Managing Difficult Symptoms - Two Different Perspectives?

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Disclosures

- We have no relevant financial relationships.
- This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.
- “NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.”

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

The following CLC & IB components will be addressed in this presentation:

- Underutilization of interpreters for patients with a language barrier.
- Medical professionals' biases when addressing a pain crisis.

Use of Interpreters

- Several articles: ● LEP migrant and refugee families: greater satisfaction with care when a professional interpreter service was used compared with using ad hoc interpreters
  ● professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that for patients without language barriers
  ● LEP patients had worse quality of end-of-life care and goals of care discussions when professional interpreters were not used
- Challenges: ● using an interpreter was perceived as a hindrance, but also needed in communication with healthcare staff and as a guide in the healthcare system
  ● selecting a part-time interpreter with the best service quality and lowest hourly rate makes the scheduling process difficult
  ● arrival of LEP emergency patients must be predicted
- LEP= Limited English Proficiency

1. **Boylen S, Cherian S, Gill FJ, Leslie GD, Wilson S. Impact of professional interpreters on outcomes for hospitalized children from migrant and refugee families with limited English proficiency: a systematic review. JBI Evid Synth. 2020 Jul;18(7):1360-1388. doi: 10.11124/JBISRIR-D-19-00300. PMID: 32813387.**
2. **Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007 Apr;42(2):727-54. doi: 10.1111/j.1475-6773.2006.00629.x. PMID: 17362215; PMCID: PMC1955368.**
3. **Silva MD, Genoff M, Zaballa A, Jewell S, Stabler S, Gany FM, Diamond LC. Interpreting at the End of Life: A Systematic Review of the Impact of Interpreters on the Delivery of Palliative Care Services to Cancer Patients With Limited English Proficiency. J Pain Symptom Manage. 2016 Mar;51(3):569-80. doi:10.1016/j.jpainsymman.2015.10.011. Epub 2015 Nov 5. PMID: 26549596; PMCID: PMC4955824.**
4. **Ahmed A, Frohn E. A predictive and prescriptive analytical framework for scheduling language medical interpreters. Health Care Manag Sci. 2021 Sep;24(3):531-550. doi: 10.1007/s10729-020-09536-y. Epub 2021 Feb 24. PMID: 33629192**
5. **Hadziabdic E, Heikkilä K, Albin B, Hjelm K. Migrants' perceptions of using interpreters in health care. Int Nurs Rev. 2009 Dec;56(4):461-9. doi: 10.1111/j.1466-7657.2009.00738.x. PMID: 19930075.**

Clinicians' Bias

- Several articles: ● "pro-white" unconscious bias in physicians' attitudes toward and interactions with patients (*limited social contact between white physicians and racial/ethnic minorities outside of medical setting*)
  - ● nonwhite patients in ED for abdominal or back pain were less likely than whites to receive analgesia and waited longer for their opiate medication
  - ● oncologists less likely to prescribe opioids to black male patients; PCPs no racial disparities
  - ● female physicians more likely to prescribe opioids for Black than White patients
  - ● opioid analgesics less widely available in pharmacies in minority neighborhood
  - ● no race-based disparity in overall analgesia administration was noted for all three conditions: LBF, migraine, and back pain

- In general, physicians may be under-prescribing opioids for cancer pain.

1. **Mills AM, Shofer FS, Boulis AK, Holena DN, Abbuhl SB. Racial disparity in analgesic treatment for ED patients with abdominal or back pain. Am J Emerg Med. 2011 Sep;29(7):752-6. doi: 10.1016/j.ajem.2010.02.023. Epub 2010 May 1. PMID: 20825892.**
2. **Burgess DJ, Phelan S, Workman M, Hagel E, Nelson DB, Fu SS, Widome R, van Ryn M. The effect of cognitive load and patient race on physicians' decisions to prescribe opioids for chronic low back pain: a randomized trial. Pain Med. 2014 Jun;15(6):965-74. doi: 10.1111/pme.12378. Epub 2014 Feb 7. PMID: 24506332**
3. **Shields CG, Griggs JJ, Fiscella K, Elias CM, Christ SL, Colbert J, Henry SG, Hoh BG, Hunte HER, Marshall M, Mohile SG, Plumb S, Tejani MA, Venuti A, Epstein RM. The Influence of Patient Race and Activation on Pain Management in Advanced Lung Cancer: a Randomized Field Experiment. J Gen Intern Med. 2019 Mar;34(3):435-442. doi: 10.1007/s11606-018-4785-z. Epub 2019 Jan 10. PMID: 30632104; PMCID: PMC6420510.**
4. **James SA. The strangest of all encounters: racial and ethnic discrimination in US health care. Cad Saude Publica. 2017 May 8;33Suppl 1(Suppl 1):e00104416. doi: 10.1590/0102-311X00104416. PMID: 28492707.**
5. **Dickason RM, Chauhan V, Mor A, Ibler E, Kuehnle S, Mahoney D, Armbrecht E, Dalawari P. Racial differences in opiate administration for pain relief at an academic emergency department. West J Emerg Med. 2015 May;16(3):372-80. doi: 10.5811/westjem.2015.3.23893. Epub 2015 Apr 21. PMID: 25987909; PMCID: PMC4427206.**

