

Palliative care for patients with brain cancer

Lyn Cave Clinical Nurse Specialist Palliative
Care Hospital2Home (H2H)

Dr Jayne Wood Clinical Lead Palliative Care
The Royal Marsden and Royal Brompton Palliative Care Service



Aim of Session

-
- Consider symptom control issues affecting end of life care in patients with brain tumours
 - Role of Hospital2Home (H2H)
 - Specialist Palliative Care



Pain

Approaches to Pain

WHO, 1996

*Moderate - severe
pain*

*Mild – moderate
pain*

*Strong opioids
+/- non-opioid
+/- adjuvant*

Mild pain

*Weak opioids +/-
non-opioid +/-
adjuvant*

*Non-opioids +/-
adjuvant*

Other:

*Psychological
support
Radiotherapy
Chemotherapy
Surgery
Spinal analgesia
Neural blockade*

**Adjuvant
analgesics:**

*NSAIDs
Steroids
Antidepressants
Antiepileptics
Antiarrhythmics
Anaesthetics
Muscle relaxants
Bisphosphonates*



Corticosteroids

- **Mechanism of action**
 - peripheral: non selective COX inhibition, reduction of inflammatory mediators, peritumoral oedema
 - central: mechanism not defined
- **INDICATION**
- **Administration:** po/iv/sc
- **Contra-indication**
 - No absolute
 - Side effects are often dose limiting

Neurological Dex 16mg/d	<ul style="list-style-type: none">● raised intracranial pressure● spinal cord compression● nerve compression or infiltration
Soft tissue infiltration Dex 8 -16mg/d	<ul style="list-style-type: none">● head and neck tumours● abdominal and pelvic tumours
Capsular stretching Dex 8 -16mg/d	<ul style="list-style-type: none">● liver metastases, other visceral metastases



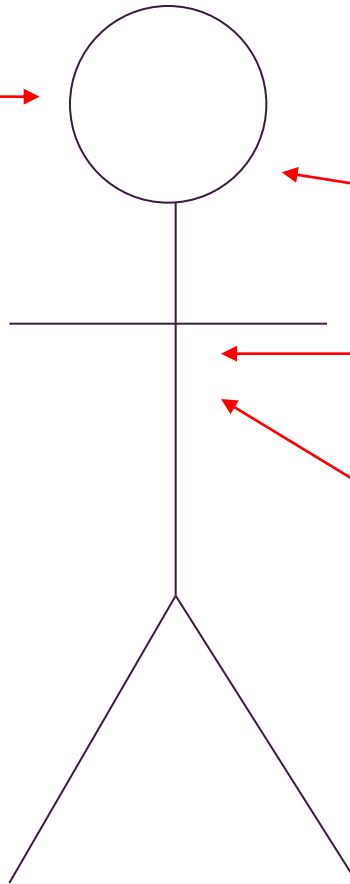
Nausea/Vomiting



Causes

Brain metastasis
Raised ICP
Anticipatory
Emotional/psychological/
spiritual

Treatment related:
Chemotherapy
Radiotherapy
Opioids
Antibiotics



Metabolic disturbance:
Uraemia
Electrolyte disturbance
Hormone imbalance

Oral thrush

Cough

Gastric stasis
Constipation
Bowel
obstruction



Management

NB some drugs lower seizure threshold!

- Treat
 - Non-drug
 - Acupuncture
 - Calm atmosphere
 - Small snacks
 - Bland foods
 - Drugs
 - Regular administration
 - Appropriate route
 - Titrate adequately



Seizures



Seizures at the End of Life

- If patient is known to have seizures and taking anti-epileptic medication:
 - DO NOT stop the medication
 - ? Liquid medication or consider an alternative route
 - Midazolam 30mgs over 24 hours via syringe pump
 - Avoid seizure lowering medication
 - Midazolam 10mgs prn if seizure lasts more than 5 minutes
- If seizures continue consider increasing midazolam or discuss with palliative care team as may need alternative (phenobarbitone)
- Some anti epileptic meds have a long half life and in an unconscious patient may continue to be effective for 2-3 days after the last po dose



Management of tumour-associated seizures

- Exclude other diagnoses e.g panic attacks
- Be prepared to accept less than perfect seizure control
- Generalised seizures usually respond better to Anti Epileptic Drugs (AEDs) than partial seizures
- Ensure patient and family are well informed about how to manage patient if seizure occurs
- Consider buccal midazolam as family members can administer if necessary



Hospital2Home & Coordinate My Care

Coordinate My Care

- Coordinate My Care (CMC) is a free service that can help to record patients views and wishes within an electronic personalised care plan
- The care plan can be viewed and updated by doctors, nurses and emergency services to share information about patient care, including where patient would like to be cared for and things they may want to avoid
- Patients details are only entered when they have given consent. If a person has lost the ability to make their own choices then a decision can be made in their best interests by a doctor or nurse after discussion where possible with the person's family and carers
- CMC record can only be accessed by health professionals emergency and Out of Hours health services



Hospital2Home Service (H2H)

H2H programme developed to enable patients with life limiting disease where the aim of treatment is palliation only to be cared for in their preferred place and to improve communication between the hospital and community

H2H service is a palliative care intervention, an approach to co-ordinating care using home-based case conferencing, based on a successful research project undertaken in Australia (Abernethy, 2006)



H2H Service

- Patients are offered a telephone service at the point of discharge where the Primary and Specialist Palliative Care Teams who will be responsible for managing the patient's care in the community will be telephoned to update them and discuss plan for future care.

