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Palliative care and pancreatic cancer

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Poll 1

- What is the most common intervention for patients with pancreatic cancer
  - Chemotherapy
  - Best supportive care
  - Surgery
  - Radiotherapy
  - Immunotherapy

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- Best supportive care is by far the most common intervention

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Introduction

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- 10th most common cancer, 6th most common cause of death
- 25% alive at 1 year, 7% at 5 years
- Treatment for all stages (curative or palliative intent)
  - 28% chemotherapy
  - 10% surgery
  - 5% radiotherapy
- High symptom burden
- Potential for rapid deterioration

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Learning outcomes

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- To have a better understanding of what ‘best supportive care’ encompasses and think about your role in this
- Think about the wide ranging impact of pancreatic cancer on patients and loved ones
- Management of patients at the end of life

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Poll 2

- Who delivers palliative care?
  - Primary care
  - Surgeons
  - Oncologists
  - CNS
  - Specialist palliative care teams
  - All of the above

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- Palliative care is delivered by anyone who interacts with a patient who is approaching the end of their life

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What we will cover

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- Best supportive care
  - Communication
  - Advance care planning
  - Symptom control
  - Emotional support
  - Practical support
- End of life care
  - Recognising signs of approaching end of life
  - Preparing for end of life
  - Symptom control at the end of life

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Case study

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- Mr DM
- 50 yo, 3 month history abdominal and back pain, loss of appetite and constipation
- Previously fit and well
- Lives with wife and 2 children (15yo and 18yo); runs own construction company- main source of income
- Investigations reveal inoperable pancreatic cancer adenocarcinoma
- Referred to oncology for consideration of chemotherapy
- Referred to City Hospice for support

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- Main issues from initial assessment
  - Physical: pain, nausea, constipation
  - Psychological: distress at diagnosis, worry of the impact on family
  - Social: financial
  - Spiritual: Christian faith, angry at God
- Other important considerations
  - Understanding of illness
  - Expectations for the future

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- We will come back to this very common scenario at the end

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Best supportive care

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- Active anticancer treatment and best supportive care are not mutually exclusive
- Those undergoing active anticancer treatment should receive best supportive care alongside
- No active anticancer treatment doesn’t equal no treatment

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Communication

- Honest, effective and empathetic communication is key to good care
  - Healthcare professional ⟷ patient and loved ones
  - Patients ⟷ loved ones
  - Healthcare professionals ⟷ healthcare professionals

- Elicit patients information needs and provide honest information
- Honesty allows patients and loved ones to plan ahead
- Avoid absolutes e.g. prognosis of 12 months
- Avoid paternalism and trying to avoid upset
  - You can’t make bad news better, but you can give it in a good way

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Poll 3

- Who should advance care plan with patients and families?
  - GP
  - District nurses
  - CNS
  - The person who knows them best
  - Surgeons
  - Specialist palliative care

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Advance care planning (ACP)

- Voluntary and according to the patient's agenda but some practicalities to consider
  - Patient and families understanding of illness and wishes for future
  - Escalation of treatment of reversible causes
  - Preferred place of care and death
  - DNACPR

