PALLIATIVE

Malignant Wounds

Vanessa Cardy, MD, and Stuart Swadron, MD << This is just a reference for the audio chapters.

Background

- Wound care is important in the palliative context
- Prone to infection
- Determine whether wound is likely to heal given the patient’s prognosis

Clinical Findings

- Exudates
- Malodorous discharge

Management

- Optimize nutrition for healing purposes
- Minimize exudates with absorbent dressings
- Treat infections (topical treatment preferred)
- Manage odor
- Ensure adequate analgesia

How You Will Be Tested

- Topical antibiotics are often preferred for treating infections

Nausea & Vomiting in Palliative Care

Vanessa Cardy, MD, and Stuart Swadron, MD

Background

- This condition should be taken seriously, as it has a strong impact on quality of life
- Causes include:
    - Medications
    - Central nervous system disease (example: brain metastasis)
    - Metabolic disturbances
    - Anxiety
    - Pain

Clinical Findings

- Evaluate for reversible causes such as:
    - Medication side effects
    - Bowel obstructions
    - Neurologic lesions

Management

Always consider goals of care prior to initiating

- Treat cause(s)
- Avoid trigger(s)
- Evaluate for electrolyte abnormalities
- Consider giving IV fluids for comfort
- Provide counseling
- Administer treatment
    - Olanzapine
    - Haloperidol
    - Dexamethasone

How You Will Be Tested

- Know that antipsychotics can be used as anti-nauseants

Terminal Pain Crisis

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Background

- Watch out for rapid escalation of patient's analgesic needs (could be a sign of underlying emergency or opiate toxicity)
- Understand patient's outpatient pain regimen and be aware of their breakthrough analgesic needs

Clinical Findings

- Anxiety, delirium, restlessness
- Signs of opioid toxicity include: Generalized pruritus, myoclonus, nausea/vomiting, and opioid-induced hyperalgesia

Management

- Evaluate for cause of acute pain and anything obviously reversible
- Treat underlying cause of pain (if possible), and treat acute pain
    - Opioid-naive: Administer 5-10 mg morphine q5-10min
    - Not opioid-naive: Double their breakthrough dose until pain resolves
    - Opioid toxicity: Convert patient to a different opioid medication and decrease dose

How Will You Be Tested

- Know the signs of opiate toxicity
- You may be given a question stem that talks about a patient with worsening pain, on a particular pain regimen at home, and asks you how to treat it acutely

Terminal Delirium

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Background

- Death is imminent for the patient

Clinical Findings

- Limit the physical exam in order to provide comfort

Management

- Confirm goals of care
- Minimize stimulation
- Provide a comforting environment
- Medication options:
  - Lorazepam 0.5-4 mg subcutaneous (SC)/ intravenous (IV)/sublingual (SL)/per rectum (PR)
  - Midazolam 1-10 mg q4h SC/IV
  - Methotrimeprazine 5 mg q6h SC/IV
  - Haloperidol 0.5-1 mg orally/SC/IV/intramuscularly q1h as needed
  - Phenobarbital (wide dose range depending on degree of agitation)
  - Consider subdissociative dose ketamine

How Will You Be Tested

- Know that the use of sedation is paramount to good palliative care, especially for a patient with terminal delirium

Terminal Dyspnea

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Background

- This condition is a very common end-of-life complaint
  - Goals of care are to:
    - relieve breathlessness
    - relieve associated anxiety

Clinical Findings

- May include breathlessness and/or anxiety

Management

- Assess the cause of the dyspnea as it may affect treatment
- Do not automatically use oxygen
- Opioid-naive
  - Morphine 5-10 mg subcutaneous (SC) q10 min prn
- Not opioid-naive
  - Double patient's breakthrough dose
- For anxiety
  - Midazolam 5 mg q10 min prn
- For bronchial secretions
  - Scopolamine 0.4 mg SC q6h
- Non-medication treatment
  - Open a window
  - Turn on a fan

How You Will Be Tested

- Oxygen does not necessarily help the sensation of dyspnea

Terminal Hemorrhage

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Background

- Identify and treat sentinel bleeds
- Identify at-risk lesions

Clinical Findings

- Variable. Patients may have signs of hemorrhagic shock or, because we do not often use vitals in terminal patients, internal blood loss may not be apparent

Management

- Use colored surgical towels/sheets (masks red blood)
- Keep patient warm
- Medications for distress:
    - Morphine
    - Midazolam

How Will You Be Tested

- Know that you should treat sentinel bleeds