OR

- Face to Face meeting at patient's home to which the GP, DN, Community Palliative Care Clinical Nurse Specialist and anyone else involved in the patients care are invited.
- Patients can decline the service altogether



Aims of H2H intervention

- Patient and carer have opportunity to be involved in discussions regarding medical, nursing, social and psychological needs and to discuss and develop a plan of care for the future
- Ensure everyone has the same information
- Where possible identify a Key worker
- Discuss responsibilities and role of HCP's + contact numbers
- Possible issues for the future e.g bowel obstruction, management of seizures, blood transfusions, titration of steroids
- Medication
- Discuss Co ordinate My Care Record + update
- Do Not Attempt Resuscitation (DNAR)
- Preferred place of care and death
- Re-referral criteria if appropriate
- Review dates



Last Hours and Days of Life

End of Life Care

- 1/3 -2/3 patients with cancer die in hospital
- This is likely to increase
- Often have unmet needs
- Appropriate training lacking
- Initiatives and strategies developed and implemented:
 - End of Life Care Strategy (DH, 2008)
 - Advance Care Planning
 - Liverpool Care Pathway



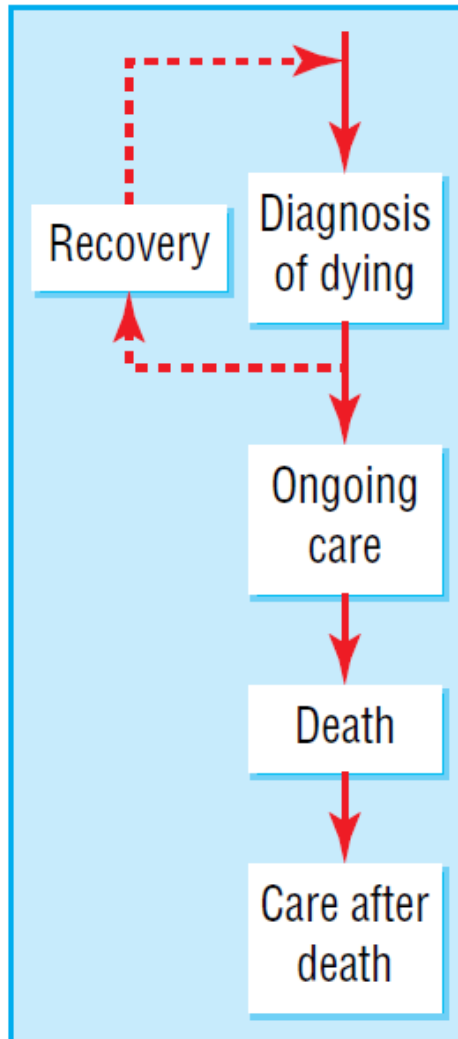
Diagnosing dying: last hours to days of life

- Less mobile - bed/chairbound
- Increasingly drowsy for much of the day → semi-conscious/less alert (Kinder & Ellershaw 2003)
- No longer able to take oral drugs/little or no oral intake
- Limited attention span - disorientated
- Increased confusion/agitation
- Reduction in urine output (Stone et al 2001)
- Changes in pulse and respiratory rate
- Change in skin colour

Ellershaw J BMJ 2003
Collis E BMJ 2013
Wilcock A PCF 4



Care of the dying patient



- Was this patient's condition expected to deteriorate in this way?
- Is further life prolonging treatment inappropriate?
- Have potentially reversible causes of deterioration been excluded?

Multi-professional diagnosis

Continuous review

Aims of anticipatory prescribing

- Prevent possible delays in the control of symptoms
- Avoid crises NB seizures
- Avoid unnecessary distress for patients and relatives
- Prevent inappropriate hospital admission



Anticipatory prescribing guidelines for Palliative Care adult patients

- Pain/Breathlessness - Morphine Sulphate 2.5-5mg sc prn up to a maximum of every hour.
- Respiratory secretions - Glycopyrronium 400mcgs sc as needed up to a maximum of tds
- Nausea + vomiting -
 - Haloperidol 1-2.5mgs sc prn up to maximum tds.
 - Levomepromazine - 3.125-6.25mg sc prn up to maximum tds NB Can lower seizure threshold
- Terminal restlessness - Midazolam 2.5mgs sc prn up to hourly
- Terminal haemorrhage/convulsions Midazolam 10mgs sc/im prn for seizure or life threatening bleed, once only.
- Diluent Water for Injections



Challenges



Challenges for Palliative Care

- More people living longer with chronic disease
- Palliative care needs becoming more complex
- Variable integration of palliative care with other services
- Variable disease trajectories
- Outcome measurement
- Specialist Palliative Care



Response to the Neuberger Review:- “One chance to get it right”

- DH, June 2014
- How health and care organisations should care for people in the last days of their life
- Leadership alliance for the care of the dying people (21 organisations): established following Neuberger review of LCP, July 2013

5 priorities for care

Early recognition, communication and regular review

Sensitive communication

Patient/those closest to them involved in decision making

Needs of families/those closest met

Individualised care plans



Review of objectives

- Consider symptom control issues affecting end of life care in patients with brain tumours
- Role of Hospital2Home (H2H)
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