than 10% weight loss
- Very high level of BNP
- Poor response to diuretics
- Poor renal function
- EF < 20%
- Previous embolic stroke or cardiac arrest

6-minute walk test





re 1. Relation between distance walked during six-minute walk and NYHA functional class in patients with PPH. *$p < 0.05$ s control subjects; †$p < 0.05$ versus NYHA functional class II; 0.05 versus NYHA functional class III.

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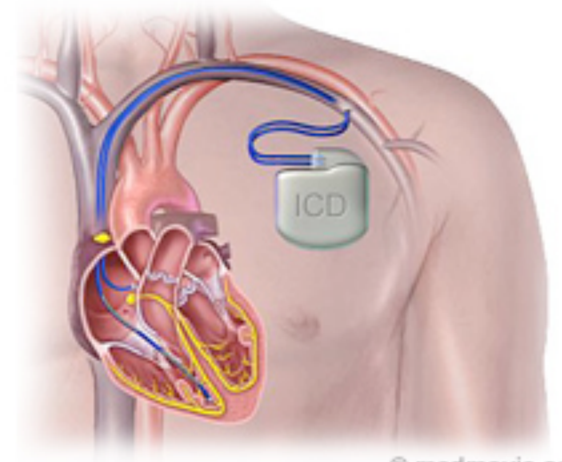
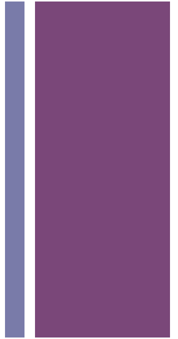
Suffering in advanced HF

- Common symptoms: dyspnea, pain, depression, fatigue, and edema
- Pain in > 50% of patients
- Comorbid chronic illnesses
- Discontinue the treatments
  - Implantable Cardioverter Defibrillator (ICDs)

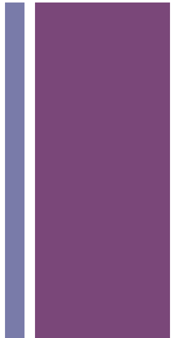


Key principles of palliative approach to HF



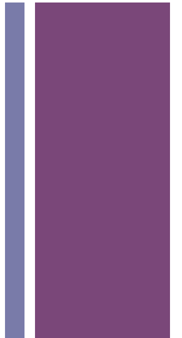
- Advance Care Plan
  - Effective communication:
    - “Breaking bad news”
    - Treatment options: Implantable cardioverter defibrillator (ICD)
    - Patient’s and Family’s goals of care
    - Revise annually or progression of disease or significant life change
- Good symptoms control and relief of sufferings

Symptom management



- Opioid for dyspnea (PO > IV)
  - Start lower dose + Increased interval in renal failure
- Benzodiazepines for dyspnea (±)
- Avoid NSAIDs
- Depression
  - Avoid TCA → prolonged QT + arrhythmia
  - SSRI → monitor QTc prolongation, Drug interaction (Sertraline and Fluoxetine may be preferred, no Citalopram)
  - Mirtazapine
  - Trazodone

Symptom management



- Cardiac resynchronization therapy
  - Decreased mortality and hospital admission

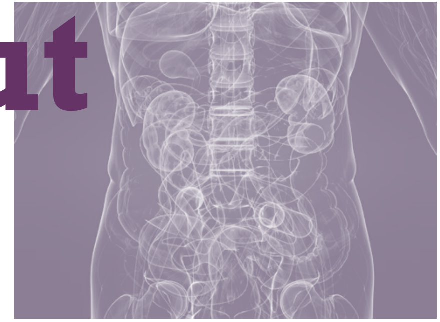
- Inotrope e.g. dobutamine
  - Only in short term to improve symptoms and QoL
  - May cause cardiac arrhythmia

ESRD

	2007 (pmp)	2008 (pmp)	2009 (pmp)	2010 (pmp)	2011 (pmp)	2012 (pmp)
Hemodialysis	20,641 (327.4)	26,438 (417.1)	27,056 (425.9)	30,835 (482.6)	34,895 (545.2)	40,505 (628.5)
Peritoneal dialysis	1,198 (19.0)	2,760 (43.5)	5,133 (80.8)	6,829 (106.9)	9,509 (148.6)	12,150 (188.5)
Kidney transplantation*	3,618 (57.4)	2,298 (36.3)	2,923 (46.0)	3,181 (49.8)	3,583 (55.9)	5,729 (88.9)
Total	**25,457 (419.9)**	**31,496 (496.9)**	**35,112 (552.8)**	**40,845 (639.3)**	**47,987 (749.7)**	**58,385 (905.9)**