Clinicians' Bias

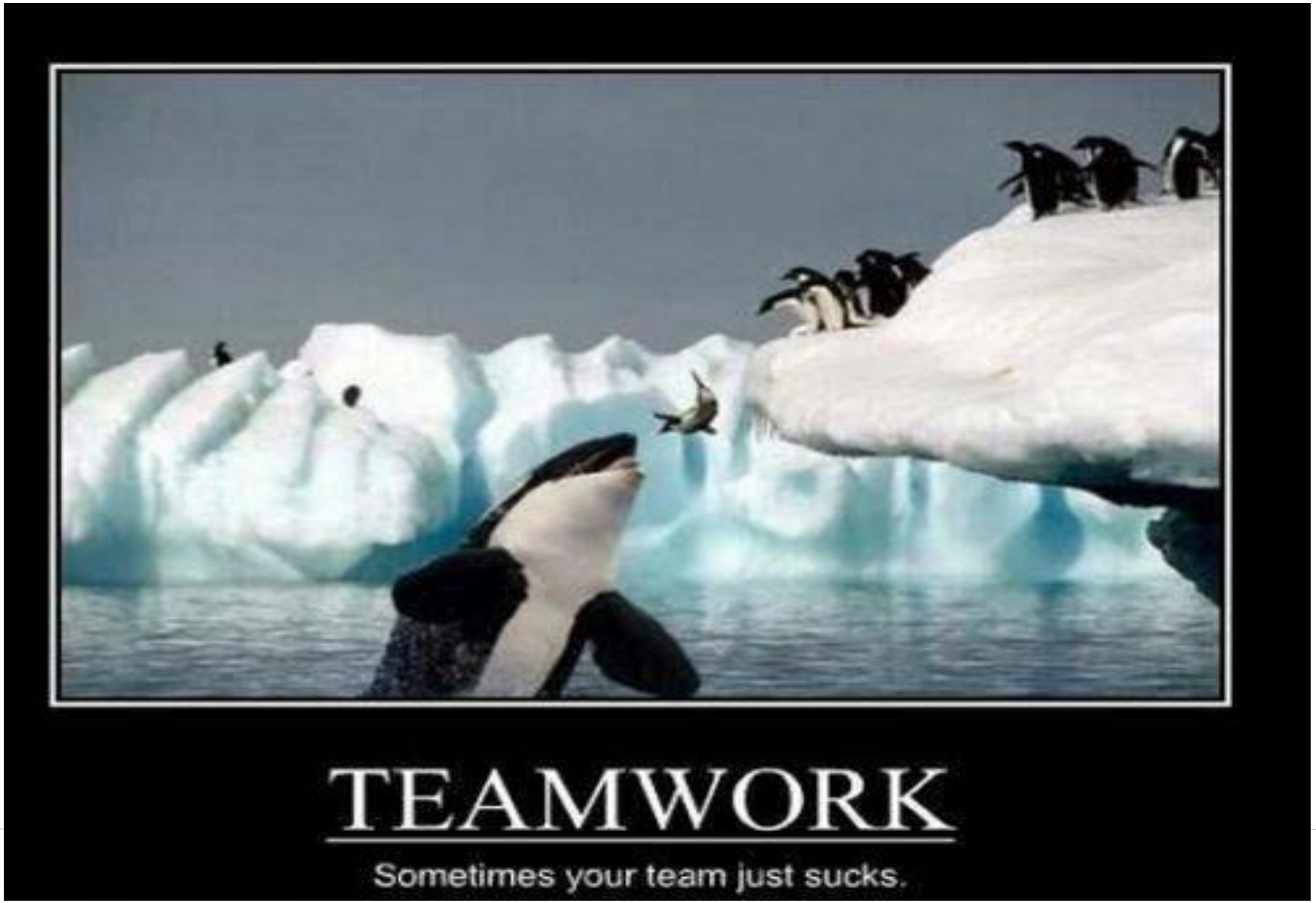
Educate	-Explore our own biases -Be mindful of our own stresses
Expose	-Be open to experience the point of view of the patient -Reflect on why a bias is perceived ie; stereotypes -Evaluate based on personal characteristics rather than affiliated group
Approach	-Embrace the diverse world we live in -Promote organizational level health equity -Cultural humility is a life-long process

Edgoose JYC, Quiogue M, Sidhar K. How to Identify, Understand, and Unlearn Implicit Bias in Patient Care. Fam Pract Manag. 2019 Jul/Aug;26(4):29-33. PMID: 31287266.

