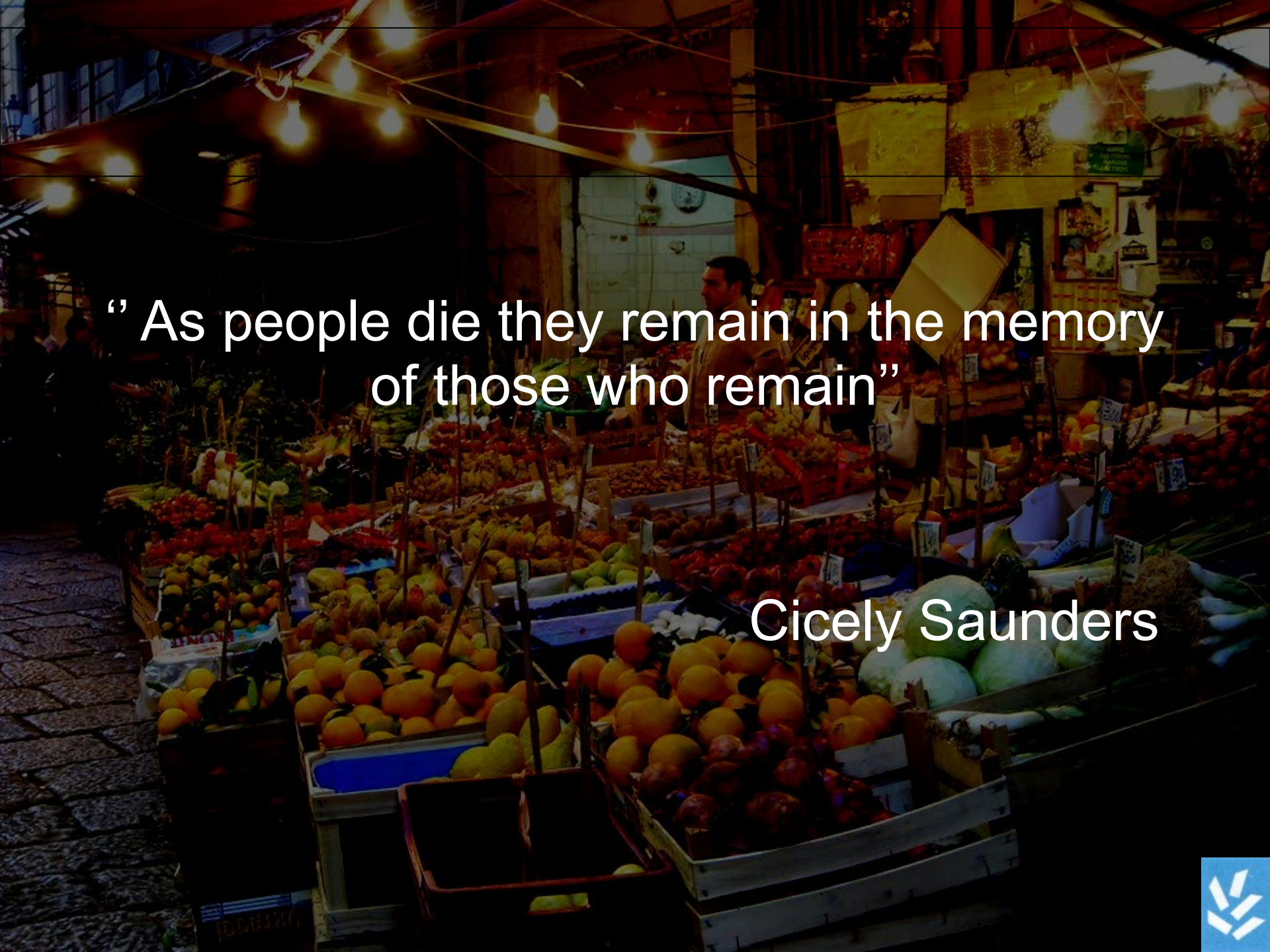
Palliative sedation in Hospital Units

XXVIII National Congress ESRA ITALY Chapter
05-07 October 2023

David Fabrizio, MD
Anesthesia and Intensive Care Unit
Pain Relief and Palliative Care Unit
La Maddalena Cancer Center, Palermo


‘’ As people die they remain in the memory of those who remain”
Cicely Saunders

Palliative Sedation (SP)

It is a therapeutic procedure aimed at controlling suffering caused by refractory symptoms, which arise in the advanced or terminal phase of disease or the discontinuation of life-sustaining treatments

SIAARTI Guidelines May 2023

Refractory Symptom

An intolerable symptom despite the most adequate means for its control having been put in place

SIAARTI Guidelines May 2023

Intermittently Sadation

Sedative drugs are administered intermittently allowing the person to have periods in wich they are not sedated or to assess whether the sypmtom is permanently refractory. We talk about relief sedation with the aim of reducing patient's discomfort-distress.