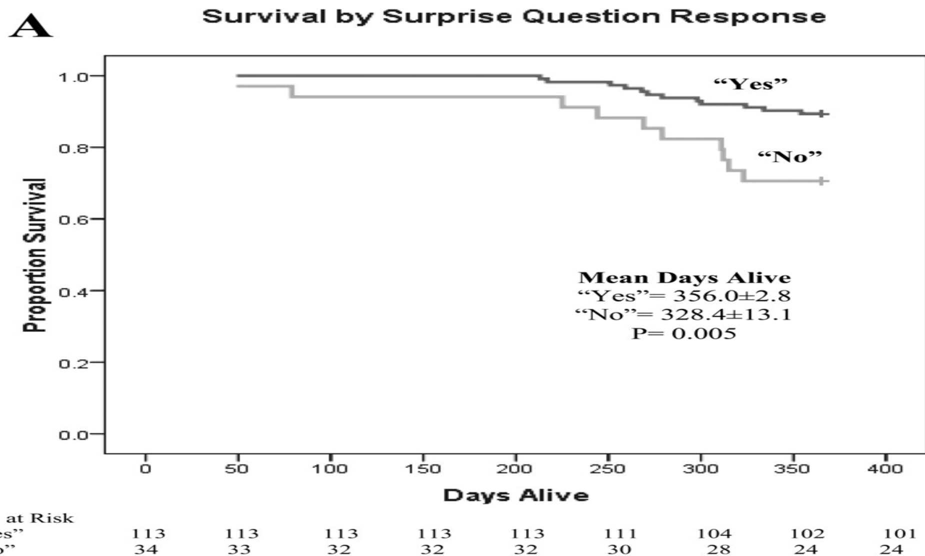
*Data from Thai Transplantation Society

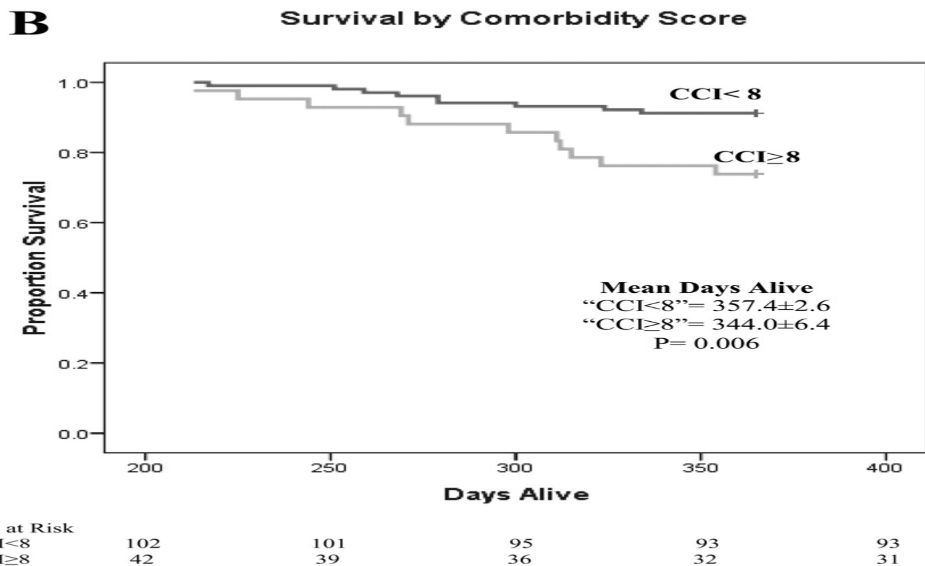
+ Some facts about ESRD



- Prognosis (from US Renal Data System)
  - 1-year survival = 76%, 5-year survival = 36%
- Age > 75 yrs with multiple comorbidities e.g. DM, CAD
  - Increased mortality rate with dialysis compared with conservative treatment
- "Refuse dialysis" ≠ "Sudden death"
  - Median survival of at least six months (range 6.3 to 23.4 months)

Survival curves for “surprise” question response and comorbidity score in days alive at 12 months





Odds of dying within 1 year were 3.507 times

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Moss A H et al. CJASN 2008;3:1379-1384

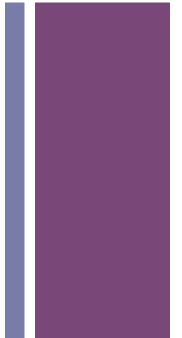
CJASN

Patient's perspectives

- **61%** regretted their decision to start dialysis
- **51.9%** reported that it was their physician's wish, and **13.9%** stated that they chose dialysis because it was the family's wish
- **Less than 10%** of patients reported having had a discussion about end-of-life care issues with their nephrologist in the past 12 months.

Clin J Am Soc Nephrol. 2010 Feb;5(2):195-204

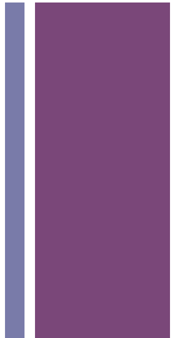
Symptoms/Suffering in ESRD



- Pain
  - MSK pain, Abdominal pain in PD patient
  - Avoid NSAIDs
  - Increased risk of opioid toxicity
  - Lower dose, increased interval
  - Fentanyl and Methadone → preferred choices

Opioids	Safe and effective use in dialysis patients
Morphine	Avoid if possible
Tramadol	Yes (with caution, max 200 mg/day)
Codeine	Avoid if possible
Fentanyl	Yes (with caution)
Methadone	Yes (with caution)

Symptoms/Suffering in ESRD

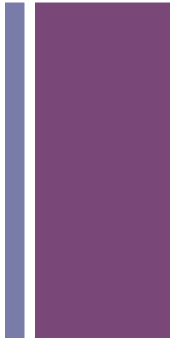


- Delirium
  - Drug of choice : haloperidol (0.5-1 mg PO/SC Q4H prn)
  - Others : Quetiapine, Risperidone, Olanzapine
- Depression
  - Fluoxetine is effective, non-toxic → lower dose
  - Others: Citalopram, Mirtazapine, Sertraline
  - Caution: DI with tramadol
- Pruritus
  - Antihistamine is ineffective
  - Drugs: SSRIs (Paroxetine, Mirtazapine), Gabapentin, Ondansetron

Discontinuation of dialysis

- Mean survival 8-10 days (1-48 days)
- Symptoms: pruritus, nausea, dyspnea, agitation, myoclonus

Better palliative care in non-CA patients



- Early recognition
- Better prognostication
- Establish "Goals of care" and "Effective advance care plans" using "Good communication"
- Therapeutic relationship & Teamwork

Thank you…