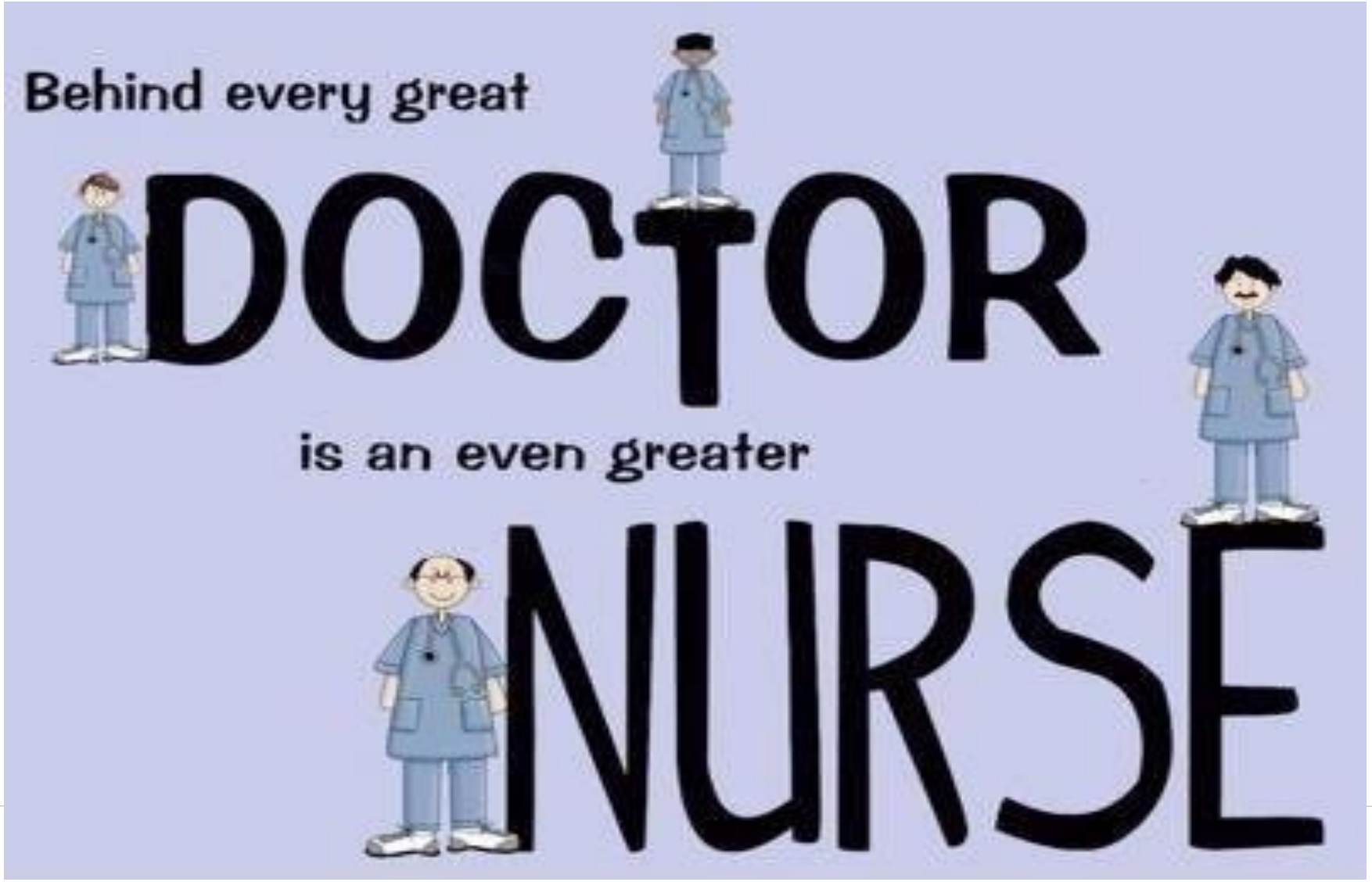
Objectives

- Intractable nausea in cancer patient
- Pain crisis in cancer patient
- CARES tool

NOT Our Objective



Our Objective



Intractable Nausea in Cancer Patients

Refractory / Intractable Nausea - Definition

- Persistence of symptoms despite an appropriate duration of use (e.g., achievement of steady-state concentrations) of at least two scheduled antiemetic agents with different mechanisms of action

Langley-DeGroot M, Ma JD, Hirst J, Roeland EJ. Olanzapine in the treatment of refractory nausea and vomiting: a case report and review of the literature. J Pain Palliat Care Pharmacother. 2015 Jun;29(2):148-52. doi: 10.3109/15360288.2015.1035831. PMID: 26095486.

- Refractory CINV : vomiting and/or nausea occurring after chemotherapy in subsequent chemotherapy cycles after guideline directed prophylactic antiemetic agents have failed in earlier cycles

Navari RM. Treatment of Breakthrough and Refractory Chemotherapy-Induced Nausea and Vomiting. Biomed Res Int. 2015;2015:595894. doi: 10.1155/2015/595894. Epub 2015 Sep 3. PMID: 26421294; PMCID: PMC4573228.

Intractable Nausea - Case Study

- R.P. is a 62 y/o F with history of pancreatic adenocarcinoma who just received second cycle of chemotherapy with last dose being 4 days ago. Patient states that she felt horrible post first cycle; vomiting for 4 days and then took multiple days after to recover just in time for her second cycle

- Oncology dosed patient prior to infusion:
  - Aprepitant 130mg IV x1
  - Odansetron 16mg IV x1
  - Dexamethasone 12mg IV x1
  - Lorazepam 0.5mg IV x1

Intractable Nausea - Case Study

- Two days post infusion, patient was admitted for uncontrolled nausea/vomiting. Nursing attempted ondansetron IV 8mg q 6 hours around the clock, with prochlorperazine as needed

- Ativan was tried but only sedated the patient and did not improve nausea

- Supportive medicine was consulted

Intractable Nausea - Nurse Approach

- Reached out to nutrition for a peppermint scented clip to attach to the patient's gown
- Did a little more digging into the chart to see what patient was given for home use post chemo
- Orders were as follows:

- *Dexamethasone 4mg PO BID x3 days*
- *Olanzapine 5mg qhs*
- *Alternate ondansetron 8mg and prochlorperazine 10mg every 4 hours as well as lorazepam 0.5mg q 6 hours prn.*
- *Patient had IV hydration NS 1 L x1 on day #2, admitted on day #3 post chemo.*

- ***Patient never started recommended orders for post chemotherapy nausea***


AND THEN I SAID,
"THE DOCTOR WILL BE WITH YOU IN A MINUTE!"

