PRESBYTERIAN

Integrating Palliative Care into Your Busy Practice: Practical Tips You Can Use Next Week

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Disclosures

- I have no conflicts to disclose

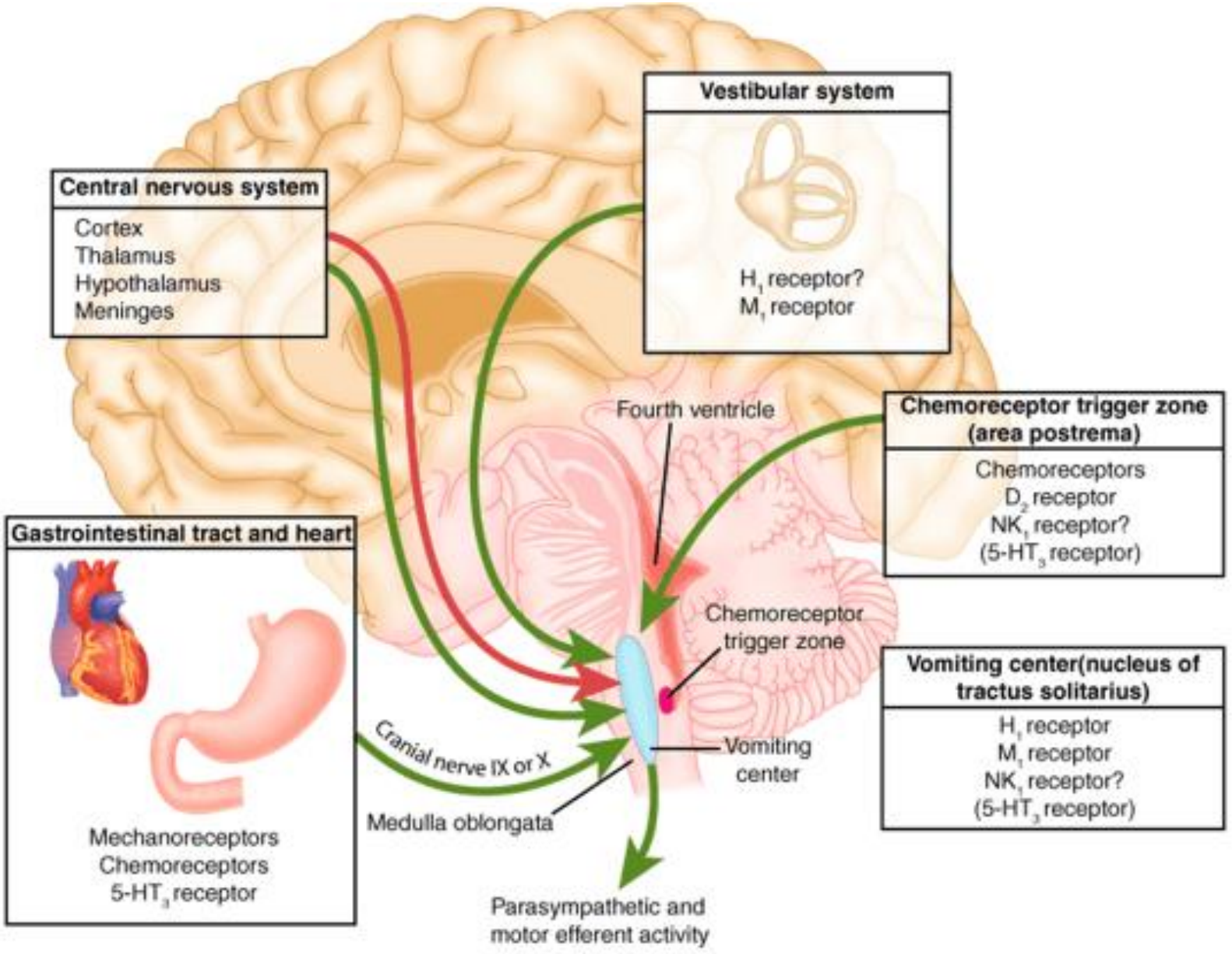
Learning Objectives

- Review palliative care
- Improve symptoms control in constipation, nausea and vomiting and neuropathy
- Review new Medical Aid in Dying Legislation

What is Palliative Care?

- Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

- Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.