- Other important considerations
  - Financial: pensions, Will, funeral plans

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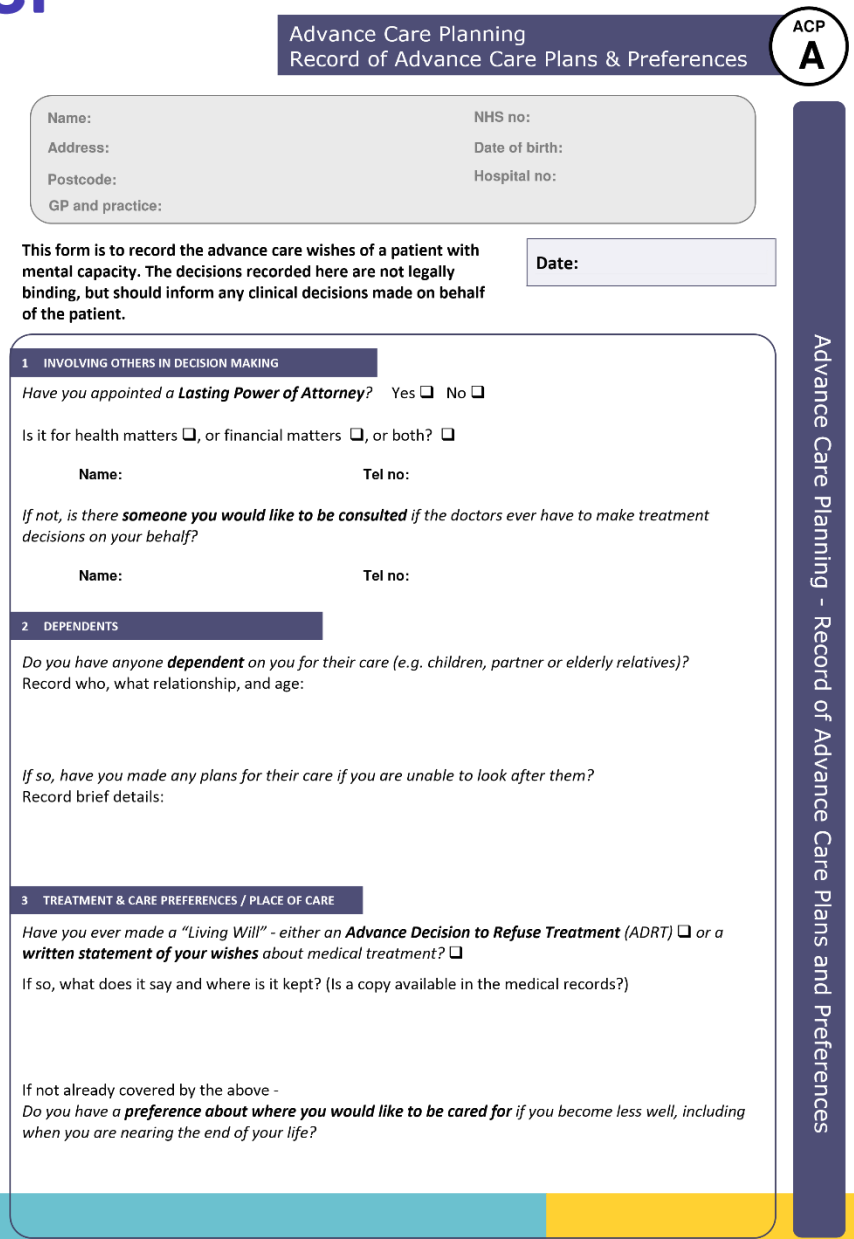
Advance care planning



Advance Care Planning
Record of Advance Care Plans & Preferences

ACP A

Name: NHS no:
Address: Date of birth:
Postcode: Hospital no:
GP and practice:

This form is to record the advance care wishes of a patient with mental capacity. The decisions recorded here are not legally binding, but should inform any clinical decisions made on behalf of the patient.

Date:

1 INVOLVING OTHERS IN DECISION MAKING

*Have you appointed a **Lasting Power of Attorney**?* Yes ❑ No ❑

Is it for health matters ❑, or financial matters ❑, or both? ❑

Name: **Tel no:**

*If not, is there **someone you would like to be consulted** if the doctors ever have to make treatment decisions on your behalf?*

Name: **Tel no:**

2 DEPENDENTS

*Do you have anyone **dependent** on you for their care (e.g. children, partner or elderly relatives)?*
Record who, what relationship, and age:

If so, have you made any plans for their care if you are unable to look after them?
Record brief details:

