Palliative Medicine &
Head and Neck Cancer

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No Relevant Financial Relationships with Commercial Interests

No Conflicts of Interest

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Learning Objectives

- Define Palliative Medicine
- List the unique symptom management needs of patients with H&N CA
- Describe the unique nature of pain management for pts with H&N CA
- Gain an increased appreciation for the patients illness perspective
What is Palliative Care?

- A philosophy of care and a multi-disciplinary system for delivering care.
  - Can be combined with life-prolonging treatment or can be the main focus of care (Hospice).

- Physical, psychological, spiritual, and practical burdens of illness addressed.

- Goals:
  - Prevent and relieve suffering
  - Enhance quality of life for patients & family
  - Assist with decision-making

National Consensus Project for Quality Palliative Care
www.nationalconsensusproject.org
# Hospice vs. Palliative Care

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Palliative Care</th>
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<tbody>
<tr>
<td>Px of 6 mo or less</td>
<td>Any time during illness</td>
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<tr>
<td>Focus on comfort care</td>
<td>May be combined with curative care</td>
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<tr>
<td>Medicare hospice benefit</td>
<td>Independent of payer</td>
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<td>Complimentary therapies</td>
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</table>
Traditional View of Illness

- Diagnosis
- Curative Treatments
- 6m
- Hospice
- Bereavement Care
- Institute of Medicine
Trajectory View of Illness

Curative Treatments

Hospice Appropriate

Actively Dying

Diagnosis

6m

Palliative Medicine
(relieve suffering, improve quality of life)

Death

Bereavement Care
Case: Mr. H

- 62 y/o divorced M
- Truck driver
- Hx of heavy EtOH & cigarette use
- PMHx: COPD, CAD, DM2 and depression
- “Lost-to-follow-up” after surgery for SCC of right tonsil 4 mo ago
- New pain and trismus
- Planned surgery includes placement of trach and peg
Comprehensive Palliative Assessment

Dame Saunders’ concept of “Total Pain and Suffering”

4 domains:

1) Physical Pain
2) Psychologic Pain
3) Social Pain
4) Existential or Spiritual Pain
Unique needs of Pts with H&N CA

- Blame & judgment
- Body image, disfigurement
- Communication
- Nutrition/wt loss
- Intimacy
- Depression
- Anxiety
- Inability to eat
- Dependence
- Pain
- Mucositis
- Odynophagia
- Dysphagia
- Loss of taste, smell
- Radiation burns, contractures, dermatitis
- Xerostomia / Sialorrhea
- Relapsing/remitting course
Case: Mr. H and suffering

- 62 y/o divorced M
- Truck driver
- Hx of heavy EtOH & cigarette use
- “Lost-to-follow-up”
- h/o Depression
- New pain and trismus
- Support system?
- PEG feeds & traveling?
- Withdrawal? Inc. opioid needs
- Compliance issues?
- Pain treatment options
- Pain Rx & driving?
Pre-operative Evaluation

- What is nature of pts support system?
- PT/OT/SLP/Nutrition evals?
- Do you discuss advance directives?
What I Evaluate

- What is the current code status?
- What is the patient’s support system?
- What is the patient’s functional status now?
- What have the last 6 months been like?
- What is prognosis for the next three?
- What issues have been identified?
- Has the patient been given all options?
- Who is the person behind the disease?
Comprehensive Palliative Assessment:

- Systematic ROS like other disciplines
  - Inventories:
    - Edmonton System Assessment System
    - Memorial Symptom Assessment Scale – Short Form
- Broader view of “symptoms”
- Goal is to relieve suffering and pain
  - DDX of suffering and pain
  - Dame Cicely Saunders’ concept of “Total Pain”
Causes of Suffering at EOL
If you don’t ask, you won’t know:

- Pain
- Dyspnea
- Nausea/vomiting
- Weakness & fatigue
- Insomnia
- Anorexia +/- cachexia
- Incontinence
- Constipation
- Agitation/Delirium
- Anxiety
- Depression

- Sense of well-being
- Uncertainty about future
- Fear of disability
- Fear of death
- Hopelessness
- Remorse
- Loneliness
- Loss of
  - Meaning/Role
  - Control
  - Dignity
  - Autonomy
Case: Mr. H

- PMHx of COPD, CAD, DM2 and depression
- RX:
  - Combivent PRN
  - Plavix
  - Aspirin
  - Metoprolol XL
  - Percocet
  - Lantus insulin

What other information would you like to know about the Percocet?
Patients taking greater than what daily dose are at risk of withdrawal with abrupt cessation?