Nausea and Vomiting

Gastric + non-gastric trigger areas are involved in N/V

- Five principal receptors mediate vomiting:
- Muscarinic M1
- Dopamine D2
- Histamine H1
- 5 hydroxytryptamine 5HT-3
- Neurokinin NK1

- N/V are common at end of life: 40% of patients report N/V during the last 6 weeks of life

Seek out the etiology

- Anxiety
- Drugs: opioids, cannabis (cannabinoid hyperemesis syndrome), chemotherapy
- Cholelithiasis
- Bowel obstruction
- Constipation
- Gastric outlet obstruction
- Gastroparesis/delayed gastric emptying
- Gastroenteritis/viral or bacterial infection
- Gastointestinal bleeding
- Increased intracranial pressure
- Migraine
- Motion
- Pancreatitis
- PUD or GERD
- Vertigo

Drug therapy:

- Metoclopramide (Reglan) D2 in GI tract 5-20mg PO/SQ/IV before meal
- Prochlorperazine (Compazine) D2 in CTZ 5-10mg PO/IV Q6, rectal 25 Q6
- Ondansetron (Zofran) 5HT3 4-8mg PO/ODT/IV Q4-8
- Promethazine (Phenergan) H1, M1, D2 12.5-25 PO/IV Q6 Rectal 25 Q6
- Haloperidol (Haldol) D2 in CTZ 0.5-2mg PO/SC/IV Q4-6
- Diphenhydramine (Benadryl) H1 25-50 oral/IV Q6
- Scopolamine M1 1.5mg transdermal patch Q3 days
- Octreotide 50-400 mcg SC Q8
- Dexamethasone 2-20mg PO/SC/IV QD or divided BID

Targeted Therapy –

Try to match the mechanism and the medication

Type	Mechanism and receptors	First Line Medications
Opioid induced N/V	Stimulation of Chemoreceptor trigger zone (CTZ) D2, Gastroparesis, D2, Constipation, H1, M1	Metoclopramide, haloperidol, prochlorperazine, Consider senna, for constipation
Chemotherapy induced N/V	Stimulation of Chemoreceptor trigger zone (CTZ) 5HT3, D2, NK1	Ondansetron, dexamethasone
Malignant Bowel Obstruction	Can be intermittent –due to masses, swelling and/or torsion; CTZ (D2), H1 M1	Metoclopramide if incomplete obstruction, octreotide, dexamethasone, NG tube if complete
Impaired GI tract motility	D2	Metoclopramide
Radiation induced N/V	5HT3	Ondansetron, dexamethasone
Brain Tumor/Mets	Increased intracranial pressure	Dexamethasone
Motion	H1	Scopolamine patch, diphenhydramine, promethazine

Pearls from a Palliative Care Doc:

- The trick to treating Nausea and Vomiting
  - Pick anti-emetics based on the etiology of N/V
  - Schedule antiemetics- Its important to schedule your therapy with available PRN medications as well
    - Start with a 5HT3 and D2 scheduled BID or TID
  - Continue to add scheduled medication addressing different receptors until the N/V is controlled

Drug Therapy Continued: Antiemetic Infusion (AEI)

Predominantly done in the in-patient setting (such as hospice in-patient unit). Combine meds in 60 cc NS and run at 2.5 cc/h SC/IV over 24 hours. May combine meds to target different receptors. Usually involves conversation with a pharmacist.

Drug	24 hour dose SC/IV
Dexamethasone	2-20mg
Diphenhydramine	25-100mg
Famotidine	20-40mg
Haloperidol	2-10mg
Metoclopramide	40-120mg
Midazolam	2-12mg
Octreotide	300-1200mcg
Ondansetron	4-32mg

Constipation

- Decrease in frequency/change in stool (hard, infrequent stool with straining). Encopresis can present with fluid stool passing around a solid blockage of stool
- Common in palliative care, hospice, end of life care
- Numerous Etiologies: Decrease in PO intake, dehydration, decreased fiber in diet, neurologic disease such as Parkinson's, MS, ALS, Spinal cord compression, neuropathy, hypothyroid, Meds such as opioids, anticholinergics, antihistamines, TCA, levodopa, iron, antihypertensives