SIAARTI Guidelines May 2023

Continous Sedation

Suspension of counsciousness until the patient's death.
There are different levels of sedation
- Mild: also colled conscious sedation
- Moderate: the patient can be awakened
- Deep: or coma, patient cannot be awakened

SIAARTI Guidelines May 2023

Proportional Sedation

It is a titration of the sedadive drugs with the aim of using the minimum dose necessary to obtain therapeutic benefit.

SIAARTI Guidelines May 2023

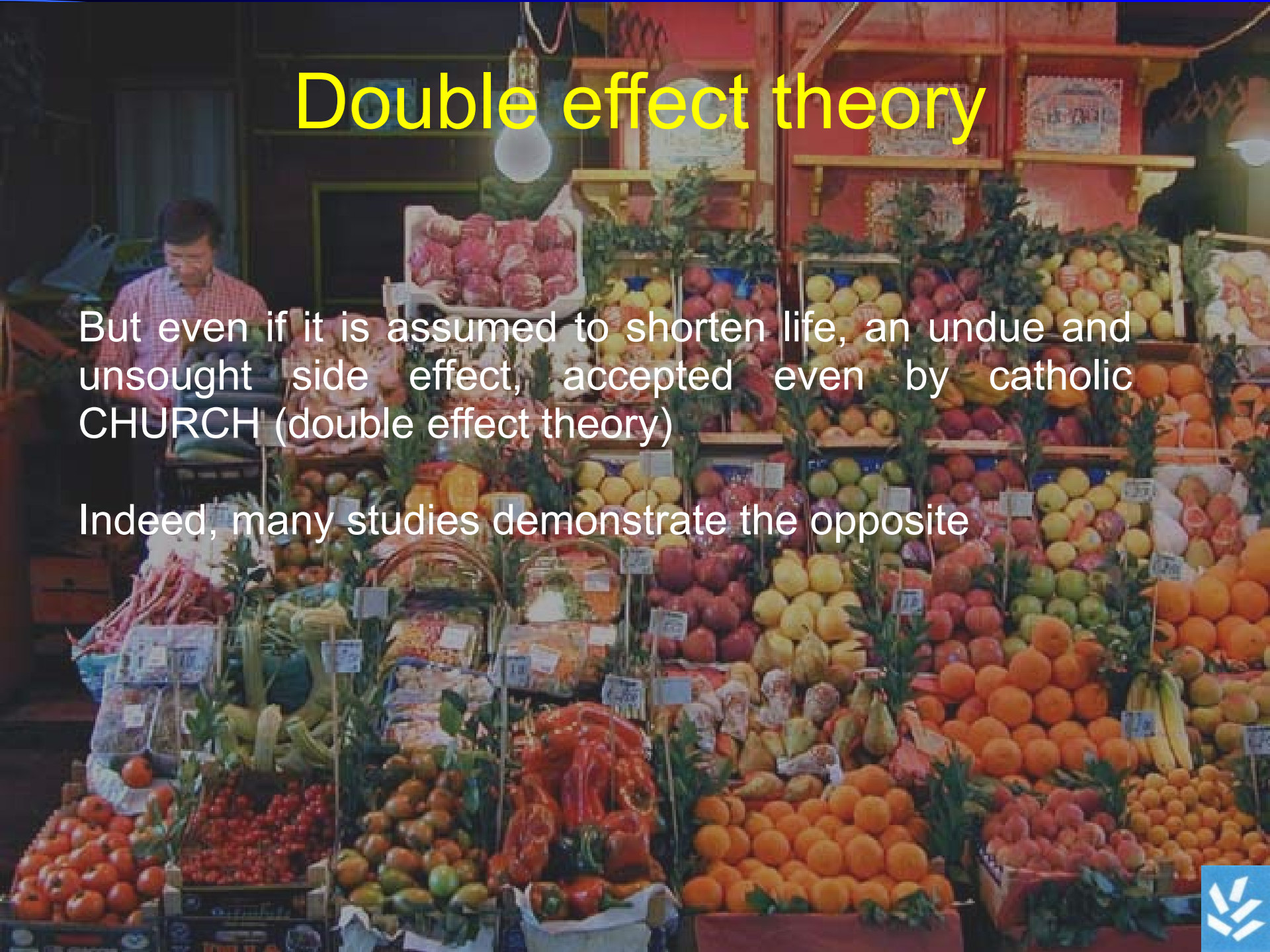
Terminal Sedation

This definition incorrectly attributed a role to sedation in causing or accelering death

La SP not is slow euthanasia.

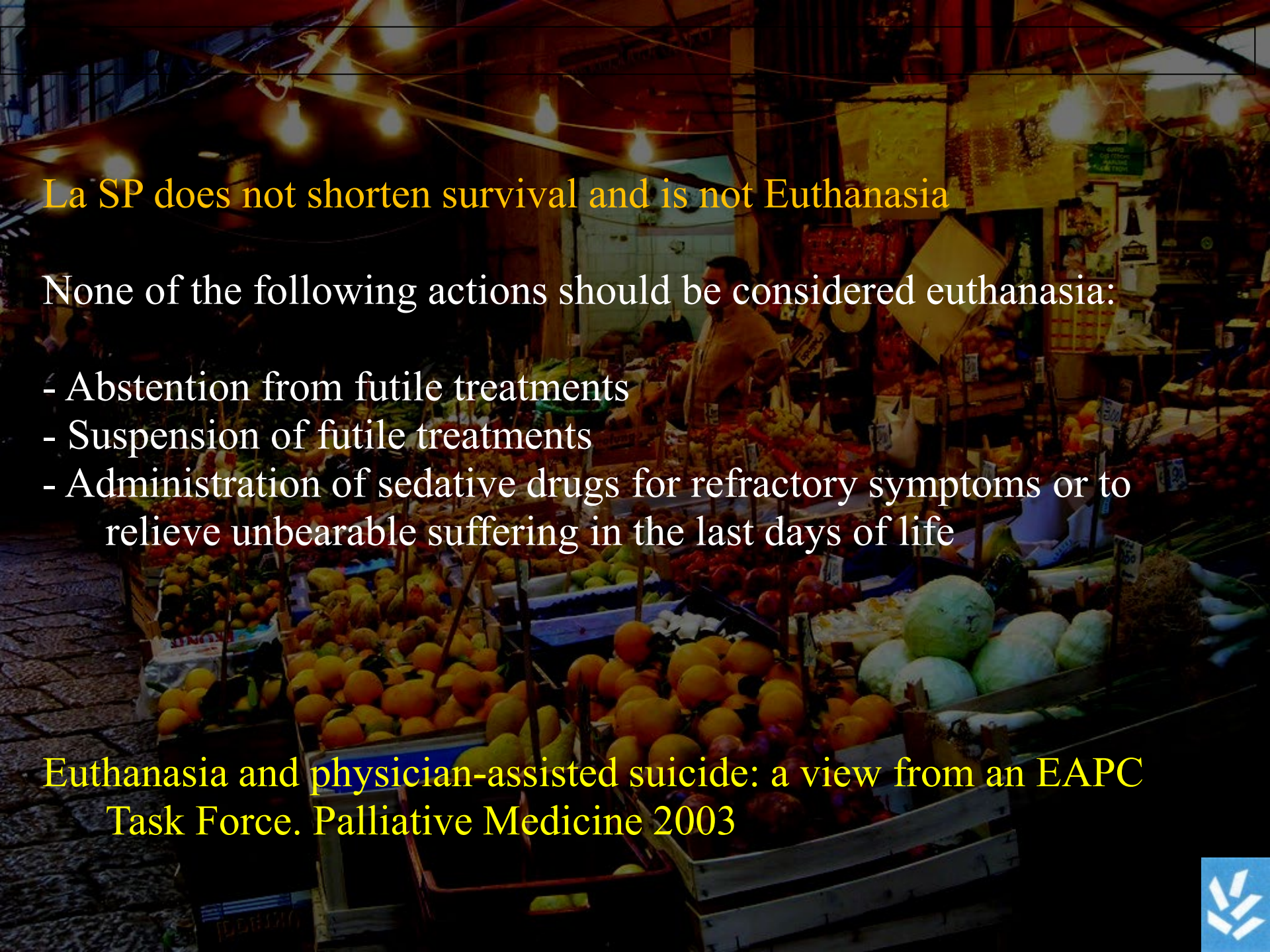
La SP does not shorten survival.

