ANAESTHETICS, PERIOPERATIVE MEDICINE AND.. SUPPORTIVE AND PALLIATIVE MEDICINE (SPM) ????

THE INTERFACE

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SPM and Anesthetics often both work in the place where treating the disease must blend with meeting the symptomatic and holistic needs of the person.

Fig. 2. Basic model of integrated palliative care.
PERI-OPERATIVE FITNESS...?
TO SURVIVE OR TO BENEFIT?

COMPLEX PAIN

Fig. 2. Basic model of integrated palliative care.

THE CROWN PRINCESS MARY CANCER CENTRE, WESTMEAD
• APS /Intrathecal Therapy in the setting of Complex cancer pain

• Pre-operative decision making in advanced organ failure or advanced malignancy
Intrathecal Analgesia in Complex Cancer Pain.

APS (Acute Pain Service) and SPM...

A Westmead Success Story
Jessica age 26

- Low grade pap smear 2013
- High grade pap smear 2015
- Colposcopy & biopsy invasive adenocarcinoma
- 3 cm tumour protruding through cervical os
- Radical hysterectomy, bilateral salpingo-oophorectomy bilateral pelvic lymph node dissection
Pathology

• Serous adenocarcinoma of cervix
• 2/20 nodes involved
• Radiotherapy + concurrent cisplatin
• Chemotherapy – Carboplatin Paclitaxel
Jessica age 26

- Sept 2015 completed chemo
- October pelvic and left hip pain. Pain free while on chemo-radiotherapy and subsequent chemotherapy. Pain recurs within days of stopping chemo.
- Repeat progress CT scan on 22 September showed increasing bladder wall and pre-sacral soft tissue thickening. Could be due to early disease progression or radiation treatment effects.
Jessica age 26

• Referred to Supportive & Palliative Care October 2015 for pain management
• Admitted late October to palliative care ward
  – Pain crisis
  – Acute renal failure due to bilateral ureteric obstruction. Ureters stented
  – Probable disease recurrence
  – Psycho social “crisis”
• PET scan showed increased FDG uptake immediately posterior to the ureteric stent and right-sided pelvic sidewall, suggesting of disease progression.

• Disease recurrence confirmed on fine needle biopsy
Psycho-social

- Anger, distress, reactive depression, despair, desperate for hope/cure
- Single mother, 2 year old daughter
- Mother left Jessica and her brother in care of their father when Jessica was 9 years old
- Abusive relationship
- Returned to mothers home when pregnant
- Future care of daughter
- Breaking bad news to 6 year old sister
Symptom Control at the End of Life: Pain

– The personal pain experience with emotional content:

– Engels Bio-Psycho-Social model of illness – as opposed to the medical model (managing the delinquent body) is very relevant

Excruciating Pain

• Unresponsive to conventional pain management
  – Opioid rotations - Oxycodone, Morphine, Hydromorphone, Methadone
  – Anticonvulsants - Pregabalin
  – Steroids
  – Ketamine
  – Systemic local anaesthetic infusions - lignocaine

• Toxicity unacceptable

• Suicidal ideation due to pain
Intrathecal analgesia

- Complex requiring multidisciplinary team
  - APS
  - Palliative Medicine
  - Highly skilled nursing, inpatient and community
- Inpatient titration
- Trade off between efficacy and side effects
  - Potential for sepsis
  - Sensory and motor block
Intrathecal catheter with catheter over needle design

Reduces CSF leak
JESS and her IT Pain management

- Tunnelled intrathecal catheter inserted at L3/4
- Initial IT infusion
  - morphine 30mg, bupivicaine 15mg, clonidine 150mcg (per 36mls, rate 1.8ml/hr)
- Systemic opioids were weaned rapidly and ceased altogether by day 7
**Baxter disposable ambulatory pump**

**Infusor LV1.5 System**
2C1087K
Product Category: Infusor Systems
Product Family: Large Volume Infusor Systems

<table>
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<tr>
<th>Trait</th>
<th>Value</th>
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<tr>
<td>Housing Color</td>
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<tr>
<td>Flow Rate (mL/hr)</td>
<td>1.5</td>
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<tr>
<td>Maximum Interval</td>
<td>7 days</td>
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<tr>
<td>Maximum Volume (mL)</td>
<td>275</td>
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Problems with small infusion rate: fitting in drug dose in volume
Progress