A. 30 mg oral morphine equivalents / 24 hours
B. 60 mg oral morphine equivalents / 24 hours
C. 90 mg oral morphine equivalents / 24 hours
D. Any dose if stopped abruptly creates withdrawal
Case: Mr. H

- Surgery & post-op uneventful
- No residual from PEG
- Wound care needs: PEG, Trach, surgery
- Trach care
- Pain controlled on Kadien granules and gabapentin elixir with Morphine 2mg IV q3hr PRN
Case: Mr. H: Discharge

- What “home” environment will promote healing and compliance?
  - Pt moves in with son and his wife
- Wound care
- Trach care
- Feedings and medication administration
- Blood sugar measurements
- “Resume home medications”
Case: Mr. H

- **Home Meds:**
  - Combivent PRN
  - Plavix
  - Aspirin
  - Metoprolol XL
  - Percocet
  - Lantus insulin

- **Hospital Meds:**
  - Duoned q6h prn
  - Metoporolol IV
  - Lantus + SSI
  - Kadien
  - Gabapentin Elixir
  - Morphine 2mg IV prn
  - Miralax daily
**Unique needs of Pts with H&N CA**

- Blame & judgment
- Body image, disfigurement
- Communication
- Nutrition/wt loss
- Intimacy
- Depression
- Anxiety
- Inability to eat
- Dependence

- Pain
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- Xerostomia / Sialorrhea
- Relapsing/remitting course
Sialorrhea/Xerostomia

- **Sialorrhea**
  - SLP training
  - Anti-cholinergics: hyoscyamine, glycopyrrolate
    - Caution in older adults: delirium, orthostasis, urinary retention, constipation

- **Xerostomia**
  - Ice chips, sugar-free lozenges, artificial saliva
  - Worsened by medications: opioids, TCAs, urinary meds
  - Pilocarpine
    - SEs = sweating, rhinorrhea, urinary frequency
Radiation Side Effects

- **Mucositis**
  - Begins 10-14d after radiation tx starts; ends 4-6 wks after radiation ends
  - Limited options for prevention or tx
  - Topical vs systemic pain relief
  - Gelclair
Nutritional issues

- Dysphagia & Odynophagia
- Logistics & Mechanics of tube-feedings
  - Dexterity
  - Privacy
  - Companionship
  - Bolus vs continuous
  - Tied to home
- Eating is a major social, cultural and religious ritual in society and pts cannot participate
- Going out to dinner not an option
Communication

- Reduced speech intelligibility
- Intonation/emotion
- Breathing and speech
- Hoarse
  - Prank phone calls
- Assistive devices
- Ease of phone vs person to person communication
Psychosocial Symptoms

- Guilt and self-blame
  - Effect on self and family
- Body Image: Appearance, function
  - Facial disfigurement causes many not to leave their homes which can be a burden to family
- Depression/anxiety
- Intimacy
- Fear of recurrence
  - Warranted, given statistics on relapse
Probative question

- Do you worry that every pain or discomfort means the cancer is back?
- What role has the illness taken on your relationship?
- Are you finding it difficult to eat out in public?
- How are you handling the changes imposed by the cancer on your social life or your religious practices?
Pain Management Pointers

- Neuropathic vs somatic pain
- Route of administration, formulation
- Long-acting options with dysphagia
- Prevent withdrawal post-op
# Types of Pain

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<tr>
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<th>Key Features</th>
<th>Examples</th>
<th>Visual mnemonic</th>
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<tbody>
<tr>
<td><strong>Somatic</strong></td>
<td>* Well localized</td>
<td>• Bone metastases</td>
<td><img src="image" alt="Somatic Pain" /></td>
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<tr>
<td></td>
<td>* Aching, often constant</td>
<td>• Osteoarthritis</td>
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<td></td>
<td>* May be dull or sharp</td>
<td>• Soft tissue pain</td>
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<tr>
<td></td>
<td>* Often worse with movement</td>
<td>• Post-op pain</td>
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<tr>
<td><strong>Visceral</strong></td>
<td>* Poorly localized</td>
<td>• Liver or lung tumors</td>
<td><img src="image" alt="Visceral Pain" /></td>
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<tr>
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<td>* Squeezing, achy quality</td>
<td>• Pancreatic dz or cancer</td>
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<td>* Constant or cramping</td>
<td>• Small bowel obstruction</td>
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<td></td>
<td>* Sometimes referred</td>
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<tr>
<td><strong>Neuropathic</strong></td>
<td>* Burning, numbness, tingling, itching</td>
<td>• Post-mastectomy pain</td>
<td><img src="image" alt="Neuropathic Pain" /></td>
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<tr>
<td></td>
<td>* Stabbing, shooting, lancinating, electric</td>
<td>• Post-thorocotomy pain</td>
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<td></td>
<td></td>
<td>• Diabetic neuropathy</td>
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<td>• Phantom pain</td>
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<td>• Shingles/Herpes zoster</td>
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Pain Management Pointers

- Elixir: Morphine, oxycodone, oxycodone/APAP, methadone
- Long-acting PEG options: methadone, Kadien®
- Neuropathic: Neurontin elixir 250 mg/5cc
  - Tegretol, Depakote elixirs

- Don’t forget Constipation!
Let’s Talk about Addiction

- Tolerance
- Physical Dependence

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Addiction / Psychological Dependence
End-of-life Issues

- Nutrition and hydration
  - Edema, pulmonary congestion, nausea & vomiting
- “Carotid Blowout”
- Hospice Care
  - Not all hospices are the same
Thank you for listening!

Questions?