



THE INSTITUTE FOR
PALLIATIVE MEDICINE
at San Diego Hospice

PAL-MED CONNECT HOTLINE 1-877-PAL-MED4 1-877-725-6334

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Challenging Symptoms? Expert Advice.

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PALLIATIVE MEDICINE
RESOURCE HOTLINE

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Do you have patients suffering from advanced illnesses and want to provide them relief from pain and other uncomfortable symptoms?

Here are a few palliative care cases received through the **PAL-MED CONNECT Hotline 1-877-PAL-MED4**. This is a grant funded hotline that provides information, education and resources to healthcare providers whenever they have any questions on palliative care. Healthcare providers can speak directly with a palliative medicine expert. The hotline is available 24/7 and is free to call.

Also featured is an article on Palliative Care Education.

Case #1: Severe Abdominal Pain



Vignette:

A 71 year old man with metastatic colon cancer describes his abdominal pain as a sensation of hot and cold for the last several months. He has such discomfort that he stabbed himself in the chest with a knife in an attempt to alleviate the sensation. He is currently being treated with a fentanyl patch that was recently increased from 25 mcg to 50 mcg. He had previously received gabapentin but it caused him to be confused and was discontinued. What else can be done to treat this man's pain?

Discussion:

This patient has neuropathic pain. His primary physician found the diagnosis challenging because the patient spoke of uncomfortable sensations instead of using the word pain. This is a common feature of neuropathic pain. Recommended removal of fentanyl patch and initiating morphine, in order to facilitate rapid titration and dose finding. Rapid titration of morphine will often provide relief within 24-48 hours. Conversion to methadone after a stable dose of morphine has been established may be an effective long-term treatment plan for the likely mixed



neuropathic/nociceptive pain. Dexamethasone would also be an option beginning with 20mg daily for 3 days as an adjuvant analgesic. If effective in pain management, dexamethasone can be tapered to lowest dose necessary to control pain. A trial of pregabalin in combination with the other drugs as an adjuvant analgesic could also be considered.

Case #2: Bowel Obstruction



Vignette:

A 76 year-old woman with colon cancer and recent small bowel obstruction refuses hospitalization for symptoms consistent with recurrent obstruction and wishes to remain at home. The patient is vomiting feculent smelling material which is distressing to the patient and family. Can anything be done to help?

Discussion:

There are several medical treatment options for small bowel obstruction. Octreotide, an analog of somatostatin, reduces the secretion of fluids in the intestines and pancreas. Octreotide can be started at 100 mcg SQ every 8 hours and titrated to 2400 mcg daily. A subcutaneous infusion of antiemetic drugs could also be initiated. The choice of drugs is customized and may contain a mixture of different medications such as Dexamethasone 5-20 mg; Famotidine 40 mg; Haloperidol 5-20 mg; Metoclopramide 40-120 mg; Diphenhydramine 25-100 mg and Octreotide. These medications can be mixed together in normal saline to make a 60 ml volume and run over a 24 hour period.

Case #3: Delirium



Vignette:

60 year old man with history of esophageal cancer was doing well until a stent in his esophagus became dislodged and fell into his stomach. Following surgery to remove the stent, patient had complications and ended up in the ICU for 6 weeks when he suddenly developed delirium. He began climbing out of bed, pulling out his NG tube and is now in restraints. What is the best way to treat delirium in an acute hospital setting?

Discussion:

Delirium is distressing for patients and everyone involved. This is a particularly difficult situation for the caregivers who have watched this patient deteriorate. Recommend discussion of goals of care between the



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various physicians involved and the family members of the patient. Consider a palliative care psychiatric consult as well to help sort out the issues. Delirium is a medical condition and requires skill in diagnosis and treatment. If delirium is reversible, treat the underlying cause while administering psychotropic drugs to manage the behavior. For this patient at risk to himself and others, haloperidol 5mg SC to start and 1-5mg SC q 1hr until settled would be standard. If sedation is desired, chlorpromazine 100mg IVPB over 20 min q 1hr until settled, then q 6hr is an alternative.

If delirium is not reversible, then controlling his behavior with benzodiazepines and antipsychotics until death is indicated.

Featured Article: Palliative Care Education

Palliative Care Education: Focusing on Care and Not Just Disease *Source: National Cancer Institute, NCI Bulletin, March 23, 2010, Volume 7, Number 6*

At the InstitutInstitute for Palliative At [The Institute for Palliative Medicine \(IPM\)](#) in San Diego, residents are training for one of the most essential aspects of medicine: caring for seriously ill patients.

"The goal is to teach them the [core competencies](#) in palliative care," explained Dr. Charles von Gunten, the Institute's provost. "These competencies include pain management, effective communication skills, and the ability to provide patients with psychosocial and spiritual assessments and to work in interdisciplinary teams in hospitals, as well as with hospices and in nursing homes."

The Institute was formed in 1989, when national data showed that patients rated doctors poorly in communications skills and end-of-life care. The need for palliative care, as part of comprehensive medical care, has generally been overlooked in the problem-oriented approach that dominates the practice of medicine, he explained, one in which doctors make a list of patients' problems and try to solve each of them. [For full article, click here.](#)

For further information...

For palliative care questions contact **PAL-MED CONNECT** at **1-877-PAL-MED4 (1-877-725-6334)** or check out the website at www.palmedconnect.org.