CINV & Chemotherapy Emetic Risk

CINV classified as:

- anticipatory
- acute (<24 hours)
- delayed (>24 hours)
- breakthrough
- refractory

- ❑ high (emetic risk >90%)
- ❑ moderate (30%–90%)
- ❑ low (10%–30%)
- ❑ minimal (<10%)

Roila F, Molassiotis A, Herrstedt J, Aapro M, Gralla RJ, Bruera E, Clark-Snow RA, Dupuis LL, Einhorn LH, Feyer P, Hesketh PJ, Jordan K, Olver I, Rapoport BL, Roscoe J, Ruhlmann CH, Walsh D, Warr D, van der Wetering M; participants of the MASCC/ESMO Consensus Conference Copenhagen 2015. 2016 MASCC and ESMO guideline update for the prevention of chemotherapy- and radiotherapy-induced nausea and vomiting and of nausea and vomiting in advanced cancer patients. Ann Oncol. 2016 Sep;27(suppl 5):v119-v133. doi: 10.1093/annonc/mdw270. PMID: 27664248.

Intractable Nausea – ASCO Guidelines

Adult Patients

High-emetic-risk antineoplastic agents

- Adults treated with cisplatin and other high-emetic-risk single agents should be offered a 4-drug combination of an NK_1 receptor antagonist, a serotonin (5-HT_3) receptor antagonist, dexamethasone, and olanzapine (day 1). Dexamethasone and olanzapine should be continued on days 2 to 4 (Type: evidence based, benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).
- Adults treated with an anthracycline combined with cyclophosphamide should be offered a 4-drug combination of an NK_1 receptor antagonist, a 5-HT_3 receptor antagonist, dexamethasone, and olanzapine (day 1). Olanzapine should be continued on days 2 to 4 (Type: evidence based, benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).

Moderate-emetic-risk antineoplastic agents

- Adults treated with carboplatin area under the curve (AUC) $\geq$ 4 mg/mL/min should be offered a 3-drug combination of an NK_1 receptor antagonist, a 5-HT_3 receptor antagonist, and dexamethasone (day 1) (Type: evidence based; benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).
- Adults treated with moderate-emetic-risk antineoplastic agents (excluding carboplatin AUC $\geq$ 4 mg/mL/min) should be offered a 2-drug combination of a 5-HT_3 receptor antagonist and dexamethasone (day 1) (Type: evidence based, benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).
- Adults treated with cyclophosphamide, doxorubicin, oxaliplatin, and other moderate-emetic-risk antineoplastic agents known to cause delayed nausea and vomiting may be offered dexamethasone on days 2 to 3 (Type: informal consensus, benefits outweigh harms; Evidence quality: low; Strength of recommendation: moderate).

Low-emetic-risk antineoplastic agents

- Adults treated with low-emetic-risk antineoplastic agents should be offered a single dose of a 5-HT_3 receptor antagonist or a single 8-mg dose of dexamethasone before antineoplastic treatment (Type: informal consensus, benefits outweigh harms; Evidence quality: low; Strength of recommendation: moderate).

Minimal-emetic-risk antineoplastic agents

- Adults treated with minimal-emetic-risk antineoplastic agents should not be offered routine antiemetic prophylaxis (Type: informal consensus, benefits outweigh harms; Evidence quality: low; Strength of recommendation: moderate).

Hesketh PJ, Kris MG, Basch E, Bohlke K, Barbour SY, Clark-Snow RA, Danso MA, Dennis K, Dupuis LL, Dusetzina SB, Eng C, Feyer PC, Jordan K, Noonan K, Sparacio D, Lyman GH. Antiemetics: ASCO Guideline Update. J Clin Oncol. 2020 Aug 20;38(24):2782-2797. doi: 10.1200/JCO.20.01296. Epub 2020 Jul 13. Erratum in: J Clin Oncol. 2020 Nov 10;38(32):3825. Erratum in: J Clin Oncol. 2021 Jan 1;39(1):96. PMID: 32658626.

Intractable Nausea – ASCO Guidelines

High-dose chemotherapy with stem-cell or bone marrow transplantation

- Adults treated with high-dose chemotherapy and stem-cell or bone marrow transplantation should be offered a 3-drug combination of an NK_1 receptor antagonist, a 5-HT_3 receptor antagonist, and dexamethasone (Type: evidence based, benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).
- (New) A 4-drug combination of an NK_1 receptor antagonist, a 5-HT_3 receptor antagonist, dexamethasone, and olanzapine may be offered to adults treated with high-dose chemotherapy and stem-cell or bone marrow transplantation. (Type: evidence based, benefits outweigh harms; Evidence quality: low; Strength of recommendation: weak).

Multiday antineoplastic therapy

- Adults treated with multiday antineoplastic agents should be offered antiemetics before treatment that are appropriate for the emetic risk of the antineoplastic agent given on each day of the antineoplastic treatment and for 2 days after completion of the antineoplastic regimen (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).
- Adults treated with 4- or 5-day cisplatin regimens should be offered a 3-drug combination of an NK_1 receptor antagonist, a 5-HT_3 receptor antagonist, and dexamethasone (Type: evidence based, benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).

Breakthrough nausea and vomiting

- For patients with breakthrough nausea or vomiting, clinicians should re-evaluate emetic risk, disease status, concurrent illnesses, and medications; and ascertain that the best regimen is being administered for the emetic risk (Type: informal consensus, benefits outweigh harms; Evidence quality: low; Strength of recommendation: moderate).
- Adults who experience nausea or vomiting despite optimal prophylaxis and who did not receive olanzapine prophylactically should be offered olanzapine in addition to continuing the standard antiemetic regimen (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).
- Adults who experience nausea or vomiting despite optimal prophylaxis and who have already received olanzapine may be offered a drug of a different class (eg, an NK1 receptor antagonist, lorazepam or alprazolam, a dopamine receptor antagonist, dronabinol, or nabilone) in addition to continuing the standard antiemetic regimen (Type: informal consensus; benefits outweigh harms; Evidence quality: intermediate for dronabinol and nabilone, low otherwise; Strength of recommendation: moderate).

