Palliative Care Pearls and Pitfalls

BROOK CALTON, MD, MHS
ASSISTANT PROFESSOR OF CLINICAL MEDICINE
DIVISION OF GERIATRICS
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Avoid These Potential Pitfalls

1. Docusate
2. Chemotherapy Near End of Life
3. Oxygen in Non-Hypoxic Patients with Dyspnea

Disclosures

I have no financial disclosures to report.

Docusate for Constipation

- Study: Double-blind RCT
  - 74 patients, 3 inpatient Canadian hospices
  - Randomized to 10 days of:
    - Senna 1-3 tabs/day + docusate 100 mg BID
    - Senna 1-3 tabs/day + placebo BID

Study Results

- Docusate group had marginally larger volume of stool \( p=0.06 \); stool consistency was slightly different between groups
- No difference in:
  - Average # of bowel movements/day
  - Patients’ perceptions of the difficulty or completeness of defecation
  - Pain
  - Percent of patients requiring additional bowel intervention (74% placebo; 69% docusate)
- Additional issues: tastes horrible, pill burden

Docusate for Constipation (continued)

No appreciable benefit of adding Docusate to Senna in hospice patients

- Constipation Pearls:
  - Easier to stay ahead than catch up
  - Always rx laxative with opioid
  - Start with Senna, then add Miralax, Lactulose, etc
  - Suppository or enema (avoid Fleet's) if > 3-4 days
  - Consider Methylnatrexone for opioid-induced constipation if above not working

Chemotherapy Near End of Life

- Goals of chemotherapy for patients with metastatic cancer:
  - Live longer
  - Live better
- Study: Association of chemo in last 6 months of life with caregiver-reported quality of life in last week of life and survival

Prigerson HG. Jama Oncol. 2015; (6):778-784
Chemotherapy Near End of Life

- 661 patients with advanced met cancer who had progressed on prior therapy
- MD estimate of < 6 months to live
- ½ of patients were on chemo at enrollment
- Median survival 4 months
- Patients with good functional status were more likely to receive chemo

Study Results

- No improvement in QOL for patients with moderate or poor baseline functional status
- Chemo associated with worse QoL for patients with better functional status at baseline
- No difference in survival (though study not designed for this)

Think twice about whether to support palliative chemotherapy for patients with metastatic cancer who are near the end of life.

Supplemental Oxygen for Dyspnea In Non-Hypoxic Patients

- Palliative oxygen therapy widely used for dyspnea
- Potential benefits: placebo effect, family feels like “doing something”
- Potential burdens: ties patient down, social stigma, uncomfortable, nosebleeds, fire risk

Supplemental Oxygen Trial

- Study:
  - Double-blind RCT
  - 239 outpatients in US, Australia and UK with life-limiting illness, refractory dyspnea, and \( \text{PaO}_2 > 55 \text{mmHg} \)
  - Randomized to RA or \( \text{O}_2 \) at 2 LPM x 7 days
    - Instructed to use \( \text{O}_2 \) at least 15 hours/day

Abernathy A. Lancet 2010;376(9743):784-93
Study Results

- No difference between supp O2 vs RA by NC in:
  - Mean AM Breathlessness scores
  - Mean PM Breathlessness scores
  - Quality of Life

Compared with RA NC, oxygen by NC provides no benefit for dyspnea in patients who are not hypoxemic.

Dyspnea Pearls

- Treat the underlying cause
  - Pleural effusion, PE, pna, ascites
- Opioids
  - Low dose, Safe even in COPD
- Position
- Breathing training
- Fan and/or fresh air
- Cold cloth to face
- Acupuncture in COPD

Practical Pearls

1. Prognostication
2. Role of Palliative Care
3. Advance Care Planning

Prognostication

- Helps patients and providers to determine realistic, achievable goals of care and proceed with interventions consistent with those goals
  - "If your heart stops, do you want electrical shocks and chest compressions to try to get your heart beating again?"
- Helps patients with life planning
- Most people want to know!
- Younger patients (often with cancer):
  - Usually clearer trajectory
- Older adults:
  - Absence of a dominant terminal condition
  - Age + Functional + Cognitive + Multimorbidity
### Key Clinical Decisions and Life Expectancy

<table>
<thead>
<tr>
<th>Life Expectancy</th>
<th>Clinical Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4-6 weeks</td>
<td>Methylphenidate over SSRI for depression</td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>Discontinue statins</td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>Refer to hospice</td>
</tr>
<tr>
<td>&lt;1-2 years</td>
<td>Nonoperative management of AAA</td>
</tr>
<tr>
<td>&lt;2-3 years</td>
<td>Tight BP control in diabetes unlikely to prevent stroke, MI</td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>Bio-prosthetic heart valve over mechanical</td>
</tr>
<tr>
<td>&lt;9 years</td>
<td>Discontinue tight blood sugar control in diabetes</td>
</tr>
</tbody>
</table>

### Prognostication - Mrs. A

Ms. A is a 79 yo woman presents to establish care since moving to this area to live with her son and his wife. PMH notable for COPD, with two hospitalizations in the past year. She has difficulty walking more than a block because of dyspnea. She lives with her son’s family who help with iADLs but she is independent in ADLs. She has a previous 50 pack year history of cigarette use but she hasn’t smoked in 10 years.

Based on this description, what is the likelihood Ms. A will be alive in 10 years:
1. 10% or less
2. 25%
3. 50%
4. 75%

### How Should We Prognosticate?

- Functional Status
- Comorbid Medical Conditions
- Cognition
- Nutrition
- Polypharmacy
- Psychological Status
- Social Support
- Geriatric Syndromes
How Should We Prognosticate?

