

# PALLIATIVE MEDICINE PEARLS

HELPING THE PATIENTS & THE FAMILY  
NAVIGATE THROUGH  
DIFFICULT TREATMENT OPTIONS

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**Naresh Pathak, M.D., F.A.C.P., F.A.A.H.P.M.**

Associate Professor, NSU School of Medicine

Adjunct faculty, UM, FAU & FIU Schools of Medicine

Fellow American Academy of Hospice & Palliative Medicine

# PALLIATIVE MEDICINE PEARLS

## FORMAT

- Multiple related topics
- Case based & Evidence based
- Clinically oriented
- Immediately applicable
- Relevant to practice of Primary Care

# PALLIATIVE MEDICINE PEARLS (DISCUSSION POINTS)

1. Depression at the end of life
2. Dyspnea in Palliative Care
3. "Gurgling" at the end of life
4. Dealing with critically ill patient with "terminal illness" requesting that "everything be done"
5. Feeding Tube in patient with advanced Dementia
6. Delirium at the end of life
7. Opioid Neuro-Toxicity in terminally ill patient

## CASE # 1

- HX: 78 yo wf with end stage NSCLC. Life expectancy of 2 months. Has hopelessness, helplessness, anhedonia, insomnia and guilt. Not suicidal.
- PMHX: No Hx of depression
- Meds: Morphine ER, Morphine IR, Gabapentin, Senna Plus

What is the best option to  
~~Manage patient's depression?~~  
(Or is it a Grief Reaction?)

## CASE # 1

1. No intervention since these symptoms are common at the end of life and Tx takes a month to work.
2. Mirtazapine 15 mg at HS → 30 mg at HS in 1 week
3. Duloxetine 30 mg daily → 60 mg daily in 1 week
4. Ketamine 10 mg SL QID
5. Methylphenidate ~~5 mg at 8 AM & Noon~~ → 10 mg BID in 4 days

## CASE # 1

5 - Methylphenidate 5 mg at 8 AM & Noon → 10 mg BID in 4 days

- No intervention is NOT appropriate since we can improve quality at end of life
- Mirtazapine is not “activating” antidepressant. It takes 2 weeks to work. It has antipsychotic effect but not a strong antidepressant effect. It can improve appetite, but may cause sleepiness during daytime.
- Duloxetine takes a month to work. It competes with gabapentin and can lead to Serotonin syndrome

## CLINICAL PEARL # 1

- Methylphenidate is “activating” antidepressant. It works in few days. It improves all the “vegetative” symptoms of depression like hopelessness, helplessness, anhedonia and guilt (helps Apathy in Alzheimer's pt)
- Depression at end of life is treatable.
- Grief is normal and adaptive at end of life, Depression is NOT
- Alterations of sleep, appetite and energy are not good indicators of depression at end of life
- Methylphenidate also helps daytime sleepiness associated with opioid use

## CASE # 2

- Hx: 68 yo female with Idiopathic Pulmonary Fibrosis. Progressive dyspnea with all ADL. Stable on O2 at 4 l/min. Not overly anxious but rather frustrated.
- Meds: O2 4 l/min continuous. Metoprolol ER 25 mg daily
- PMHx: No COPD, No Asthma, Non-Smoker, No CAD
- PE: VSS. Dry "Velcro" crackles ½ way up from lung bases. Pulse Ox 94% at rest & 90% with ambulation. Dyspneic, tachypneic and tachycardic with ambulation.

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What is the most appropriate Tx for her Dyspnea?

## CASE # 2

1. Haloperidol 0.5 mg PO BID → 1 mg PO BID in 2 weeks
2. Lorazepam 0.5 mg PO BID & Q 4 hours PRN
3. Morphine Sulphate Liquid 2.5 mg SL q 4 hours PRN → Eventually convert to MS ER
4. Increase O2 to 5 l/min
5. Add Jet nebulizer Tx with Albuterol + Ipratropium Bromide \_\_\_\_\_

## CASE # 2

3 - Morphine Sulphate Liquid 2.5 mg SL q 4 hours PRN → Eventually convert to MS ER

- Haloperidol helps agitation but has no effect on "air hunger"
- Lorazepam helps anxiety associated with dyspnea but does not have direct effect on dyspnea. It may be a good adjunct, but not the primary Tx
- Higher flow of O<sub>2</sub> has no benefit and may be detrimental. It will not alleviate dyspnea. O<sub>2</sub> by nasal cannula, air by nasal cannula & fan blowing on face had equal effect on symptoms of "air hunger" in Non-Hypoxic patient
- Jet nebulizer Tx with Albuterol and Ipratropium Bromide has no benefit in ~~absence of COPD, Asthma, bronchospasm or tracheal secretions~~. It may add to tachycardia.