Anticipatory nausea and vomiting

- All patients should receive the most active antiemetic regimen appropriate for the antineoplastic agents being administered. Clinicians should use such regimens with initial antineoplastic treatment rather than assessing the patient's emetic response with less-effective antiemetic treatment. If a patient experiences anticipatory emesis, clinicians may offer behavioral therapy with systematic desensitization (Type: informal consensus, benefits outweigh harms; Evidence quality: low; Strength of recommendation: moderate).

Hesketh PJ, Kris MG, Basch E, Bohlke K, Barbour SY, Clark-Snow RA, Danso MA, Dennis K, Dupuis LL, Dusetzina SB, Eng C, Feyer PC, Jordan K, Noonan K, Sparacio D, Lyman GH. Antiemetics: ASCO Guideline Update. J Clin Oncol. 2020 Aug 20;38(24):2782-2797. doi: 10.1200/JCO.20.01296. Epub 2020 Jul 13. Erratum in: J Clin Oncol. 2020 Nov 10;38(32):3825. Erratum in: J Clin Oncol. 2021 Jan 1;39(1):96. PMID: 32658626.

PRINCIPLES OF EMESIS CONTROL FOR THE CANCER PATIENT

- Prevention of nausea/vomiting is the goal.
  - The risk of nausea/vomiting (acute ≤24 hours vs. delayed nausea >24 hours) for persons receiving anticancer agents of high and moderate emetic risk lasts for at least 3 days for high and 2 days for moderate after the last dose of anticancer agents. Patients need to be protected throughout the full period of risk.
- Oral and parenteral serotonin receptor antagonists (5-HT3 RAs) have equivalent efficacy when used at the appropriate doses and intervals.
- Consider the toxicity of the specific antiemetic(s). See Pharmacologic Considerations for Antiemetic Prescribing (AE-B).
- Choice of antiemetic(s) used should be based on the emetic risk of the therapy, prior experience with antiemetics, and patient factors. Continuous infusion may make an agent less emetogenic. The emetic risk is expected to be the same for biosimilars as for the parent compound unless otherwise noted.
  - Patient risk factors for anticancer agent-induced nausea/vomiting include:
    - Younger age
    - Female sex
    - Previous history of anticancer agent-induced nausea and vomiting (chemotherapy-induced nausea and vomiting [CINV])
    - Little or no previous alcohol use
    - Prone to motion sickness
    - History of morning sickness during pregnancy
    - Anxiety/high pretreatment expectation of nausea
- There are other potential causes of emesis in patients with cancer. These may include:
  - Partial or complete bowel obstruction
  - Vestibular dysfunction
  - Brain metastases
  - Electrolyte imbalance: hypercalcemia, hyperglycemia, or hyponatremia
  - Uremia
  - Concomitant drug treatments, including opioids
  - Gastroparesis: tumor or chemotherapy (eg, vincristine) induced or other causes (eg, diabetes)
  - Excessive secretions (eg, seen in patients with head and neck cancers)
  - Malignant ascites
  - Psychophysiologic:
    - Anxiety
    - Anticipatory nausea/vomiting
  - Cannabinoid hyperemesis syndrome
  - Rapid opioid withdrawal
  - Pancreatitis
- For uses of antiemetics for nausea/vomiting that are not related to radiation and/or anticancer therapy, see NCCN Guidelines for Palliative Care.
- For multi-drug regimens, select antiemetic therapy based on the drug with the highest emetic risk. See Emetogenic Potential of Parenteral Anticancer Agents (AE-2 and AE-3), and see Emetogenic Potential of Oral Anticancer Agents (AE-7).
- Antiemetic regimens added to a patient's anticancer agents may have a potential risk for drug-drug interactions. However, no clinically significant drug-drug interactions have emerged to date in randomized clinical trials of anticancer agents with antiemetics. The panel feels, given a short duration of use (<4 days; not chronic use) of these prophylactic antiemetic regimens, they would not result in clinically relevant interactions with anticancer agents. However, in all situations where medications are prescribed, clinicians must balance the benefit and risk for each patient.
- Consider using an H_2 blocker or proton pump inhibitor to prevent dyspepsia, which can mimic nausea.
- Lifestyle measures may help to alleviate nausea/vomiting, such as eating small frequent meals, choosing healthful foods, controlling the amount of food consumed, and eating food at room temperature. A dietary consult may also be useful. See NCI's "Eating Hints: Before, During, and After Cancer Treatment" (https://www.cancer.gov/publications/patient-education/eating-hints).
- While anticancer agents or radiation therapy-induced nausea and vomiting can significantly impact a patient's quality of life and lead to poor outcomes, providers must be aware of the potential for the overuse of prophylactic antiemetics, especially for anticancer therapy with minimal and low emetic risks, which may expose the patient to potential adverse effects from antiemetic drugs and pose an undue economic burden. Guideline adherence is always encouraged.
- When planning an anti-emetic regimen, the health literacy of the patient must be considered, taking into account sociocultural differences. Effective provider-patient communication may improve patient satisfaction, compliance, safety, and outcomes. Clinicians need to identify language and literacy barriers and provide appropriate resources (eg, printed material, medication calendars, interpreter services) to help whenever possible.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Cancer Pain / Pain Crisis

Cancer Pain - Definition

An unpleasant sensory and emotional experience associated with actual or potential tissue injury or described in terms of such damage

Association for the Study of Pain

The most common reason people seek medical attention

Cancer Pain - Prevalence

- Meta-analysis: 39% in cancer survivors post treatment
  55% when receiving anticancer therapy
  66% with metastatic disease or at the end of life