• November – January: HOME!!
  – Discharged home with intrathecal
  – LV infusor changed weekly by community nurses
  – RECIST clinical trial

• Readmitted January 2016
  – Reinsertion of IT after displacement into epidural space, re-titration of IT mix
Westmead Intrathecal audit 2013 2000-2012

- 51 patients
- All managed jointly by APS and Palliative care in palliative care unit
- No patients had an implantable device
- Average total catheter days – 58
- Range 5-326 days

Dr Desi Seccombe 2013
IT problems

• IT “mix” - polypharmacy
  – Bupivacaine, Clonidine, Hydromorphone, Ketamine, Midazolam

• Catheter displacement

• IT leak

• Increased motor / sensory block vs analgesia effect

• Hypotension
Jess- final stages: Refocussing hope

- Trial not effective
- Destroying hope
- Refocussing hope

Pain control
Discharge home
“Good Bye Work “
Time with daughter
Advanced medical plan
A good death
We need to know we are at the crossroads to take another path
Death – It comes to us all, and always has
Death and Dying: How we respond to it has changed

The “Medical Model” – that is dealing with a “Delinquent Body” - prevails
ANAESTHETICS, PERIOPERATIVE MEDICINE AND SUPPORTIVE AND PALLIATIVE MEDICINE (SPM)

ANAESTHETISTS AS AGENTS OF CULTURAL CHANGE

THE CROWN PRINCESS MARY CANCER CENTRE, WESTMEAD
ANAETHETISTS AS CHANGE AGENTS

In the Perioperative space

– **Pre operative** decision making –
  (what are the Goals of Care Here?)

– **Post operative** care – does this patient need Supportive and Palliative Care?
  (Early referrals lead to better outcomes)

– **Departmental M+Ms and Guidelines**

**Institutional Culture** – LHD End of Life Committee
PERI-OPERATIVE FITNESS...?
TO SURVIVE OR TO BENEFIT?

Fig. 2. Basic model of integrated palliative care.
ANAESTHETICS, PERIOPERATIVE MEDICINE AND...
SUPPORTIVE AND PALLIATIVE MEDICINE (SPM)

Pre-operative decision making in
• advanced organ failure
• advanced malignancy
  • The very frail
  • The very old
FROM ...The Daze of your Lives/ - or an anaesthetic bay near you

Case 1  Mr DF

• 78 year old from home
• Barely coping – carer stress
• Amputee, CRF, CCF, DM, Vision impaired
• Gangrenous foot, sick
• Pre op assessment for BKA –
  – tells the anesthetist he is not worried about dying, just wants to be comfy and never go to ACF
FROM ...The Daze of your Lives/ - or an anaesthetic bay near you

Case 2: Mrs DA

• 83 year old patient from NH in A+E resusc bay
• Dementia Bed bound
• Leaking AAA –
• Large family gather demanding the best for Nonna and that means surgery and ICU....
• Vascular surgery and ICU consult
Good Clinical Decision Making
(Remember Clinical Ethics?)
JONSEN’S FRAME WORK FOR ETHICAL CLINICAL ACTION\(^1\)

- HOW CAN WE HELP THESE PATIENTS AND AVOID HARM
  (beneficence and non-maleficence)

- PATIENT PREFERENCES
  (autonomy vs paternalism)

- QUALITY OF LIFE (QuOL)
  (as defined and desired by the patient)

- CONTEXTUAL FEATURES
  (justice)

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\(^1\) A. Jonsen et al “Clinical Ethics: a Practical Approach to Ethics in Clinical Medicine” McGraw Hill
Good Clinical Decision Making

• WHO IS THE PATIENT?

• WHAT ARE THEIR VALUES, and GOALS?

• HOW LIKELY is the INTERVENTION to ACHIEVE THEIR GOALS?
Good Clinical Decision Making …

Do we recognise dying any more?

