

Abstracts: Palliative Care Symposium 2006

ABBREVIATIONS Chronic Kidney Disease (CKD), Non-steroidal anti-inflammatory drug (NSAID), World Health Organization (WHO)

SESSION I

UPDATE ON PAIN AND SYMPTOM MANAGEMENT

Chairman: Dr S Scragg, Consultant in Palliative Medicine, Queen Margaret Hospital, Fife, Scotland

There's more to life than morphine...

Dr M Bennett, Senior Clinical Lecturer in Palliative Medicine St Gemma's Hospice, Leeds, England

Email m.bennett@st-gemma.co.uk

Abstract

Background Pain affects about 50% of cancer patients at diagnosis, and occurs in around 75% of those with advanced disease. Cancer pain is often a mixture of nociceptive (tissue damage) and neuropathic pain mechanisms, and good assessment will lead to effective management and improved quality of life. It is axiomatic that good disease control usually results in good symptom control and so chemotherapy or radiotherapy, surgery or hormonal manipulation remain important treatments for cancer pain.

Methods or Theme The WHO's analgesic ladder has served well for over 20 years and matches appropriate analgesia to the intensity of cancer pain. A large European survey showed that paracetamol, NSAIDs and morphine were the most commonly used analgesics in this context. Observational studies have shown that this approach has resulted in good pain control in around 75% of cancer patients. But what about the remainder?

Some patients are unable to tolerate morphine, and so switching to alternative opioids may result in a reduction in adverse effects and allow dose escalation to achieve pain control. Alternative opioids differ both pharmacodynamically and pharmacokinetically, and these differences can be exploited to achieve a good balance between pain control and adverse effects in individual patients. Examples include oral oxycodone or methadone, and transdermal patches containing fentanyl or buprenorphine.

In other patients, opioids alone are not enough to control pain which may be dominated by neuropathic pain mechanisms. In these situations, adjuvant analgesia is required. Good examples include tricyclic

antidepressants, antiepileptics and drugs active at the NMDA receptor, such as ketamine.

Key words Adjuvant analgesia, analgesic ladder, buprenorphine, fentanyl, methadone, morphine, NSAIDs, oxycodone, paracetamol, transdermal patches.

Sponsors None.

Declaration No conflict of interest declared.

Bone pain: Science into practice

Dr C Urch, Consultant in Palliative Care, St Mary's Hospital, London, England

Email c.urch@st-marys.nhs.uk

Abstract

Background Cancer induced bone pain has a significant impact on patients' quality of life and survival. It has been noted that bone pain occurs in up to 80% of cancer patients and is one of the more difficult pains to control. Until seven years ago, there was a lack in understanding the pathophysiology of this pain, and consequently a lack in novel therapeutic treatments.

In 1998, a novel way of producing an animal model, with confined tumour growth, was developed. Since then, there has been an explosion of different tumour types studied (sarcoma, breast, prostate, colon cancer and myeloma). Understanding of the peripheral and central neuronal changes that occur have been significant, and are beginning to lead to novel therapeutics.

Methods or Theme The discussion will centre around the development of the murine sarcoma and the rat breast cancer models. The murine sarcoma model was the original, and has yielded fascinating data on the peripheral bone changes and the efficacy on pain behaviours of a range of treatments. Coupled with the insights from the breast cancer model, which has focused on the dorsal horn changes, it appears that cancer induced bone pain, is a unique pain state. It has features of chronic inflammation (with inflammatory infiltrate, and active prostaglandin and bradykinin pathways) however there are significant features of neuropathy, with peripheral afferent destruction, and novel lamina I excitation in the dorsal horn.

Immunocytochemical staining suggests that bone is heavily innervated with CGRP positive C fibres. These express

TRPV-1 channels, endothelin and TrKA receptors amongst others. All of these entities have been targeted in *in vivo* models, with antagonists or sequestering antibodies and have been shown to significantly reduce pain behaviours. ET-A receptor antagonists are in trial clinically, where a secondary endpoint of pain reduction has been noted in prostate cancer.

Dorsal horn work has suggested gabapentin is effective in reducing pain behaviours, and normalising dorsal horn pathophysiology. In addition descending facilitatory pathways are active and susceptible to inhibition by serotonin antagonists.