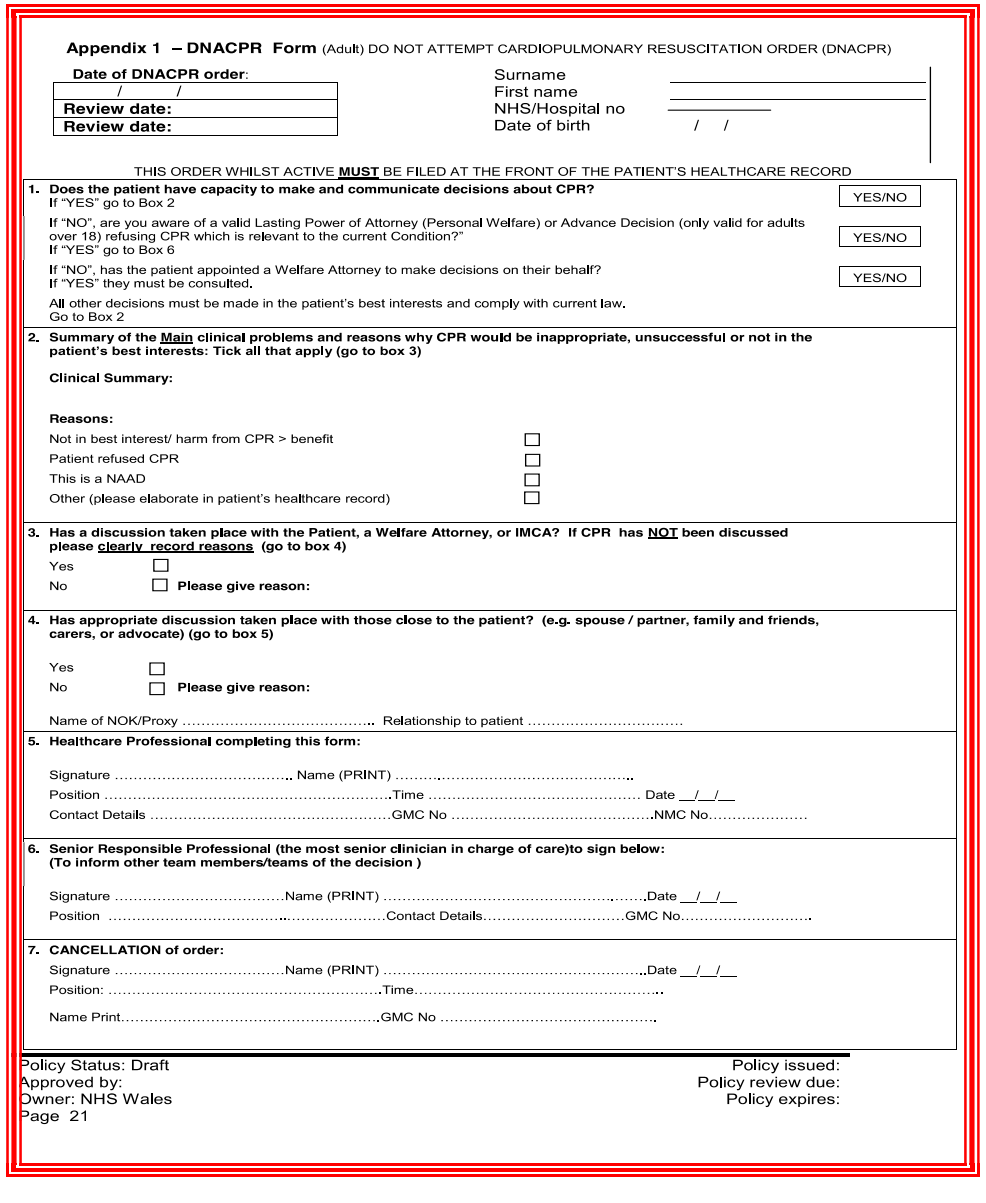
3 TREATMENT & CARE PREFERENCES / PLACE OF CARE

*Have you ever made a "Living Will" - either an **Advance Decision to Refuse Treatment** (ADRT) ❑ or a **written statement of your wishes** about medical treatment?* ❑

If so, what does it say and where is it kept? (Is a copy available in the medical records?)

If not already covered by the above -
*Do you have a **preference about where you would like to be cared for** if you become less well, including when you are nearing the end of your life?*

Advance Care Planning - Record of Advance Care Plans and Preferences



Appendix 1 – DNACPR Form (Adult) DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION ORDER (DNACPR)

Date of DNACPR order: / /
Review date:
Review date:

Surname
First name
NHS/Hospital no
Date of birth / /

THIS ORDER WHILST ACTIVE **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. **Does the patient have capacity to make and communicate decisions about CPR?** YES/NO
   If "YES" go to Box 2
   If "NO", are you aware of a valid Lasting Power of Attorney (Personal Welfare) or Advance Decision (only valid for adults over 18) refusing CPR which is relevant to the current Condition?" YES/NO
   If "YES" go to Box 6
   If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES/NO
   If "YES" they must be consulted.
   All other decisions must be made in the patient's best interests and comply with current law.
   Go to Box 2
2. **Summary of the Main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Tick all that apply (go to box 3)**
   Clinical Summary:
   Reasons:
   Not in best interest/ harm from CPR > benefit ☐
   Patient refused CPR ☐
   This is a NAAD ☐
   Other (please elaborate in patient's healthcare record) ☐
3. **Has a discussion taken place with the Patient, a Welfare Attorney, or IMCA? If CPR has NOT been discussed please clearly record reasons (go to box 4)**
   Yes ☐
   No ☐ **Please give reason:**
4. **Has appropriate discussion taken place with those close to the patient? (e.g. spouse / partner, family and friends, carers, or advocate) (go to box 5)**
   Yes ☐
   No ☐ **Please give reason:**
   Name of NOK/Proxy …….. Relationship to patient ……
5. **Healthcare Professional completing this form:**
   Signature …….. Name (PRINT) ……..
   Position ……Time …… Date __/__/__
   Contact Details ……GMC No ……NMC No……
6. **Senior Responsible Professional (the most senior clinician in charge of care)to sign below: (To inform other team members/teams of the decision)**
   Signature ……Name (PRINT) ……Date __/__/__
   Position ……Contact Details……GMC No……
7. **CANCELLATION of order:**
   Signature ……Name (PRINT) ……..Date __/__/__
   Position: ……Time……..
   Name Print……GMC No ……

Policy Status: Draft
Approved by:
Owner: NHS Wales
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Policy issued:
Policy review due:
Policy expires:

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Advance care planning

- Communication is key
  - Patients, families, healthcare professionals
- Communicate decisions, ideally in writing
  - ACP documents
  - Advance decision to refuse treatment (ADRT)
  - Lasting power of attorney
  - DNACPR form
- If the ACP isn't available when it's needed there was no point in doing it in the first place
- Some patients will not want information or to consider ACP, but usually loved ones will

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Symptom control

- Common physical symptoms
  - Lethargy
  - Abdominal/back pain
  - Nausea, early satiety
  - Bowel changes: loose stools, constipation
  - Weight loss/cachexia
  - Jaundice
  - Hyperglycaemia: polyuria, polydypsia
  - Hypercalcaemia: confusion, constipation, pain

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Symptom control

- Tailor symptom control to the patient and likely underlying mechanism for the symptom
- Compliance is key: there is no point prescribing it if they won't take it or can't take it
- Put in mechanisms to review symptom control: efficacy and side effects of medicines, compliance
- Consider the psychological and social impact of symptoms