How can we accurately estimate prognosis?
Symptoms at the End of Life:
(Everything changes but nothing Changes)

- **HIPPOCRATES:**
- Fatigue – “confined to bed, insomnolence
- Anorexia – “food returned but little changes
- N+V: Dejections copious and thin or bilious
- Pain “a great Pain and heaviness “
- Delirium: ”senses much disordered – crying out”
- Breathlessness “hurried respiration”
- Incontinence – “Much looseness of Bowels”
## Symptoms at the End of Life

### Table 4. Symptom prevalence during the final days of life

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<td><strong>Design</strong></td>
<td>Prospective/retrospective</td>
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<td>Retrospective</td>
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<tr>
<td><strong>Population</strong></td>
<td>200 deaths</td>
<td>176 consecutive patients with advanced cancer</td>
<td>2598 enrolled patients (41% cancer)</td>
<td>185 convenience sample (14% cancer)</td>
<td>370 patients (25% cancer)</td>
<td>181 patients with advanced cancer</td>
<td>357 consecutive patients with advanced cancer</td>
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<td><strong>Setting (place of death)</strong></td>
<td>Hospice (home or inpatient)</td>
<td>Home, hospitals, hospices</td>
<td>Home, hospitals</td>
<td>Long-term care</td>
<td>Hospitals</td>
<td>Palliative care units</td>
<td>Palliative care units</td>
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<td><strong>Symptom assessment</strong></td>
<td>Research nurses’ impression when patients were likely to die or after death</td>
<td>Clinicians’ impression during the last week of life</td>
<td>Caregiver recall after death</td>
<td>Chart documentation</td>
<td>Nurse recall after death</td>
<td>Chart documentation</td>
<td>Edmonton Symptom Assessment Scale among patients who were able to communicate, nursing impression</td>
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<table>
<thead>
<tr>
<th>Symptom</th>
<th>Time frame</th>
<th>Last 2 days</th>
<th>Last 7 days</th>
<th>Last 3 days</th>
<th>Last 2 days</th>
<th>Last 3 days</th>
<th>Last 2 days</th>
<th>Last 3 days serially</th>
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<tr>
<td>Fatigue</td>
<td>NR</td>
<td>92%</td>
<td>80%</td>
<td>NR</td>
<td>93%</td>
<td>NR</td>
<td>60–78%</td>
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<tr>
<td>Pain</td>
<td>51%</td>
<td>30%</td>
<td>34–45%</td>
<td>NR</td>
<td>44%</td>
<td>75%</td>
<td>24%</td>
<td>38–50%</td>
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<tr>
<td>Anorexia</td>
<td>NR</td>
<td>80%</td>
<td>NR</td>
<td>NR</td>
<td>73%</td>
<td>5%</td>
<td>74–83%</td>
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<tr>
<td>Dyspnea</td>
<td>22%</td>
<td>47%</td>
<td>28–83%</td>
<td>NR</td>
<td>62%</td>
<td>70%</td>
<td>21%</td>
<td>48–73%</td>
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<tr>
<td>Confusion</td>
<td>9%</td>
<td>68%</td>
<td>24–34%</td>
<td>NR</td>
<td>29%</td>
<td>55%</td>
<td>33%</td>
<td>NR</td>
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<tr>
<td>Dysphagia</td>
<td>29%</td>
<td>46%</td>
<td>NR</td>
<td>NR</td>
<td>28%</td>
<td>49%</td>
<td>NR</td>
<td>24–53%</td>
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<td>Death rattle</td>
<td>56%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>39%</td>
<td>45%</td>
<td>NR</td>
<td>11–39%</td>
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<td>Myoclonus</td>
<td>12%</td>
<td>NR</td>
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<td>NR</td>
<td>8–11%</td>
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<td>Incontinence</td>
<td>32%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>57%</td>
<td>NR</td>
<td>NR</td>
<td>39–65%</td>
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<tr>
<td>Anxiety</td>
<td>NR</td>
<td>46%</td>
<td>25%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>6%</td>
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</table>
Good Clinical Decision Making...

Assessing Prognosis

many scales....
Clinical Frailty Scale

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up,” and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.