## CLINICAL PEARL # 2

- Systemic opioids are beneficial in management of dyspnea from malignant and non-malignant causes
- Opioids help relieve dyspnea by acting on central as well as peripheral receptors – Opioids help anxiety too
- Though Opioid MU receptors are abundant in lungs, inhalation of preservative free Morphine via jet nebulizer has not been shown in double blind placebo controlled studies ~~to be as effective as systemic opioids~~

## CLINICAL PEARL # 2 (CONTINUED)

- Opioids relieve dyspnea from CHF very quickly by pulmonary vein dilatation and central action, and give patient comfort till the definitive Tx has chance to work
- Knowing all this, O<sub>2</sub> is used widely in non-hypoxic patients in hospice & palliative care because it is a potent symbol of medical care. And if psychological benefit to patient and family (provided no harm is done) is achieved at end of life...then is is consideed acceptable Tx.

## CASE # 3

- Hx: 82 YOWF living with daughter comes with acute SOB. W/U shows CHF, New A-Fib, AKI on top of CKD, Aortic Stenosis with Valve area of 0.8 Square CM and LVEF of 25%.
- PMHx: Moderate Dementia, HTN, CKD-3, Frequent falls
- Meds: Metoprolol, Losartan, Furosemide, Potassium, Baby ASA, Donepezil
- PE: BP=110/60. P=124 A-Fib, R=28. No evidence of MI. CXR & Lung exam compatible with CHF. She is given Low Molecular Weight Heparin along with standard Tx
- Hosp Course: Day # 3 she is out of CHF but she develops Rt hemiplegia with lethargy and dysphagia. CT is positive for bleed in the Brain. She continues to decline and begins to "gurgle". Family elects ~~Hospice services~~. PE reveals upper airway rhonchi rather than basal rales.

## CASE # 3

Along with sublingual Morphine, Lorazepam  
& supplemental Oxygen,

What would you give for her  
Respiratory "discomfort"?

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## CASE # 3

1. Elevate head of bed and blow fan over her face
  2. Furosemide 40 mg IV STAT and 2 x daily
  3. Atropine 1% 2 drops SL STAT and every 2 hours PRN
  4. Oro-Pharyngeal Suction PRN
  5. Bi-PAP with FIO2 titrated to maintain Pulse Ox of 92%
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## CASE # 3

### 3 – Atropine 1% 2 drops SL STAT and every 2 hours PRN

- This patient is suffering from “Terminal Secreations” (also called “Death Rattle”) – NOT in acute CHF
- Though fan, air by nasal cannula and O2 by nasal cannula have equal efficacy in relieving “Air Hunger” in non-hypoxic & alert patient, fan is not appropriate in Terminal Secreations.
- In Hospice & Palliative Medicine “Dry Death” is better than “Wet Death”. That is why IV hydration is not advisable in terminally ill patient who is not taking oral intake. Furosemide will dry the patient but has minimal effect on Terminal Secreations
- Oro-Pharyngeal suction has no value since these are tracheal secreations. Besides, it causes more distress without benefit
- Bi-PAP is ~~more distressful, causes abdominal distention and not beneficial~~ in Terminal Secreations

## CLINICAL PEARL # 3

- Terminal Secretions are a common occurrences at end of life.
- They are due to due to Para-Sympathetic discharge from the dying brain
- Atropine is easily available, inexpensive & absorbed very well sub-lingually
- It has predictable effect in drying out the Terminal Secretions
- Adverse effects of Tachycardia, blurred vision, urine retention and ~~all other Anti-Cholinergic~~ effects are unimportant when life expectancy is few hours

## CLINICAL PEARL # 3 (CONTINUED)

- By the time, Terminal Secreations occur, the patient is not aware of any distress. Treating the family and their perception of "How the Patient Dies" is just as important
  - If the interventions at terminal phase of life, intended for the comfort of the patient, hastens the death, they are still considered appropriate and warranted.
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## CASE # 4

- Hx: 78 YO BM with advanced, O2 dependent COPD. Brought by brother to ER with worsening SOB. Patient repeatedly states to ER staff, "I don't want die yet". CXR now shows a new 3 cm mass in the lung. Brother also tells ER doctor, "Do whatever you have to, but don't let my brother die". Patient eventually declines and is intubated in the ER.
- Meds: O2 at 2 l/min, Jet neb with long acting Steroids and Beta Agonist, Inhaled Once daily Anticholinergic, Diltiazem, Temazepam, Atorvastatin and ASA
- PMHx: O2 dependent severe COPD, HTN, MAT, Hyperlipidemia

## CASE # 4

Considering patient's severe underlying Lung Dz,  
and possible Lung Cancer,

How can you deliver Critical Care required for  
respiratory failure and Palliative Care at the  
same time?