- ESMO: > 70% in the advanced stage of disease
  33% in patients after curative treatment
  59% in patients on anticancer treatment
  64% in patients with metastatic, advanced or terminal disease

- NCCN: 59% of patients undergoing cancer treatment
  64% of patients with advanced disease
  33% of patients after curative treatment

Fink RM, Gallagher E. Cancer Pain Assessment and Measurement. Semin Oncol Nurs. 2019 Jun;35(3):229-234. doi: 10.1016/j.soncn.2019.04.003. Epub 2019 Apr 26. PMID: 31036386.
Fallon M, Giusti R, Aielli F, Hoskin P, Rolke R, Sharma M, Ripamonti CI; ESMO Guidelines Committee. Management of cancer pain in adult patients: ESMO Clinical Practice Guidelines. Ann Oncol. 2018 Oct 1;29(Suppl 4):iv166-iv191. doi: 10.1093/annonc/mdy152. PMID: 30052758.

Pain Crisis - Definition

- An event in which the patient reports severe, uncontrolled pain that is causing the patient, family, or both severe distress
- The pain may be acute in onset or may have progressed gradually to an intolerable threshold (as determined by the patient), but requires immediate intervention

Moryl N, Coyle N, Foley KM. Managing an acute pain crisis in a patient with advanced cancer: "this is as much of a crisis as a code". JAMA. 2008 Mar 26;299(12):1457-67. doi: 10.1001/jama.299.12.1457. Erratum in: JAMA. 2008 May 14;299(18):2150. Dosage error in article text. Erratum in: JAMA. 2009 Mar 25;301(12):1230. Dosage error in article text. PMID: 18364488.

Pain Crisis – Case Study

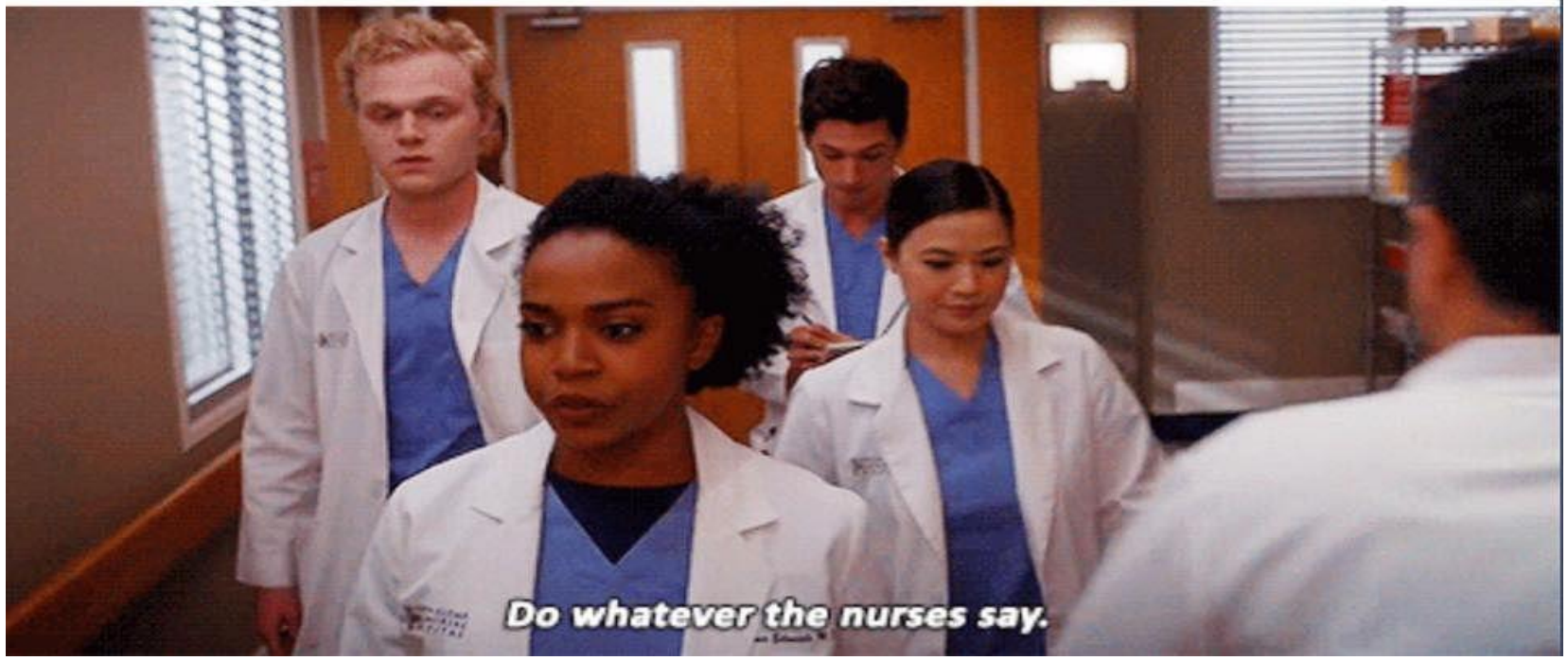
- R.P has been without nausea/vomiting for 3 days. Patient now is experiencing increased abdominal pain that radiates to the mid back and feels like a constant stabbing sensation.
- Nursing administered oral Morphine IR 15 mg every 3 hours as needed for breakthrough pain for the last 24 hours without relief.
- Patient was then given morphine 4mg IV x1 but calls the nurse 15 minutes later stating that she has had no relief and the pain feels like it is worsening.

- How do we assess and treat the patient?