Constipation Management

- Fiber (rarely effective in end of life care).
- Anal digital stimulation for PD, Spinal cord injury, MS, ALS
- Insert gloved, lubricated finger into anus move in a circle
- Enemas
- Laxative

Opioid Induced Constipation

- 1 Stimulant – Sennosides
- 2 Osmotic laxatives – Polyethylene glycol, lactulose, sorbitol
- 3 Prokinetic Metoclopramide
- 4 Enemas
- 5 Methylnaltrexone (relistor) 38-62kg 8mg SC QOD, 62-114kg 12mg SC QOD, Oral 150-450 QD
- 6 Milk of magnesia

- Proactive use of stimulants and osmotic laxative (together, often) will avoid a crisis

Constipation Medication Pearls

- Stool softeners – docusate sodium. Draws water into colon to soften stool. Won't work if lack of peristalsis is the issue e.g. doesn't work well for opioids
- Fiber – Metamucil, Citrucel, Fibercon, Benefiber, increases stool bulk which distends colon to increase peristalsis. Bulk can worsen obstruction, can cause gas and bloating
- Stimulant laxative – Dulcolax, Senokot. Stimulates peristalsis, therefore can cause cramping, bowel can develop tolerance. Senna is often titrated to high doses to achieve effect.
- Osmotic laxatives – lactulose, sorbitol, MiraLAX, milk of magnesia, magnesium citrate. Sugars or minerals pull water into stool, increases peristalsis. Lactulose is very sweet and bad tasting, magnesium products should be avoided with CrCL <25
- Enemas – Warm water, mineral oil, fleets. NS preferred in elderly or if dehydration, mineral oil for hard dry stool

Neuropathic Pain

- Damaged, dysfunctional or injured nerve fibers
- Includes peripheral and/or central injury
- Often complex pain state that extends beyond healing time. Described as burning, tingling, shooting, stabbing, electrical, itching.
- Gabapentin 1800-3000 divided TID
  Pregabalin 300-600 divided BID
  amitriptyline, nortriptyline 75-100 HS
  venlafaxine 150-225 QD
- Duloxetine 30-60mg QD
- Carbamazepine 200-400 BID
- Capsaicin (0.075%) QID (2-3 weeks to see effect)
- Cannabinoids?

Rational polypharmacy

- PGB + imipramine
- GBP + nortriptyline
- GBP + morphine
- GBP +venlafaxine

The End of Life Options Act

Medical Aid in Dying

New Mexico is the 11th state/jurisdiction in the U.S.

- Oregon “Death with Dignity” – 1997
- Washington – 2008
- Montana – 2009
- Vermont – 2013
- California – 2015
- Colorado – 2016
- D.C – 2017
- Hawai’i – 2018
- Maine – 2019
- New Jersey – 2019
- New Mexico – June 18, 2021
  - At this point, 30 patients have used MAID in New Mexico

Key features in all U.S. Jurisdictions

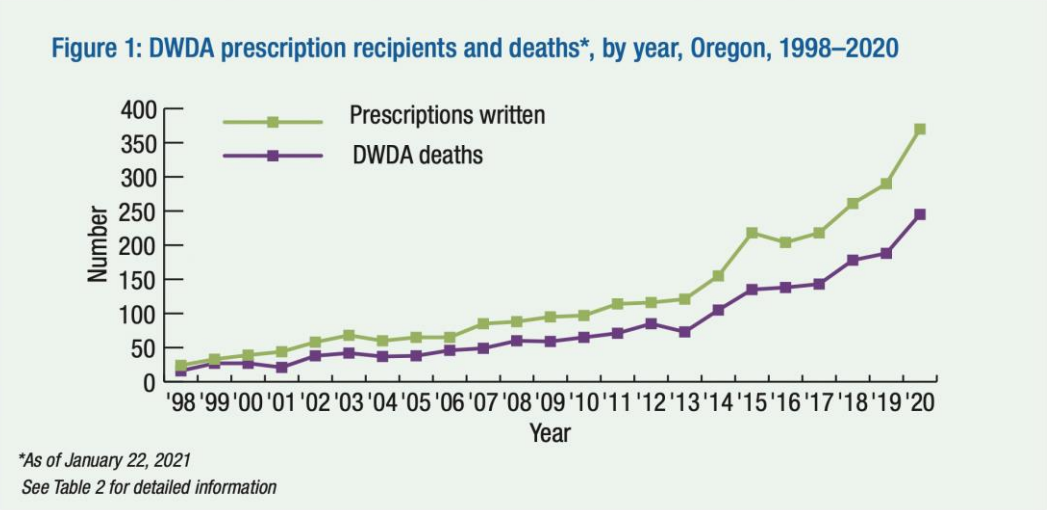
- Requirements:
  - a patient has a terminal illness with a limited prognosis
  - a patient has decisional capacity and requests MAID themselves
  - the patient must be able to self-administer the medication
  - the opportunity for any clinician/staff to opt out of participation
  - more than one provider to concur that the patient meets criteria
  - uses specially compounded medications