Classical treatments with radiotherapy and bisphosphonates continue to be the mainstay of symptom control. The new nitrogenous bisphosphonates (for example Ibandronate, or Zolidronate) are several 1,000 times more potent than first and second generation. They have been shown to delay the time to first radiotherapy, first skeletal event, and improve bone pain.

Conclusions Cancer induced bone pain, remains a poorly diagnosed and under-treated pain. Recent experimental models have allowed the pathophysiology to be explored and novel therapies to be developed. In addition, a new generation of bisphosphonates are offering a significant improvement in quality of life.

References

- 1 Mantyh PW. Cancer pain and its impact on diagnosis, survival and quality of life. *Nat Rev Neurosci* 2006; **7**:797–809.
- 2 Mantyh PW, Clohisy DR, Koltzenburg M, Hunt SP. Molecular mechanisms of cancer pain. *Nat Rev Cancer* 2002; **2**:201–9.
- 3 Urch CE, Donovan-Rodriguez T, Dickenson AH. Alterations in dorsal horn neurones in a rat model of cancer-induced bone pain. *Pain* 2003; **106**:347–56.
- 4 Donovan-Rodriguez T, Dickenson AH, Urch CE. Gabapentin normalizes spinal neuronal responses that correlate with behavior in a rat model of cancer-induced bone pain. *Anesthesiology* 2005; **102**:132–40.

Key words Bain, bisphosphonates, bone pain, bradykinin, cancer, CGRP positive C fibres, dorsal horn changes, endothelin receptors, ET-A receptor antagonists, gabapentin, Ibandronate, neuropathy, prostaglandin, rat breast cancer models, serotonin antagonists, TrKA receptors, TRPV-1 channels, Zolidronate.

Sponsors PhD student on a Wellcome Fellowship.

Declaration No conflict of interest declared.

Fatigue in advanced cancer – Is it inevitable?

Dr P Stone, MacMillan Senior Lecturer in Palliative Medicine, Division of Mental Health, St George's University, London, England

Email p.stone@sgul.ac.uk

Abstract

Background Fatigue is a common and debilitating problem for patients with cancer. This presentation reviews the literature regarding the prevalence and treatment of this condition in patients with advanced cancer.

Methods or Theme Medline search using key terms 'fatigue' and 'neoplasms' limited to 'humans and English language and review articles and 2001–2006', and a search of relevant references of retrieved articles. Search of the Cochrane database and the National Guideline Clearing House.

Fatigue is a common problem in cancer patients and particularly in patients with advanced cancer. The prevalence of fatigue is influenced by the assessment method and definitions used. Clinicians should use validated instruments to measure fatigue severity. Correctable causes of fatigue should be treated. When no easily correctable cause is found then patients should be provided with information and support about how to cope with fatigue. Patients may also be suitable for specific psychosocial support interventions, exercise therapy, nutritional support, or sleep interventions. Selected patients should be considered for drug treatments. Fatigued, anaemic patients receiving chemotherapy may benefit from erythropoietin. Other drug treatments (particularly psychostimulants) are still being evaluated.

Conclusions Fatigue is a common problem in advanced cancer. Exercise and psychological support are probably helpful in cancer-fatigue in general but their role in patients with advanced cancer needs to be more clearly defined. Other interventions need rigorous assessment in controlled clinical trials.

References

- 1 Murphy H, Alexander S, Stone P. Investigation of diagnostic criteria for cancer-related fatigue syndrome in patients with advanced cancer: a feasibility study. *Palliative Medicine* 2006; **20**:413–8.
- 2 Stone P. The measurement, causes and effective management of cancer-related fatigue. *Int J Palliat Nurs* 2002; **8**(3):120–8.
- 3 Mock V. Evidence-based treatment for Cancer-related fatigue. *JNCI* 2004; **32**:112–8.
- 4 Morrow GR, Shelke AR, Roscoe JA, Hickok JT, Mustian K. Management of cancer-related fatigue. *Cancer Invest* 2005; **23**:229–39.

Key words Fatigue, neoplasms, palliative care.

Sponsors None.