Pain Crisis – Nurse Approach

- Hot packs were placed on the lower abdomen and back to help ease the radiating pain.
- Patient's favorite music was played in the background to help with distraction.
- Diclofenac gel 1% was offered to patient to apply to the mid back.
- Nursing insisted to have Supportive Medicine consulted to better treat the patient's pain.


Alright, I have 3 rules. One, listen to the nurses. Respect the nurses.


Do whatever the nurses say.

Pain Crisis - Assessment

- Believe the patient's complaint of pain.
- Take a careful history of each pain complaint.
- Assess the characteristics of each pain.
- Clarify the temporal aspects of the pain.
- Clarify the response to previous and current analgesic therapies to guide therapy.
- Evaluate the psychological state of the patient.
- Ask whether the patient has a past history of alcohol or drug dependence.
- Perform a careful medical and neurological examination.
- Treat the patient's pain at the same time as determining the etiology of the pain exacerbation.
- Provide continuous monitoring and support of the patient and family until the pain is brought under control.
- Continuously reassess the patient's response to pain therapy.
- Continuously document drug doses administered, patient response, and reasons for dose escalation.
- Talk to the dying patient's family about what to expect during the dying process

Moryl N, Coyle N, Foley KM. Managing an acute pain crisis in a patient with advanced cancer: "this is as much of a crisis as a code". JAMA. 2008 Mar 26;299(12):1457-67. doi: 10.1001/jama.299.12.1457. Erratum in: JAMA. 2008 May 14;299(18):2150. Dosage error in article text. Erratum in: JAMA. 2009 Mar 25;301(12):1230. Dosage error in article text. PMID: 18364488.

Pain Crisis - Management

Patients Who Have Inadequate Pain Relief and No Significant Opioid Adverse Effects

- Continue the current opioid and use rescue doses for titration.
- If taking an oral opioid, convert the patient's rescue dose to an intravenous equivalent using relative potency tables.
- Administer double the rescue dose intravenously.
- Repeat same dose in 15 minutes if there is no or minimal pain relief.
- If pain persists at 7 or higher on a 10-point scale without adverse effects, increase the intravenous rescue dose by 50%.
- Continue to administer this dose every 15 minutes until patient experiences more than 50% pain relief or adverse effects develop.
- Consider intravenous adjuvants or co-analgesics.
- Once the patient has obtained adequate pain relief, calculate the new 24-hour opioid requirements including rescue doses and order accordingly.
- Decide route of opioid administration best suited to the patient's ongoing analgesic needs and adjust dose accordingly.

Moryl N, Coyle N, Foley KM. Managing an acute pain crisis in a patient with advanced cancer: "this is as much of a crisis as a code". JAMA. 2008 Mar 26;299(12):1457-67. doi: 10.1001/jama.299.12.1457. Erratum in: JAMA. 2008 May 14;299(18):2150. Dosage error in article text. Erratum in: JAMA. 2009 Mar 25;301(12):1230. Dosage error in article text. PMID: 18364488.

Pain Crisis - Management

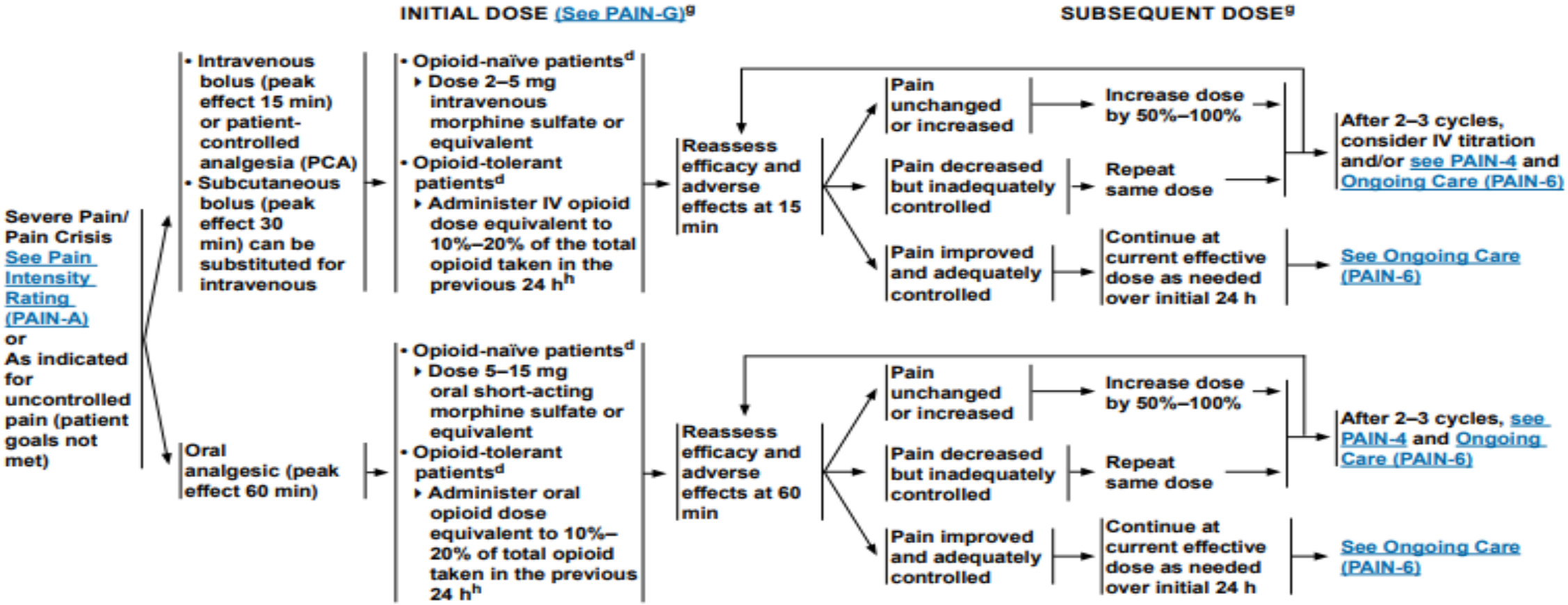
Patients Who Have Significant Opioid Adverse Effects