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## CASE # 4

### (PROBLEMS TO CONSIDER)

- Hospital team may not have established relationship with the patient and family
- Patient may not be able to participate in “goal of care” discussion.
- If patient did not have that discussion with the family, their wishes may not coincide with that of the patient
- In Critical Care setting, people are more focused on “treating the disease” rather than “treating the patient”
- Many view “aggressive care” and “palliative care” as opposites (pro-life vs. pro-death)
- What unites them is the aim to “reduce suffering”. “Suffering” occurs in persons, not bodies or organs.

## CLINICAL PEARL # 4

- Decision regarding intensive, disease focused care must take in to account how it affects the whole person
  - Relief of Suffering should be the goal in Critical Care as well as Palliative Care.
  - Avoiding Premature Death while Preparing Die Peacefully can coexist simultaneously
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## CLINICAL PEARL # 4 (CONTINUED)

- Time limited interventions, therapeutic trials with specific end-points related to relieving suffering and prolonging life are appropriate
- “Un-addressed Fear” is the source of much suffering. Acknowledging fear can be therapeutic
- All physicians have an obligation to discuss end-of-life decisions prospectively prior to crisis with all patients with life-limiting illness
- Goals of Care change as the patient progresses through a disease. Change should be anticipated and planned for before crisis.

## CLINICAL PEARL # 4 (FOR HOSPITALISTS)

- Hospitalists play a crucial role in providing appropriate care at end of life
- More people are dying in hospital than at home
- The lack of prior relationship between the Hospitalist and the Patient presents challenges. BUT also the opportunities to discuss advance directives
- Hospitalists should routinely address advance directives and preference of care with the patient at the time of admission and as the clinical status changes
- Hospitalists should involve the Primary Care Physicians in the end of life discussions and decisions

## CASE # 5

- Hx: 90 YO WF with advanced dementia, non-ambulatory, requiring total care, living in NH, sent to ER with SOB and lethargy. She was found to have her 2<sup>nd</sup> episode of aspiration Pneumonia
- Meds: Baby ASA, Losartan, Tylenol, Omeprazole, Mirtazapine
- PMHx: HTN, ASCVD, PVD, GERD, Diverticulosis
- Hospital Course: Antibiotics given for Pneumonia. She failed swallowing study. Speech Pathologist suggested "Alternative means of nutrition". When out of town daughter was contacted, she stated, "I don't want my mom to starve to death"

CASE # 5

Should the  
Feeding Tube  
Be placed in this patient?

(How would you discuss the Pros & Cons  
of the PEG tube with daughter?)

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## CASE # 5

1. Yes. Because you do not want to starve the patient.
2. Yes. Because it will reduce the risk of Aspiration Pneumonia
3. Yes. Because it reduces the risk of decubiti
4. No. Because it does does not reduce the risk of Aspiration, does not prevent decubiti, does not prolong life and may even shorten life and increase aspiration risk
5. No. Because it will lead to infection in NH and patient will play with it and ~~pull it out~~

## CASE # 5

4 - No. Because it does not reduce the risk of Aspiration, prevent decubiti, nor prolong life and may even shorten life and increase aspiration risk

- This patient is dying from complications of Dementia
- Sense of "hunger" is not present at end of life
- Aspiration risk is increased by Feeding Tube due to dysfunction of LES, inability of care givers to judge how much feeding can be tolerated by the patient, impaired bowel motility under this condition and these patients commonly remain supine
- Feeding tube does not reduce risk of decubiti. They occur due to prolonged pressure on one area of body with impaired circulation to skin. Once they occur, feeding tubes do not heal them either.
- Pulling of the tube or infections are not a major concern in feeding tubes. They can be easily prevented.