Declaration Dr Stone has previously received research funding from Orthobiotech.

SESSION 2 DEPRESSION AND DELIRIUM

Chairman: Dr J Spiller, Consultant in Palliative Medicine, Marie Curie Hospice Edinburgh and St John's Hospital, Livingston, Scotland

Depression

Dr J Mitchell, Consultant Liaison Psychiatrist, Stobhill Hospital, Glasgow, Scotland

Email John.Mitchell@glacomen.scot.nhs.uk

Abstract Depression is a common psychiatric condition in palliative care, with prevalence rates reported at about 13% in cancer patients. It is common for a variety of reasons – multiple losses, pain and other physical symptoms, a cancer effect, due to clinicians being increasingly aware, and misdiagnosis. The differential diagnoses include: adjustment reactions, grief and anger, delirium, substance misuse, personality disorder and physical complications. Making the diagnosis is discussed from clinical presentation and mental state examination to formal rating scales notably the Endicott scale and Chochinov screening question. The importance of assessing suicidality is emphasised.

Depression can be effectively treated improving quality of life, survival, symptom control and decreasing time in hospital. Physical treatments including antidepressants, psychostimulants, mood stabilisers and ECT are discussed. Differing classes of antidepressant and prescribing are described. General and specific psychological approaches are mentioned including psychodynamic, cognitive – behavioural and supportive – psychotherapies. The importance of targeting the right patients for psychological treatments is emphasised. Social treatments are also beneficial.

Finally reasons for referral to psychiatry are listed and a summary of mental health legislation (Common law, Mental Health Act 2003 and Adults with Incapacity Act 2000) and their use in palliative care inpatients is explained.

References

- 1 Laird B, Mitchell J. The assessment and management of depression in the terminally ill. *J Palliat Care* 2005; **12**(3):101–4.
- 2 Wilson KG, Chochinov HM, de Faye BJ *et al*. Diagnosis and Management of Depression in Palliative Care. In: Chochinov HM, Breitbart W (editors). *Handbook of Psychiatry in Palliative Medicine*. Oxford: Oxford University Press; 2000; 3:25–49.

Key words Chochinov screening question, depression, Endicott scale, palliative care.

Sponsors None.

Declaration No conflict of interest declared.

SYDNEY WATSON SMITH LECTURE

Chairman: Professor N Douglas, President, Royal College of Physicians of Edinburgh, Edinburgh, Scotland

Delirium: An omen for the final exit, but not always

Dr P Lawlor, Consultant in Palliative Medicine, Our Lady's Hospice and St James's Hospital, Dublin, Ireland

Email plawlor@olh.ie

Abstract Delirium is a neuropsychiatric syndrome characterised by altered consciousness, reduced clarity of awareness, and associated attention difficulties. Other cognitive deficits, perceptual disturbance, psychomotor disturbance (hyper-, or hypoactivity, or a mix of both) and emotional lability are often present. Unlike dementia, whose onset is insidious, the onset of delirium is usually over hours to days. Fluctuation in symptom intensity is common and often results in lucid intervals. Misdiagnosis as dementia or depression often occurs. Delirium is common in patients with advanced disease. Although it invariably accompanies the dying phase in terminal and nonreversible episodes, other episodes may often be reversible. Reversibility is determined by the nature of the underlying medical or pharmacological precipitants. Screening, early diagnosis and the prompt identification and management of underlying treatable precipitants, if consistent with the goals of care, can result in reversal or part reversal of many episodes. Adjustment of opioids and assisted hydration are simple measures that may help to reverse many episodes.

Education of the family regarding the nature of the syndrome and its potential outcomes are essential. Symptomatic treatment of agitation and perceptual disturbance requires a neuroleptic such as haloperidol. More sedating agents such as midazolam may be required to treat severe agitation.