- Discontinue the current opioid and rotate the patient to a different opioid (opioid rotation).
- Refer to the equianalgesic tables.
- If the pain control is good but significant adverse effects are present, reduce the equianalgesic dose of the new opioid by 25% to 50% (accommodates for cross-tolerance); continue to monitor the patient for reduction in adverse effects and adequacy of pain relief; and provide for rescue doses for breakthrough pain.
- If pain control is poor and significant adverse effects are present, rotate opioids without reduction in the equianalgesic dose; continue to monitor the patient for reduction in adverse effects and adequacy of pain relief; and provide for rescue doses.
- For opioid-tolerant patients, estimate the safe starting dose of the new opioid depending on the patient's tolerance (the higher the previous opioid dose, the greater the level of tolerance).
- In all situations of opioid rotation, monitor the patient closely for adequacy of pain relief and reduction of adverse effects.

Moryl N, Coyle N, Foley KM. Managing an acute pain crisis in a patient with advanced cancer: "this is as much of a crisis as a code". JAMA. 2008 Mar 26;299(12):1457-67. doi: 10.1001/jama.299.12.1457. Erratum in: JAMA. 2008 May 14;299(18):2150. Dosage error in article text. Erratum in: JAMA. 2009 Mar 25;301(12):1230. Dosage error in article text. PMID: 18364488.

MANAGEMENT OF PAIN CRISIS

Monitor for acute and chronic adverse effects. See Management of Opioid Adverse Effects (PAIN-H)



[d] Opioid-naïve patients are those not chronically receiving opioid analgesic on a daily basis and therefore have not developed significant tolerance. Opioid tolerant includes patients who are chronically receiving opioid analgesic on a daily basis. The FDA identifies tolerance as receiving at least 25 mcg/h fentanyl patch, at least 60 mg of morphine daily, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydomorphone daily, or an equianalgesic dose of another opioid for a week or longer.

[g] Dose and titrate with caution in patients with risk factors such as decreased renal/hepatic function, chronic lung disease, upper airway compromise, sleep apnea, and poor performance status.

[h] Not including transmucosal fentanyl dose.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

CARES TOOL
Addressing symptoms at the end of life

C.A.R.E.S. Tool

- "There are worse things than having someone you love die. Most basic, there is having the person you love die badly, suffering as he or she dies. Worse still is realizing later on that much of his or her suffering was unnecessary."

Byock, I. (2012). The best care possible: A physician's quest to transform care through end of life. New York, NY: Avery

C.A.R.E.S. Tool

C	**Comfort**	**- Pain and suffering is the greatest fear for any dying patient and his / her family. - Comfort must be provided holistically and should not only focus on pain management, but also include reducing anxiety, stress, and interruptions to allow closure. - Terminal pain / pain during dying is best managed by around the clock, scheduled or a continuous infusion of opioids and additional doses (boluses) given as needed for breakthrough pain. - Discontinue unnecessary tests and activities that will not be treated and will reduce time for closure. - There are no dosage limits. Titrate to effect.**
A	**Airway**	**- Support airways and declining respiratory function. - Educate family regarding the normal process of dying and breathing patterns of the dying versus suffering. - The use of supplemental oxygen during the dying process is often ineffective but may help to minimize the family's fears of their loved one suffering. - Consider use of anticholinergics, anxiolytics, or opioids.**
R	**Restlessness (terminal delirium)**	**- Nearly 90% incidence of terminal or restless delirium in actively dying patients. - Provide education for the family on methods to minimize agitation and anxiety. - Consider the use of anxiolytics or antipsychotics.**
E	**Emotions**	**- Support the emotional and spiritual management requirements of the dying through conversation, touch, and celebration of the individual's life. - Remember every family is unique and grieves differently. - Support rituals and assist with obtaining desired clergy or equipment. - Your humanity is needed the most now. Always be available.**
S	**Self-care**	**- Emphasized for the healthcare providers. - Address issues of moral distress, burn-out, and compassion fatigue. - The need to communicate and seek out personal and professional meaning is encouraged, as is the acceptance of professional grieving, and reframing the sense of failure.**

B Freeman - CARES: An Acronym Organized Tool for the Care of the Dying - Journal of Hospice & Palliative Nursing: May 2013, Vol. 15, Issue 3, p 147-153

C.A.R.E.S. Tool

- *Do not believe the pedestal you were placed upon*
- *A power greater than you will decide your patient's fate*
- *Do not equate death with failure.*
- *Take comfort in knowing you did your very best*
- *Learn to celebrate the journey.*

- *Review your day and give yourself quiet time.*
  - *Recognize parallels that lead to over-identification*
  - *Identify unresolved grief.*
  - *Challenge yourself to understand why the event/situation was so upsetting.*
- *Stay in the present*
- *Eat healthy, get rest and try to exercise.*

- *Make laughter and joy daily parts of your life.*
- *Identify some meaning or growth from the experience*
- *Do not fear professional grieving, for it is when the heart is most broken that we are the most open to change and personal growth.*

Freeman, B. (2012). A tool for the care of the dying. Cares tool booklet

C.A.R.E.S. Tool

- File: 20000-NEW-2874 CARES Program_CARES-NURSES_FINAL ~ Salesforce - Unlimited Edition

Thank You ! Questions ?