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DALHOUSIE UNIVERSITY
Inspiring Minds
The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

ECOG >+3
SPICT TOOL: a Haem Disease/Malignancy and 2+ score associated with Poor Px
Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate alternative care (CriSTAL)

Magnolia Cardona-Morrell,¹ Ken Hillman²

BMJ SPC Feb 2015
| Proposed components of the Criteria for Screening and Triaging to Appropriate alternative care tool to identify end-of-life status before hospital admission |
|-----------------|-----------------|
| **Age ≥65** | AND |
| ON | Meets 2 or more of the following deterioration criteria on admission |
| • Decreased LOC: Glasgow Coma Score change > 2 or AVPU = P or U |
| • Systolic blood pressure < 90 mm Hg |
| • Respiratory rate < 5 or > 30 |
| • Pulse rate < 40 or > 140 |
| • Need for oxygen therapy or known oxygen saturation < 90% |
| • Hypoglycaemia: BGL |
| • Repeat or prolonged seizures |
| • Low urinary output (< 15 mL/h or < 0.5 mL/kg/h) |
| OR MEW or SEWS score > 4 |
| AND |
| **OTHER RISK FACTORS / PREDICTORS OF SHORT-MEDIUM-TERM DEATH** |
| Personal history of active disease (at least one of): |
| • Advanced malignancy |
| • Chronic kidney disease |
| • Chronic heart failure |
| • Chronic obstructive pulmonary disease |
| • New cerebrovascular disease |
| • Myocardial infarction |
| • Moderate/severe liver disease |
| • Evidence of cognitive impairment (e.g., long term mental disorders, dementia, behavioural alterations or disability from stroke) |
| • Previous hospitalisation in past year |
| • Repeat ICU admission at previous hospitalisation (associated with a fourfold increase in mortality) |
| Evidence of frailty: 2 or more of these: |
| • Unintentional or unexplained weight loss (10 lbs in past year) |
| • Self-reported exhaustion (felt that everything was an effort or felt could not get going at least 3 days in the past week) |
| • Weakness (low grip strength for writing or handling small objects, difficulty or inability to lift heavy objects >= 4.5 Kg) |
| • Slow walking speed (walks 4.5 m in > 7 s) |
| • Inability for physical activity or new inability to stand |
| • Nursing home resident/in supported accommodation |
| • Proteinuria on a spot urine sample: positive marker for chronic kidney disease & predictor of mortality: > 30 mg albumin/g creatinine |
| • Abnormal ECG (Atrial fibrillation, tachycardia, any other abnormal rhythm or ≥ 5 ectopics/min, Changes to Q or ST waves) |

ICU, intensive care unit; MEW, modified early warning.
Good Clinical Decision Making …

How can we accurately estimate prognosis?

COMMON ELEMENTS TO ALL SCALES

Poor Functional Status
Frailty (weight loss, exhausted, weak, slow walk)
Age (+/- Biological)
Malignancy
Organ failure
Recent admissions via A+E or to ICU
Good Clinical Decision Making ...

AT the Pre op stage:

Goals of Care and Advanced Directives –

Should be known – usually are not

Don’t wait for the crisis – or ICU is the default option (surrogate decision makers will default to aggressive Rx choices)
• 79% Patients had capacity at the start of admission
• 40% lost it at goals of care discussions time
• 59% of patients whose surrogates made the decisions went to ICU vs 26% who made the decision (in a crisis!)
Good Clinical Decision Making

Does it matter if clinicians and patients share unrealistic expectations?

- Impact on QuOL
- Impact on good EOL planning
- Increased trauma and mental health issues for the Family
- High Chance of a Bad Death (Non Maleficence)

1: JCO 1995 13: 858-68
2: BMJ 1990 300: 1458
3: Myers: Curr Opin in SuppPall Vol (1) 2015
Back to our Elders in Trouble

• Case 1 – Mr DF
• Gangrene many co-morbidities –
• Surgery - went to Surgical HDU
• Unstable with Sepsis – after APS discussion with surgeons Pall Care was involved
• Patient and family happy to cease antibiotics and have pain control – died 1 week later
Back to our Elders in Trouble

- Case 2 Mrs DA
- AAA leaking - demented, bed bound
- Family would not accept surgical recommendation
- Surgery
- Patient died after 2 weeks in ICU
TWO WEEKS IN ICU CAN SAVE AN HOUR OF CONVERSATION
We need to know we are at the crossroads to take another path

CHANGE AGENTS SEE THE CROSS ROADS