Double effect theory



But even if it is assumed to shorten life, an undue and unsought side effect, accepted even by catholic CHURCH (double effect theory)

Indeed, many studies demonstrate the opposite

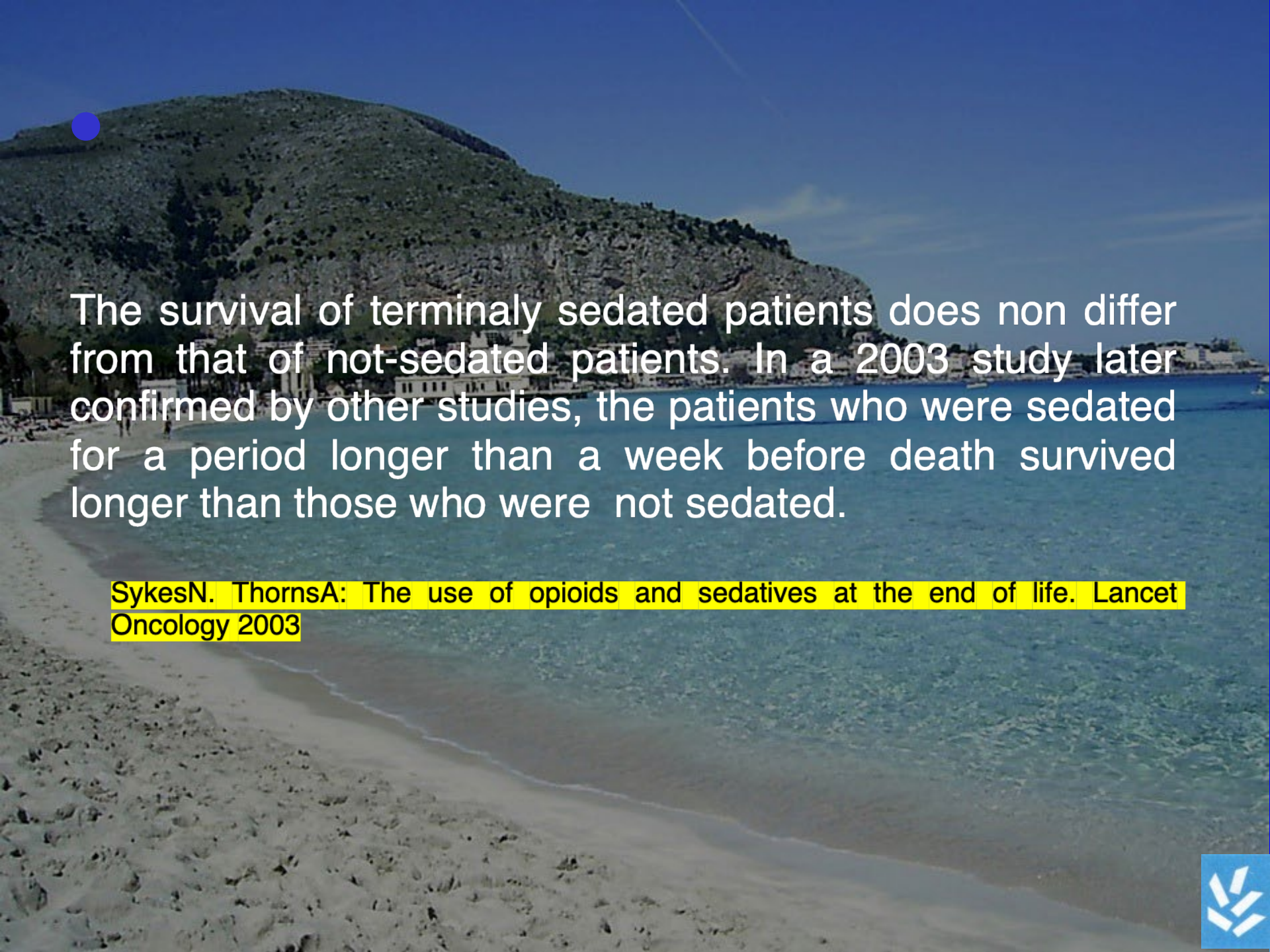


La SP does not shorten survival and is not Euthanasia

None of the following actions should be considered euthanasia:

- Abstention from futile treatments
- Suspension of futile treatments
- Administration of sedative drugs for refractory symptoms or to relieve unbearable suffering in the last days of life

Euthanasia and physician-assisted suicide: a view from an EAPC Task Force. Palliative Medicine 2003



The survival of terminaly sedated patients does non differ from that of not-sedated patients. In a 2003 study later confirmed by other studies, the patients who were sedated for a period longer than a week before death survived longer than those who were not sedated.