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Pain

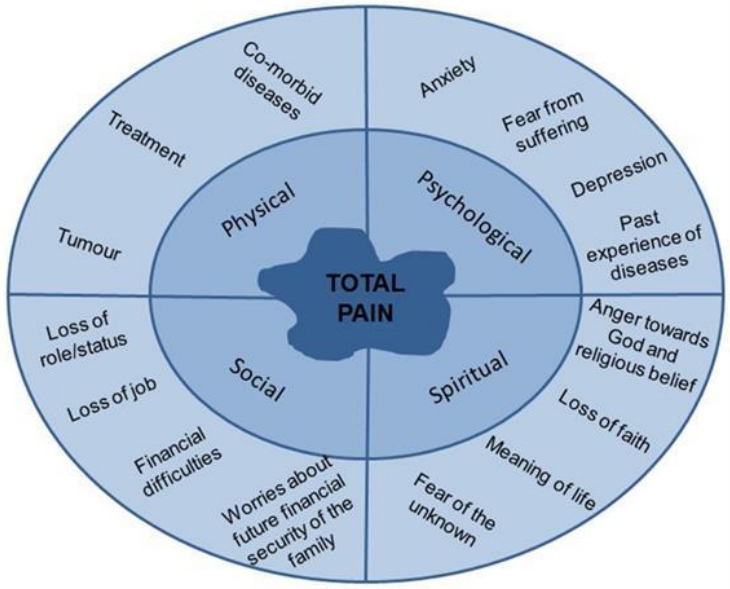
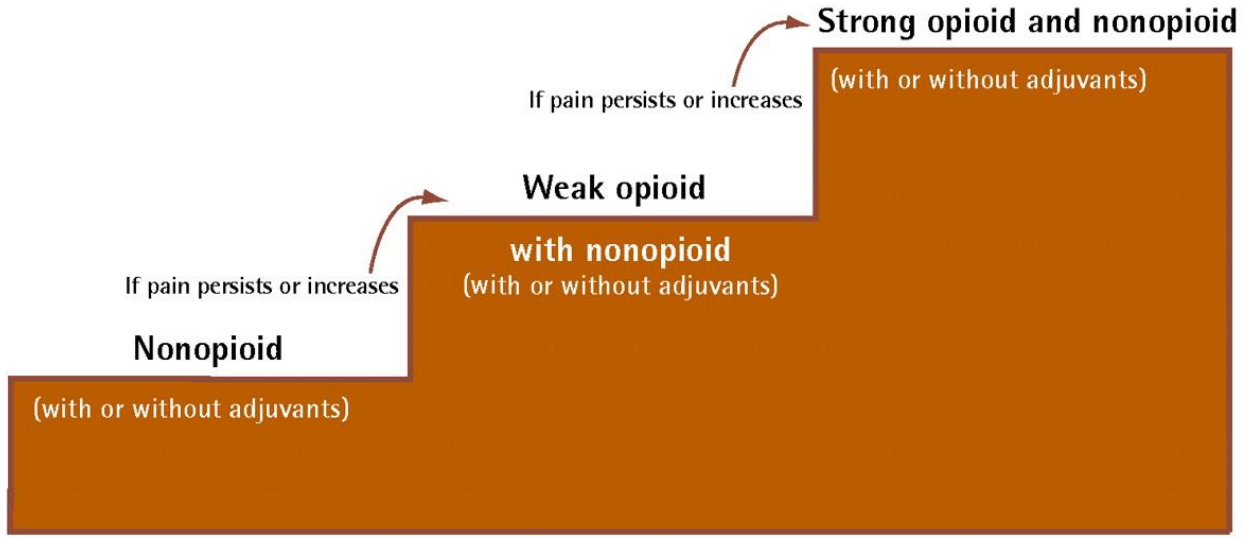


Figure 1. The World Health Organization analgesic ladder for treating cancer pain



Adapted from the World Health Organization.[1]

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Pain

- Most patients will require strong opioids: usually morphine or oxycodone
- Pain in pancreatic cancer often neuropathic
  - Adjuvant analgesics: gabapentin, pregabalin, amitriptyline, steroids
- Intractable pain: consider coeliac plexus block

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OPIOID CONVERSION CHART

There are differences in the literature regarding opioid conversion ratios. The conversion ratios listed below are the conversion ratios commonly used in practice at Our Lady's Hospice and Care Services (OLH&CS). The information outlined below is intended as a guide only. All medication doses derived using the information below should be checked and prescribed by an experienced practitioner. The dosage of a new opioid is based on several factors including the available equi-analgesic dose data, the clinical condition of the patient, concurrent medications and patient safety. It is recommended that the new dose should be reduced by 30-50% to allow for incomplete cross-tolerance. The patient should be monitored closely until stable when switching opioid medications.

GOLDEN RULE: WHEN CHANGING FROM ONE OPIOID TO ANOTHER ALWAYS CONVERT TO MORPHINE FIRST.

ORAL MORPHINE TO ORAL OPIOIDS		ORAL OPIOIDS TO PARENTERAL OPIOIDS		PARENTERAL MORPHINE TO OTHER OPIOIDS		TRANSDERMAL OPIOID TO ORAL MORPHINE	
PO → PO	RATIO	PO → IV/SC	RATIO	IV/SC → IV/SC	RATIO	TD → PO	RATIO
Morphine → Oxycodone	1.5:1	Morphine → Morphine	2:1	Morphine → Oxycodone	1.5:1	Buprenorphine → Morphine	1:75
Morphine → Hydromorphone	5:1	Oxycodone → Oxycodone	2:1	Morphine → Hydromorphone	5:1	Fentanyl → Morphine	1:100
		Hydromorphone → Hydromorphone	2:1	Morphine → Alfentanil	15:1		

(Note: This table does not incorporate recommended dose reductions of 30-50%.)