References

- 1 Lawlor PG, Fainsinger RL, Bruera ED. Delirium at the end of life – Critical issues in clinical practice and research. *JAMA* 2000; **284**:2427–9.
- 2 Lawlor PG, Gagnon B, Mancini IL *et al*. Occurrence, causes, and outcome of delirium in patients with advanced cancer – A prospective study. *Arch Intern Med* 2000; **160**:786–94.
- 3 Meagher DJ. Delirium: optimising management. *BMJ* 2001; **322**:144–9.
- 4 Breitbart W, Gibson C, Tremblay A. The delirium experience: Delirium recall and delirium-related distress in hospitalized patients with cancer, their spouses/caregivers, and their nurses. *Psychosomatics* 2002; **43**:183–94.

Key words acute confusional state, agitation, delirium, palliative care, sedation.

Sponsors None.

Declaration No conflict of interest declared.

More than cancer: palliative care in non-malignant disease

Dr S Chater, Consultant in Palliative Medicine, Western General Hospital, Edinburgh, Scotland

Email Schater@doctors.org.uk

Dr C Whitworth, Consultant in Renal Medicine, Royal Infirmary of Edinburgh, Edinburgh, Scotland

Email caroline.whitworth@luht.scot.nhs.uk

Dr J McKnight, Consultant in Diabetes, Western General Hospital, Edinburgh, Scotland

Email john.mcknight@luht.scot.nhs.uk

Abstract

There is increasing evidence that patients dying from progressive non-malignant disease may be significantly symptomatic in the last months of their lives and may have levels of distress and symptom burdens equating with that of dying cancer patients.

We will explore some of the evidence and then move to one category of progressive non-malignant disease CKD (End Stage Renal Disease) to discuss in more detail.

Using an illustrative patient we will explore:

- 1 Prognosis in CKD both with renal replacement therapy and conservative management.
- 2 Common symptoms in advanced CKD.
- 3 Common pain syndromes in CKD.
- 4 Prescribing analgesics in CKD.
- 6 Managing diabetes in palliative patients and in advanced CKD.
- 7 Management of End of Life care for the CKD patient.
- 8 Helpful resources for professionals needing palliative care advice for this patient group.

References

- 1 Chambers EJ, Germain M, Brown E (editors). *Supportive care for the Renal patient*. Oxford: Oxford University Press; 2004.
- 2 Cohen LM, Moss AH, Weisbord SD, Germain MJ. Renal palliative care. *J Palliat Med* 2006; **9(4)**:977–92.
- 3 Ford-Dunn S, Smith A, Quin J. Management of diabetes during the last days of life: attitudes of consultant diabetologists and consultant palliative care physicians in the UK. *J Palliat Med* 2006; **20**:197–203.

Key words Chronic kidney disease, end stage renal disease, non-malignant disease, palliative care.

Sponsors None.

Declaration No conflict of interest declared.

SESSION 3 NON-CANCER PALLIATIVE CARE

Chairman: Dr C Sugden, Consultant in Palliative Medicine and Medical Director, St Andrew's Hospice, Airdrie, Scotland

Supporting children when a parent is diagnosed with a life threatening illness

J Anderson, Department of Clinical Psychology, Beatson Oncology Centre, Glasgow, Scotland

Email Jenny.anderson@northglasgow.scot.nhs.uk

Abstract

Background Clinical experience tells us that the welfare of the children is often the most pressing concern when a parent becomes ill. When the diagnosis becomes terminal these worries are heightened. How do I tell the children? What should I tell them? Will they remember me? Who will look after them when I die? How will they cope? These questions are difficult for parents to ask, and for staff to hear. Staff may, through lack of training, confidence or time, or because they find it too emotionally distressing, not feel comfortable raising, addressing or exploring concerns about children.

Fortunately, most children will adjust to a parent's (or other close family member's) illness, and to the death of a parent, given support, understanding and the opportunity to express their feelings. However, there is a significant minority who will have difficulty coping and will require more specific intervention.

Methods or Theme The Child and Adolescent Support Service at the Beatson Oncology Centre offers specialist advice, information and intervention pre and post bereavement. It also offers training to health professionals in: assessment; provision of age-appropriate information; and communicating with and involving children, as well as access to a library of resources for children of cancer patients.

Conclusions Support to patients is becoming more freely available and strides are being made to provide equitable access to services, but urgent consideration needs to be given to models of service delivery that support the whole family.

