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

Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients

- **Cancer** (n=5)
- **Organ failure** (n=6) CHF, COPD, exacerbations w/ hospitalizations
- **Physical and cognitive frailty** (n=7) Dementia, the dwindles
- **Other** (n=2)

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)

- Memorial Symptom Assessment Scale (MSAS)

- Needs at the End-of-Life Screening Tool (NEST)
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
- Hospice and Palliative Nurses Association Dyspnea Task Force
Bibliography