MORPHINE 24 hour dose		**OXYCODONE** 24 hour dose		**HYDROMORPHONE** 24 hour dose		**FENTANYL**	**ALFENTANIL** 24 hour dose	**BUPRENORPHINE**
ORAL	IV/SC	ORAL	IV/SC	ORAL	IV/SC	TRANSDERMAL#	IV/SC	TRANSDERMAL#
5mg	2.5mg	3.33mg	1.66mg	1mg	0.5mg	-	0.16mg	-
10mg	5mg	6.66mg	3.33mg	2mg	1mg	-	0.33mg	5 micrograms/hour*
14.4mg	7.2mg	9.6mg	4.8mg	2.88mg	1.44mg	6 micrograms/hour	0.48mg	-
20mg	10mg	13.33mg	6.66mg	4mg	2mg	-	0.66mg	10 micrograms/hour*
28.8mg	14.4mg	19.2mg	9.6mg	5.76mg	2.88mg	12 micrograms/hour	0.96mg	-
30mg	15mg	20mg	10mg	6mg	3mg	-	1mg	15 micrograms/hour*
50mg	25mg	33.33mg	16.66mg	10mg	5mg	-	1.6mg	25 micrograms/hour*
60mg	30mg	40mg	20mg	12mg	6mg	25 micrograms/hour	2mg	35 micrograms/hour*
100mg	50mg	66.66mg	33.33mg	20mg	10mg	-	3.3mg	52.5micrograms/hour*
120mg	60mg	80mg	40mg	24mg	12mg	50 micrograms/hour	4mg	70 micrograms/hour*
150mg	75mg	100mg	50mg	30mg	15mg	-	5mg	
180mg	90mg	120mg	60mg	36mg	18mg	75 micrograms/hour	6mg	
200mg	100mg	133.33mg	66.66mg	40mg	20mg	-	6.66mg	
240mg	120mg	160mg	80mg	48mg	24mg	100 micrograms/hour	8mg	

 # Transdermal fentanyl and buprenorphine patches are prescribed in micrograms (mcg)/hour. Equivalent doses are based on the 24 hour dose of fentanyl or buprenorphine received from a patch.
*** Based on buprenorphine to morphine ratio of 1:70-83.**

Prepared by: Palliative Meds Info. (See www.olh.ie for Terms and Conditions.) Prepared: August 2012 Review: August 2013

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Pain

- Usually err on the side of caution and uptitrate analgesia
- Reasonable to skip step 2 on WHO analgesic ladder
- Patients often equate strong opioids with end of life: allay fears
- Always co-prescribe a PRN laxative and antiemetic with strong opioids
- Simpler is better
- Generally avoid tramadol

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Nausea and early satiety

- Nausea and vomiting are different things
- Commonly gastric stasis or element of outlet obstruction
- May be due to metabolic causes e.g. hypercalcaemia, chemotherapy
- Treat underlying constipation
- Psychological impact and overlap
- Commonly require prokinetic if no CI's: metoclopramide, domperidone
- Metabolic cause: consider haloperidol
- May require syringe driver if intractable vomiting

Bowel changes

- Loose stools
  - Usually due to malabsorption: creon
  - Ensure not overflow
  - Rule out infection if risk factors
  - Consider loperamide

- Constipation
  - Multiple factors: drugs, reduced mobility, reduced oral intake etc.
  - Oral laxatives +/- rectal measures
  - Oral laxatives
    - Osmotic: Laxido
    - Stimulant if no colic: senna, bisacodyl
    - Softener: docusate
  - Tolerance is a big factor
  - Generally avoid lactulose (bloating)

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Cachexia and fatigue

- Common symptoms
- Usually impossible to reverse in the presence of advanced disease
- Distressing to patients and loved ones
- Reverse reversible: other symptoms, metabolic disturbances
- Dietetics input: advice, supplements
- Realistic goal setting
- Consider trial of dexamethasone e.g. 4mg OD for 2 weeks for appetite and/or wellbeing

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Steroids

- Lots of indications for steroids in palliative care: appetite, fatigue, pain control, MSCC, SVCO, brain metastases
- If starting steroids, start PPI and monitor BMs prior and during
- Don’t continue them if they are not effective: review after 1-2 weeks
- If effective, wean to lowest effective dose