References

- 1 Needs Assessment Report on Child and Adolescent Mental Health. Public Health Institute of Scotland. Final Report. March 2003.
- 2 Rolls L, Payne S. Childhood Bereavement Services: a survey of UK provision. *J Palliat Med* 2003; **17**:5, 423–32.
- 3 Dowdney L. Childhood bereavement following parental death. *J Child Psychol Psychiatry* 2000; **7**:819–30.
- 4 Cross S. *I can't stop feeling sad – calls to Childline about bereavement*. Childline Report April 2002.
- 5 www.winstonswish.org.uk (pre/post bereavement, parents, children and professionals).
- 6 www.childbereavement.org.uk (bereavement, parents and professionals).
- 7 www.riprap.org.uk (cancer (Sheffield University) – for children/young people).
- 8 www.rd4u.org.uk (bereavement, Cruise Youth Involvement Project – for children/young people).

- 9 www.whybother.org.uk (cancer (Macmillan) – for children/young people).
- 10 www.class-action.org.uk/local/homepage/ (cancer (Macmillan) – for teachers and youth workers).

Key words Bereavement, children, palliative care, psychology, supportive care.

Sponsors None.

Declaration No conflict of interest declared.

...diagnose dying?

Dr S Hutchison, Consultant in Palliative Medicine, Highland Hospice, Inverness, Scotland

Email stephen.hutchison@highlandhospice.org.uk

Abstract

Background Reliable prediction of prognosis in patients with advanced disease is difficult and notoriously inaccurate, but can provide patients and clinicians alike with important information.

Methods or Theme Doctors systematically over-estimate survival, but accuracy improves as death approaches. Doctors' predictions are discriminatory, but poorly calibrated. Specific clinical parameters make only a modest additional contribution to accurate survival prediction. Prediction in terms of time categories is more helpful for the patient than attempts at detailed accuracy.

The Gold Standards Framework provides guidance for identification of patients who are in the last year of life and who may need supportive and palliative care.

The Liverpool Care Pathway for the dying patient facilitates recognition of the terminal phase and provides a valuable means of documenting optimal care.

References

- 1 Glare P, Virik K, Jones M *et al*. A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ* 2003; **327**:195–200.

Key words Gold Standards Framework, Liverpool Care Pathway, predicting prognosis.

Sponsors None.

Declaration No conflict of interest declared.

SESSION 4 HOW DO WE..?

Chairman: Professor J Welsh, Glasgow University, Consultant in Palliative Medicine, Beatson Oncology Centre, Western Infirmary, Glasgow, Scotland

...discuss end of life care?

Dr K Boyd, Consultant in Palliative Medicine, Royal Infirmary, Edinburgh, Scotland

Email kirsty.boyd@luht.scot.nhs.uk

Abstract

Background Death and dying are topical, yet we often choose not to talk about it personally or professionally. Most people still die in hospital and Illich's critique of the medicalisation of dying is often true. Palliative medicine has been a speciality for nearly 20 years and much has been achieved to improve care of the dying. However, communication about dying remains challenging and, if done badly or not at all, hinders effective advance care planning.

Methods or Theme This presentation will draw on some of the published literature in the area of end-of-life communication and combine this overview with poetry, pictures, an interactive quiz and a little drama to enable us to reflect on how we might address our concerns about fostering hope, while giving appropriate information so as to meet the needs of our patients and their carers better.

References

- 1 Clark D. Between hope and acceptance: the medicalisation of dying. *BMJ* 2002; **324**:905–7.
- 2 Davison SN, Simpson C. Hope and advanced care planning in patients with end-stage renal disease: qualitative interview study. *BMJ* 2006; **333**:886–9.
- 3 Fallowfield LJ, Jenkins VA, Beveridge HA. Truth may hurt but deceit hurts more: communication in palliative care. *J Palliat Med* 2002; **16**:297–303.
- 4 Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? *BMJ* 2004; **328**:1343–7.
- 5 Murray SA, Boyd K, Kendall M *et al*. Dying of lung cancer or cardiac failure: a prospective, qualitative interview study of patients and their carers in the community. *BMJ* 2002; **325**:929–32.

Key words Communication, doctor-patient relationship, dying, hope.

Sponsors None.

Declaration No conflict of interest declared.