Palliative Medicine & Head and Neck Cancer

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Disclosures

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

Hospice vs. Palliative Care

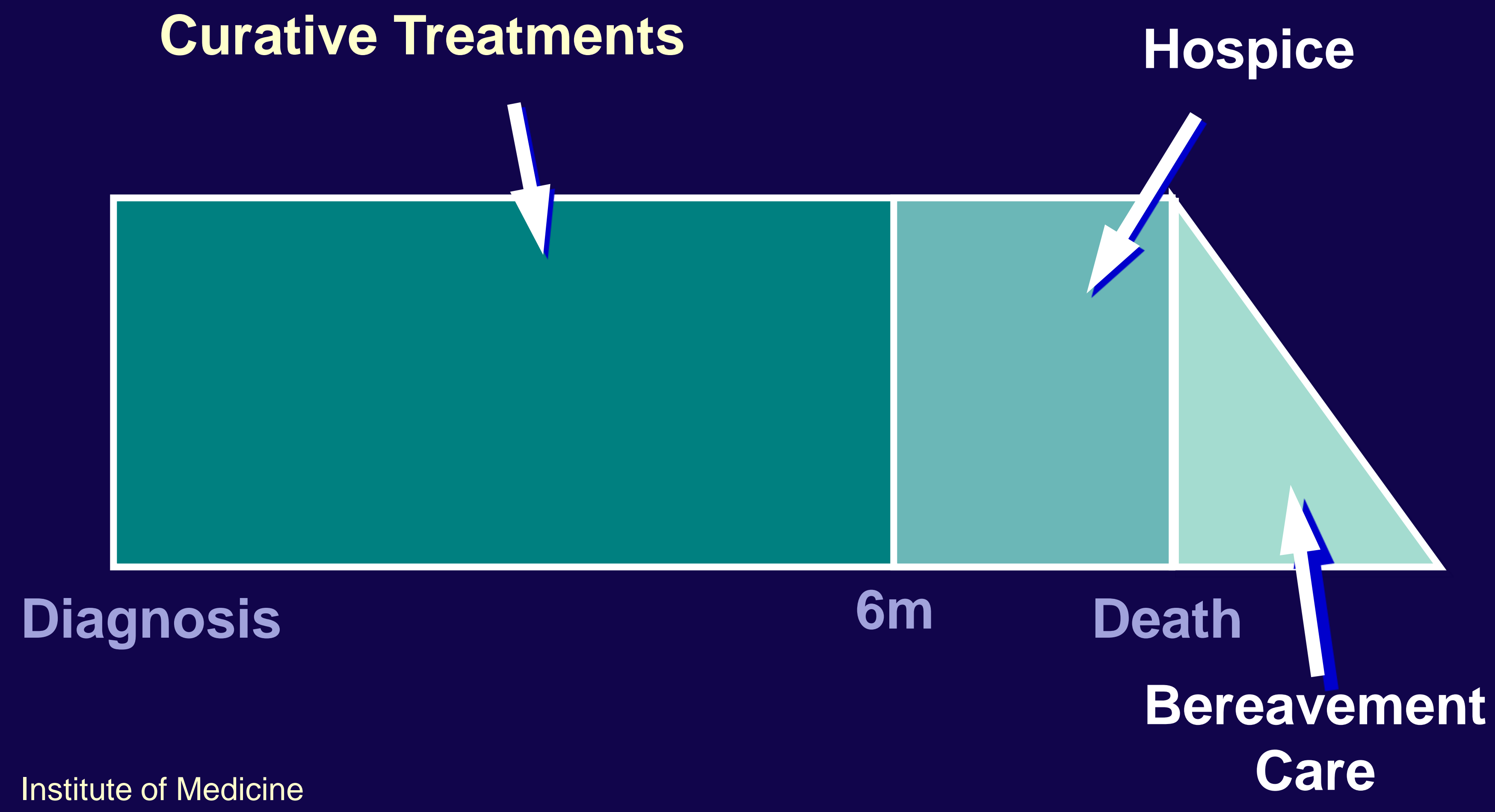
<u>Hospice</u>

- Px of 6 mo or less
- Focus on comfort care
- Medicare hospice benefit

<u>Palliative Care</u>

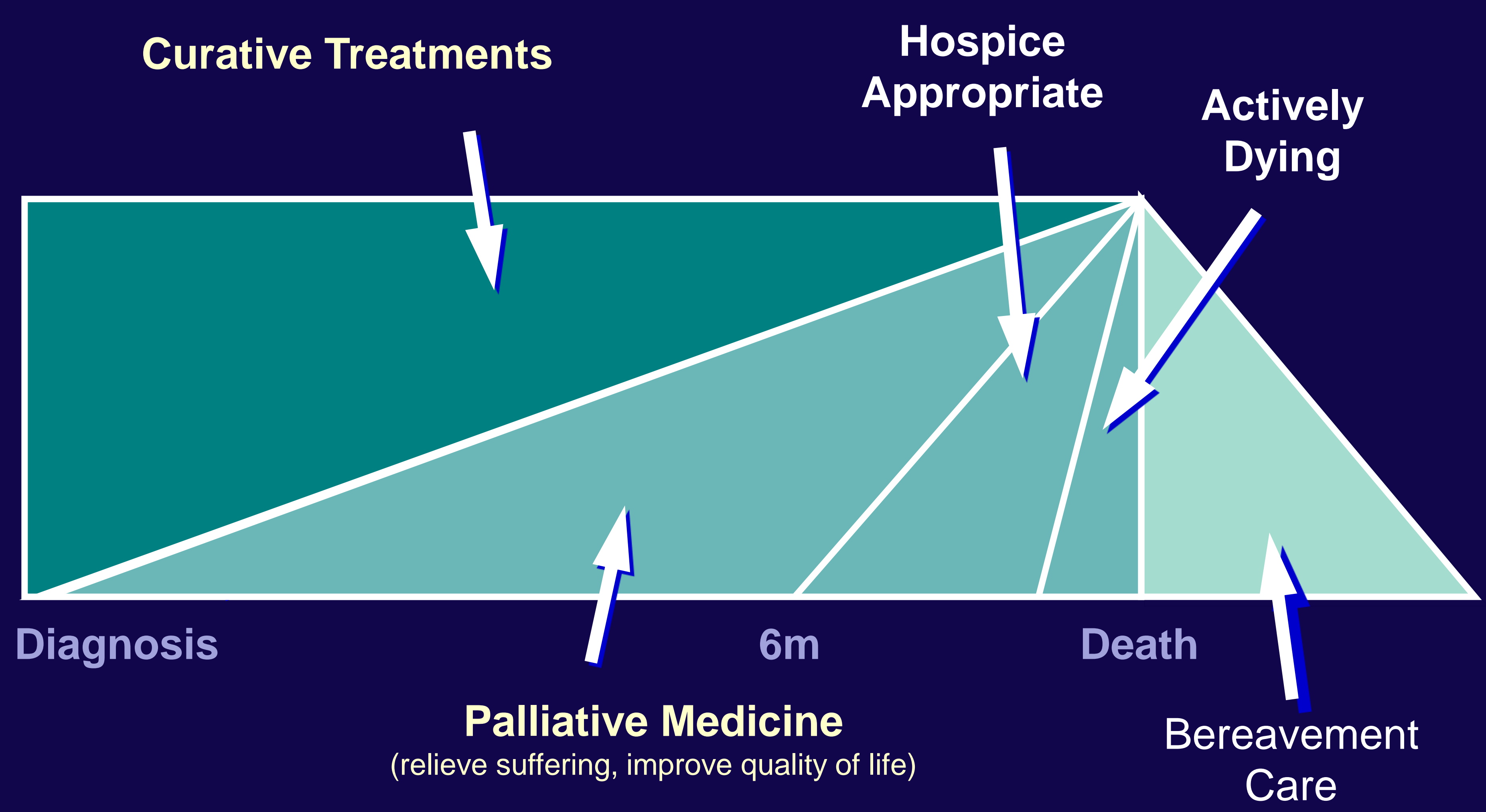
- Any time during illness
- May be combined with curative care
- Independent of payer
- Complimentary therapies

Traditional View of Illness



Institute of Medicine

Trajectory View of Illness



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?

Pain Management Pointer

? 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
  - Metoporol IV
  - Lantus + SSI
  - Kadien
  - Gabapentin Elixir
  - Morphine 2mg IV prn
  - Miralax daily

Unique needs of Pts with H&N CA

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- Nutrition/wt loss
- Intimacy
- Depression
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- Inability to eat
- Dependence
- Pain
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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

	Key Features	Examples	Visual mnemonic
Somatic	* Well localized * Aching, often constant * May be dull or sharp * Often worse with movement	▪Bone metastases ▪Osteoarthritis ▪Soft tissue pain ▪Post-op pain	
Visceral	* Poorly localized * Squeezing, achy quality * Constant or cramping * Sometimes referred	▪Liver or lung tumors ▪Pancreatic dz or cancer ▪Small bowel obstruction	
Neuropathic	* Burning, numbness, tingling, itching * Stabbing, shooting, lancinating, electric	▪Post-mastectomy pain ▪Post-thorocotomy pain ▪Diabetic neuropathy ▪Phantom pain ▪Shingles/Herpes zoster	

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

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?