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Emotional support

- Grief and psychological distress at facing a life limiting illness should not be underestimated
- Commonly the most difficult symptom to tackle, for patients and loved ones
- Effects the patient and the patients' wider support network
- Distress is not pathological (usually)
- Prolonged feeling of anxiety, low mood, depression may be pathological
- The emotional aspects of a terminal illness effects all other aspects: physical, psychological, social, spiritual

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Emotional support

- Be honest and empathetic
- Usually the fear of the unknown or unasked question is worse than the reality
- ACP often allays many psychological worries: ‘get things in order’
- Tools
  - A kind ear
  - Counselling
  - Psychology
  - Reflexology
  - Hypnotherapy
  - Occasionally medicines: antidepressants, anxiolytics

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Practical support

- Do not underestimate this
- One of the commonest contributory factors for people being admitted to hospital at the end of life is a care crisis
- Environmental support
  - OT, simple equipment, physio, carers
- Financial support
  - Benefits, grants, completion of wills and funeral plans: ensure the person has been seen by a welfare rights officer as a minimum

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Practical support

- In a crisis, if someone is at the end of life and wishes to remain at home
  - Fastrack care can be put in: talk to the district nursing team and your local palliative care team
  - Basic equipment can be put in: hospital bed, pressure relief, commode
- It’s better to pre-empt these situations and plan before they arise

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5 minute break

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End of life care

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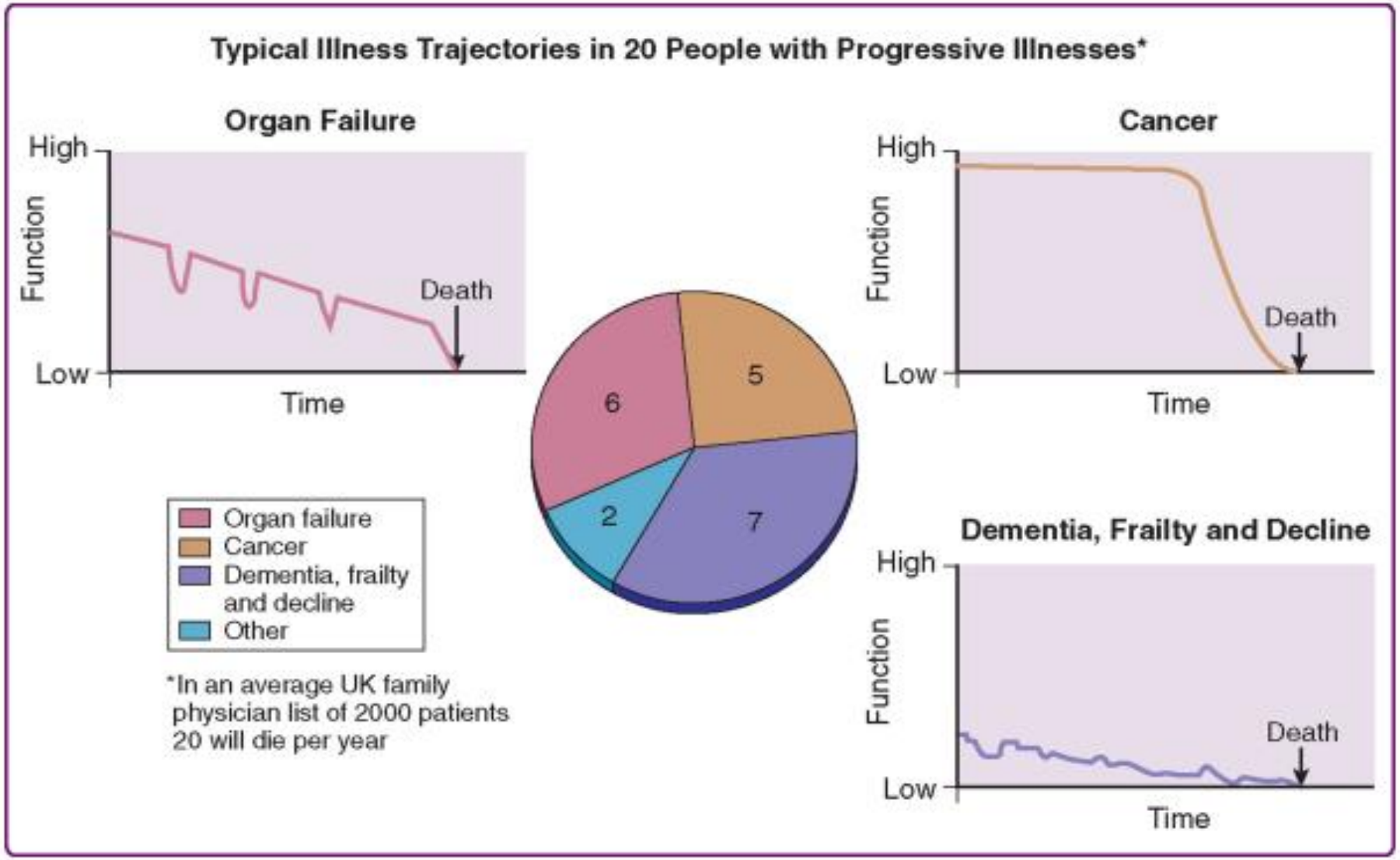
Recognising signs of approaching end of life