SykesN. ThornsA: The use of opioids and sedatives at the end of life. Lancet Oncology 2003

Searching literature

- In the study produced in UK, one patient survived for 39 days. This would confirm that sedation does not shorten life. On the other hand, in truth, it's plausible that the timing for SP was not exactly adequate

- We must not confuse the sedation of dying patient with the control of the psycological distress that accompanies patients with advanced cancer. The proof of this is that many studies, in which the word palliative sedation is used, show that doses of Midazolam or haloperidol have been rather low.

- What is certain is that if, as from an Australian study, it emerges that BDZ has been used orally, perhaps we are talking about existential suffering that accompanies refractory symptoms.

Withholding or withdrawing of life sustaining treatments may involve: - endotracheal intubation and invasive mechanical ventilation - renal replacement therapy – vasopressor therapy - nutrition – blood products - antibiotics – Cardiopulmonary resuscitation.

A recent cluster randomized trial demonstrated that early multidisciplinary discussion with palliative team may help defining more appropiate trajectories of care after ICU admission.

Ma J., Chi S., Buettner B. et al. Early palliative care Consultation in the Medical ICU: a cluster randomized crossover trial. Crit Care Med 2019

Degree of Sedation: Rudkin scale

1st level: patient awake and oriented

2nd level: patient drowsy but awakenable

3rd level: patient with eyes closed but awakenable to the call

4th level: patient with eyes closed but awakenable wiyh tactile stimulus

5th level: patient with eyes closed non responding to tactile stimulus

Refractory Symptoms:

Dyspnea

Delirium

Psychomotor restessness

Irreprensible nausea e Vomiting

Pain

Psycological-existential distress

Bleeding

Drugs

Benzodiazepines (BDZ) (GABAercig action): Midazolam is the first choice for rapid effect and long half-life

Phenothiazine Neuroleptics (Antidopaminergic - anticholinergic - antiserotoninergic and adrenolitic action): Promazine and Clorpromazine in addition to BDZ for the control of delirium/psycomotor agitation

Butyrophenone Neuroleptics (Antidopaminergic action): Haloperidol for subcutaneous route and Droperidol for intravenous route in addition to BDZ for the control of delirium/psychomotor agitation

Propofol: Hypnotic for intravenouse route, rapid effect and short action

Dexmedetomidine: intravenous route, not as a bolus due to risk of bradicardia, arythmias and hypotension

Oppioids: Morphine and Fentanyl are the first choice in addition to other sedative drugs if the patient is undergoing a course with oppioids

Routes of administration

Intravenous: the most usual route in inpatient departements

Subcutaneous: the most usual route in hospices and in setting home

Death Rattle

Is the sign of the beginning of the agony phase due to movement of air through secretions in the oropharynx and bronchus. It is usually caused from the failure of the cough and swallowing reflex in the terminal phases of life.

Treatment:

Anticholinergics :

Scopolamine: short half-life – continous infusion or transdermal route

Hyscina Bromide (Buscopan): 60 - 120 mg /day – xerostomia , urinary retention, tachycardia, slowed peristalsis

Treatment should be started as early as possible

Position : the patient must be correctly positionated to facilitate drainage.

Hydration : should be reduced.

It is often not felt by the patient, therefore suction is not necessary.

Is very stressful for relatives, therefore adequate family counseling is needed.