## CLINICAL PEARL # 5

- Dementia is a Terminal Illness
- Functional Assessment Stage (FAST) score of 7c (loss of speech and locomotion) dictates 6 month prognosis and qualifies the patient for Hospice
- Feeding Tubes do not improve nutritional parameters, prevent Pneumonia or heal Decubiti
- Mortality in this population is high and may be higher after Feeding Tube is placed
- Mortality (post PEG) = 24% in 1 mo., 37% at 2 mo., 70% at 1 yr.
- Patients with advanced Dementia who stop eating do not suffer from hunger & thirst

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- These patients should be offered slow hand feeding and nurturing care consistent with palliative focus

## CASE # 6

- Hx: 89 YO WM with moderate Dementia, HTN and CHF is brought from HN to hospital because he is “not himself”, crying, swearing at staff and pulling his cloths off and inattentive. The NH staff could not calm him or control his behavior. He c/o strangers standing in his room, starring at him though there was no one there. ½ hour later he was calm, difficult to arouse but appearing comfortable.
- Meds: Donepezil, Metoprolol, Lisinopril, Furosemide, Potassium, Baby ASA

How would you describe his behavior?

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And

What are the hallmark features of it?

## CASE # 6

1. Schizophrenia marked by visual hallucination
  2. Progressive dementia marked by worsening confusion
  3. Histrionic reaction marked by acute alteration of mental status
  4. Delirium marked by acute fluctuating pattern of mentation and inattention
  5. Bipolar Disorder marked by alternating agitation and calmness
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## CASE # 6

### 4 - Delirium marked by acute fluctuating pattern of mentation and inattention

- Acute fluctuating pattern of mentation with inattention is typical of Delirium
  - Disorganized thinking, hallucination and delusion can occur
  - Other Psychiatric Dx requires longer Hx
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## PALLIATIVE PEARL # 6

- Delirium is always due to an underlying cause
  - In elderly and demented patients .... UTI, Constipation, Aspiration Pneumonia, Exacerbation of CHF, Subtle hypoxia should be considered as possible etiologies
  - Hallucination and Paranoia can occur in Delirium but not required
  - Disorganized thinking is more common
  - Antipsychotics work better than Benzodiazepines (which may have paradoxical effect)
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## CASE # 7

- Hx: 60 YOBF with Hx of Breast cancer with Bony Mets is undergoing chemo Tx. Her pain is well controlled on MS Contin 60 mg PO Q 8 hours. She reports to you during a visit that for past week, she is not eating or drinking much, and notices jerky movements of her arms and legs.
- Other Hx: Recent PET/CT = stable, Serum Calcium = normal
- Meds: MS Contin 60 mg OP Q 8 hours, Gabapentin 300 mg BID, IV Bisphosphonate

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What is the next Course of Action?

## CASE # 7

1. Initiate Anticonvulsant Tx
  2. Initiate Benzodiazepine Tx
  3. Decrease the Morphine dose
  4. Increase the Morphine dose
  5. Increase the Gabapentin dose
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## CASE # 7

### 2 - Initiate Benzodiazepine Tx

- Patient has MYOCLONUS not seizures
  - The Tx is Benzodiazepine NOT anticonvulsants
  - When the pain is well controlled with a given dose of Morphine, there is no reason to change it
  - More Morphine will make it worse
  - More Gabapentin will not make it better
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## CLINICAL PEARL # 7

- Myoclonus can occur in patient receiving high doses of opioids
- Localized Myoclonus (fasciculation of few muscle fibers) may be normal in healthy people with muscle fatigue, dehydration or electrolyte imbalance
- It happens from accumulation of Morphine metabolites in patient on high dose Tx especially in setting of dehydration or electrolyte imbalance
- Focal seizures do not occur bilaterally & generalized seizures cause loss of consciousness

## CLINICAL PEARL # 7 (CONTINUED)

- Benzodiazepine work predictably in relieving myoclonus
  - Hydration helps as well by clearing the metabolites
  - Opioid Rotation should be considered rather than increasing the Morphine if the pain is not well controlled
  - The Opioid Rotation should take into account possibility of "Hyperalgesic Effect" of opioid induced "Neurotoxicity" .... And thus requires lower dose of alternate drug.
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## FINAL WORDS

Never say to the patient,  
"There is nothing I can do for you".

- Be an active listener
- Acknowledge the patient's fear of death
- Just because you can not treat the disease, does not mean you can not treat the patient
- You may not control the QUANTITY of life but you can certainly influence the QUALITY of it

FINAL WORDS

DON'T WORRY

Ultimately

We Are All

Biodegradable

# PALLIATIVE MEDICINE PEARLS

## My Contact Information

[jaima310@gmail.com](mailto:jaima310@gmail.com)

[www.carehealthcenter2.com](http://www.carehealthcenter2.com)

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