Clinical Judgement
Life Tables
Prognostic Indices

Great Variation Even by Same Age!

Walter LC. JAMA 2001; 285:2750-56

Life Expectancy for Women

Great Variation Even by Same Age!
Ms. A is a 79 yo woman presents to establish care since moving to this area to live with her son and his wife. PMH notable for COPD, with two hospitalizations in the past year. She has difficulty walking more than a block because of dyspnea. She lives with her son’s family who help with iADLs but she is independent in ADLs. She has a previous 50 pack year history of cigarette use but she hasn’t smoked in 10 years.

Based on this description, what is the likelihood Ms. A will be alive in 10 years:
1. 10% or less
2. 25%
3. 50%
4. 75%

**Prognostication - Mrs. A**

Ms. A's 10 year mortality risk is 87%.

**10 year mortality risk:**
87%

Graphic adapted from New 2013.
Communication about Prognosis

- Ask for permission and preferences for how information is relayed
- Use ranges
- “In other people in a similar situation to you....”

Palliative Care

- Specialized medical care by a team of doctors, nurses, social workers, chaplains and other specialists for people with serious illnesses.
- Focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family.


A New Paradigm

- Medicare Hospice Benefit
- Life Prolonging Care
- Palliative Care
- Hospice Care
- Old
- New
Palliative Care Improves Value

Quality Improves
- Reduction in symptom burden
- Improved quality of life
- Longer length of life
- Increased family satisfaction
- Better family bereavement outcomes
- Care matched to patient centered goals

Costs Reduce
- Lower hospital cost/day
- Less use of ER, hospital, ICU
- Reduction in 30d readmissions
- Labs, imaging, pharmaceuticals

Early Palliative Care Intervention

- Study:
  - Non-blinded, RCT (single site)
  - Ambulatory patients with newly diagnosed met NSCLC
  - Immediate PC + onc vs onc
  - Primary outcome: change in QOL at 12 weeks


Study Results
- Baseline characteristics did not differ between groups
- Intervention group:
  - Better QOL scores
  - Less depression
  - More documentation of resuscitation preferences
  - Less aggressive care at the end of life
  - Lived two months longer

Palliative Care appears beneficial for patients with newly diagnosed metastatic NSCLC.
Advance Care Planning

- An **ongoing process** of discussing care preferences and making care plans between patients **(and their caregivers)** and providers
- Should include discussion of a person's priorities, beliefs, and values AND prognostic information
- May or may not lead to completion of advance directive
- Both physicians and patients think it's important

Benefits of ACP

- Patients who have advance care planning or EOL conversations with their provider are:
  - **Less likely to:**
  - **More likely to:**
    - Receive outpatient hospice and be referred to hospice earlier (Zhang et al. 2009, Wright et al. 2008)
    - Have their wishes known and followed (Detering et al. 2010; Houbin 2014)
    - Have caregivers who are satisfied with the quality of their loved one's death (Detering et al. 2010)

Audience Poll

In my practice, I aim to have advance care planning conversations with:

1. None of my patients
2. All my patients over 65 years old
3. My patients who are terminally ill
4. Both 2 and 3
5. All my patients regardless of age

ACP Practices in Primary Care

- Systematic review of 10 studies (5 US) among PCPs providing care for patients living in the community or an assisted living
- ACP most frequently done with patients with cancer, Alzheimer's dementia, or other terminal illness
- Of patients who died of non-sudden deaths, one-third had ACP
- Provider-reported ACP rates higher than patient-reported ones
- Lack of systematic approach; hard to judge when to initiate
- Patients want to discuss, even if healthy; feel it is responsibility of provider to bring up

Glaudermans et al. (2015) Fam Practice
ACP Documentation

- Include on problem list; be specific
- Health systems streamlining EMR ACP documentation
- Ideally, complete advance directive and medical order (for patients with less than 1y prognosis; in states where available)

ACP Billing

- ACP CPT codes NEW in 2016
  - "ACP includes the explanation and discussion of advance directives such as standard forms (with completion of such"
  - [Link to CMS Payment-One-Pager.pdf]
  - 99497 (wRVU 1.5): >16 min
  - 99497 (wRVU 1.5) & 99498 (wRVU 1.4): >46 min
  - Include pertinent diagnoses; can bill more than once/yr

When Advance Care Planning services occur at the same time as the Annual Wellness Visit (AWV):
- Billing modifier -33
- No Part B coinsurance or deductible (consistent with the AWV)

When Advance Care Planning services occur during another visit (such as EBM, CCM, or TC)
- Cost sharing (coinsurance/deductible) applies as for other physicians’ services

ACP Tools

[Link to www.prepareforyourcare.org]

[Link to www.govish.org]
### Miscellaneous PC Pearls

- “Easier to stay ahead of [insert symptom], than catch up”
- Symptom management and ACP are processes
- “Patients (and families) aren’t always looking to be “fixed,” often they just want someone to listen to them, validate them, and bear witness to their story.”

### Summary

#### Potential Pitfalls
- Consider avoiding Docusate, chemotherapy near the end of life, and oxygen in non-hypoxic patients

#### Practical Pearls
- Consider the role of prognostication, specialty-level palliative care services, and advance care planning in helping you take the best care possible of your seriously ill patients and families.

#### Additional Resources:
- [https://www.capc.org/fast-facts/](https://www.capc.org/fast-facts/)