Unique features of New Mexico MAID

- For the first time in the U.S.
  - Allows NP's and PA's to be prescribers
  - Only requires one written request
  - Only requires a 48 hour waiting period, after prescription
  - Hospice Exemption: enrollment in hospice allows for a patient to receive a prescription after a visit with a single prescribing provider

Very few terminal patients use MAID

- Since the law was passed in Oregon in 1997, a total of 2,895 people have received prescriptions under the DWDA and 1,905 people (66%) have died from ingesting the medications. In 2020, 245 patients died from MAID



2020: 245 deaths

- **81% > age 65**
- **Cancer: 66%**
- **Heart Failure: 11%**
- **Neurological Diseases: 8 %**

95% enrolled in hospice care

Primary Reasons:

- **Loss of ability to participate in activities that made life enjoyable**
- **Loss of autonomy**
- **Loss of dignity**

New Mexico

Elizabeth Whitfield End of Life Options Act

- Requires two providers to evaluate the patient, perform any necessary exam and review of the medical record and document that patient has a terminal prognosis of 6 months or less.

- One of the two providers can be an NP or PA, the other must be a physician. Either can be the prescriber.

- A physician is always required to document the following prior to a prescription being written:

  - Confirmation of Terminal Prognosis
  - Decisional capacity
  - The ability of patient to self-administer the medication

New Mexico

Elizabeth Whitfield End of Life Options Act

- The prescriber must document:
  - Receiving a written request from the patient
  - Terminal prognosis, decisional capacity, ability to self-administer
  - That the request is voluntary and not due to any coercion
  - Counseling on the risks of and probable result of taking the medication, and the option of obtaining the medication and not taking it
  - Counseling of feasible alternative, concurrent or additional treatment opportunities, including hospice care and palliative care focused on relieving symptoms and reducing suffering
- MAID prescription composed of two parts, taken 30 minutes apart:
  - 2 Anti-emetics (Ondansetron, Metoclopramide)
  - Compounded mixture of Digoxin, Diazepam, Morphine, Amitriptyline, Phenobarbital

Decisional Capacity

- Only individuals who have the ability to understand and appreciate health care options available to that individual, including significant benefits and risks, and to make and communicate an informed health care decision are eligible for medical aid in dying.

- If there are concerns that “a mental health condition or intellectual disability” is affecting that capacity, an individual must be referred to a mental health professional for an assessment before Medical Aid in Dying can be prescribed.

- Mental health professional means a state-licensed psychiatrist, psychologist, master social worker, psychiatric nurse practitioner or professional clinical mental health counselor

Indemnity & Right to Conscience-based Decisions

- A person shall not be subject to criminal liability, licensing sanctions or other professional disciplinary action for:
  - participating, or refusing to participate, in medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act
  - being present when a qualified patient self-administers the prescribed medical aid in dying medication

  - Missing from this list: Civil Liability

Sanction free for Participation & Non Participation

- A health care entity, professional organization or association, health insurer, managed care organization or health care provider shall not subject a person to censure, discipline, suspension, loss or denial of license, credential, privileges or membership or other penalty for participating, or refusing to participate, in the provision of medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act.

Patient Right to Referral

- A health care provider shall inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-of-life care.

Community Resources on NM EOLO

- End of Life Options New Mexico
  - Still building their implementation, modeled on non-profits in other states that have legalized MAID

- Formed to assist patients in:
  - Understanding Options
  - Navigating patients to prescribers
  - Training for community clinicians
  - Building a team of volunteers to assist patients

- https://endoflifeoptionsnm.org

Questions?