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Performance status/Symptoms	Partial score
Palliative Performance Scale	
10–20	4
30–50	2.5
>60	0
Oral Intake	
Mouthfuls or less	2.5
Reduced but more than mouthfuls	1
Normal	0
Edema	
Present	1
Absent	0
Dyspnea at rest	
Present	3.5
Absent	0
Delirium	
Present	4
Absent	0

Scoring

PPI score > 6 = survival shorter than 3 weeks

PPI score >4 = survival shorter than 6 weeks

PPI score $\leq$4 = survival more than 6weeks

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Prognostication

- Rate of deterioration if no intervention gives a guide as to prognosis
  - Deteriorating month by month = months
  - Deteriorating week by week = weeks
  - Deteriorating day by day = days
- An accelerated deterioration should be a trigger for ACP and putting things in place

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Preparing for end of life care

- Should they be dying- ? reversibility
- Where do they want to die vs where can they die?
- What needs to be in place to die at home?
  - ACP including DNACPR
  - Anticipatory prescribing
  - Care and equipment
  - Patient and family expectations
  - Support including out of hours

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Symptom control at the end of life

- Potential symptoms
  - Pain
  - Breathlessness
  - Nausea and vomiting
  - Respiratory secretions (‘death rattle’)
  - Others bespoke to patients situation
    - Bleeding
    - Seizures
- Anticipatory medications: just that, anticipatory ideally
  - Subcutaneous medications administered by nurses for symptom control at the end of life

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Symptom control at the end of life

- Anticipatory medications: 4 A's
  - Analgesic: strong opioid (usually morphine or oxycodone) for pain or breathlessness
  - Antiemetic: common SC options are metoclopramide, cyclizine, haloperidol, levomepromazine
  - Anxiolytic: midazolam for anxiety or agitation
  - Antisecretory: hyoscine hydrobromide for respiratory secretions at the end of life

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Prescribing in palliative care including the 4As

- If you're unsure or unfamiliar with medications check
- Online resources
  - https://www.wales.pallcare.info
  - Look up your local resources
- Friendly local palliative care teams
- Some but not all patients will require a syringe driver to deliver medicines over 24 hours if multiple PRN doses are required or they are no longer able to take regular opioids/anxiolytics/antiemetics

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Case study

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- DM initially had a positive response to chemotherapy, but subsequently progressed and opted out of active anticancer treatment
- Pain was well controlled with a combination of MST, paracetamol and gabapentin
- Nausea was managed with regular pre-meal metoclopramide and PRN oral levomepromazine
- Constipation was managed with regular laxido, titrated to bowels
- Himself and his wife underwent counselling at City Hospice; the children were supported through their education institutions

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- He received PIP and a Macmillan grant as well as accessing the City Hospice free will service to alleviate financial concerns
- As his general condition deteriorated he opted to remain at home for end of life care, which his family supported
- Equipment and a package of care was put in place
- A syringe driver was commenced and titrated during the last days of his life
- He died peacefully at home 8 months after diagnosis

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Take home messages

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- Palliative care has a central role in pancreatic cancer
- Palliative care is everyone's responsibility
- Honest and open conversations between healthcare professionals, patients and families and other healthcare professionals is the cornerstone to good palliative and end of life care
- Think about early ACP, be proactive rather than reactive
- Resources are out there: use them (including friendly palliative care teams!)

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Thank you and any questions?