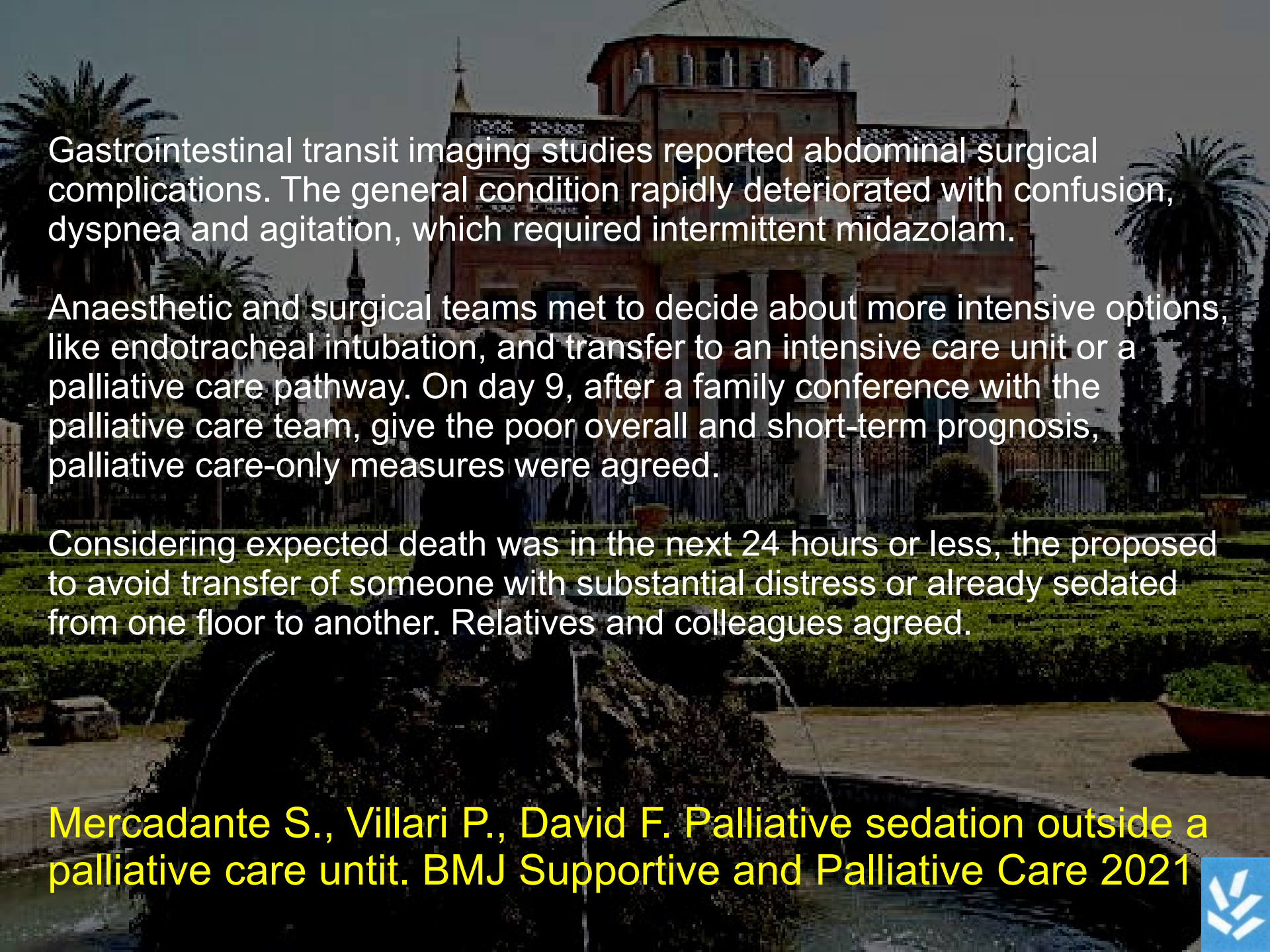

Clinical case number 1

A man in his 50s was admitted to the surgical Unit with cancer rectal relapse. He had a previous diagnosis of dementia. He was operated successfully and a colostomy placed.

On day 5, after attempted insertion of a nasogastric tube, he vomited and gastric material was inhaled. A broncoscopy with washing was performed. The next day he developed Dyspnea with diffuse pulmonary damage, by CT, and disorientation.

After non invasive ventilation (NIV) Respiratory and cognitive function improved. An attempt to switch to high flow nasal therapy was unsuccessful, and NIV was continued, with full face mask.

Mercadante S., Villari P., David F. Palliative sedation outside a palliative care untit. BMJ Supportive and Palliative Care 2021



Gastrointestinal transit imaging studies reported abdominal surgical complications. The general condition rapidly deteriorated with confusion, dyspnea and agitation, which required intermittent midazolam.

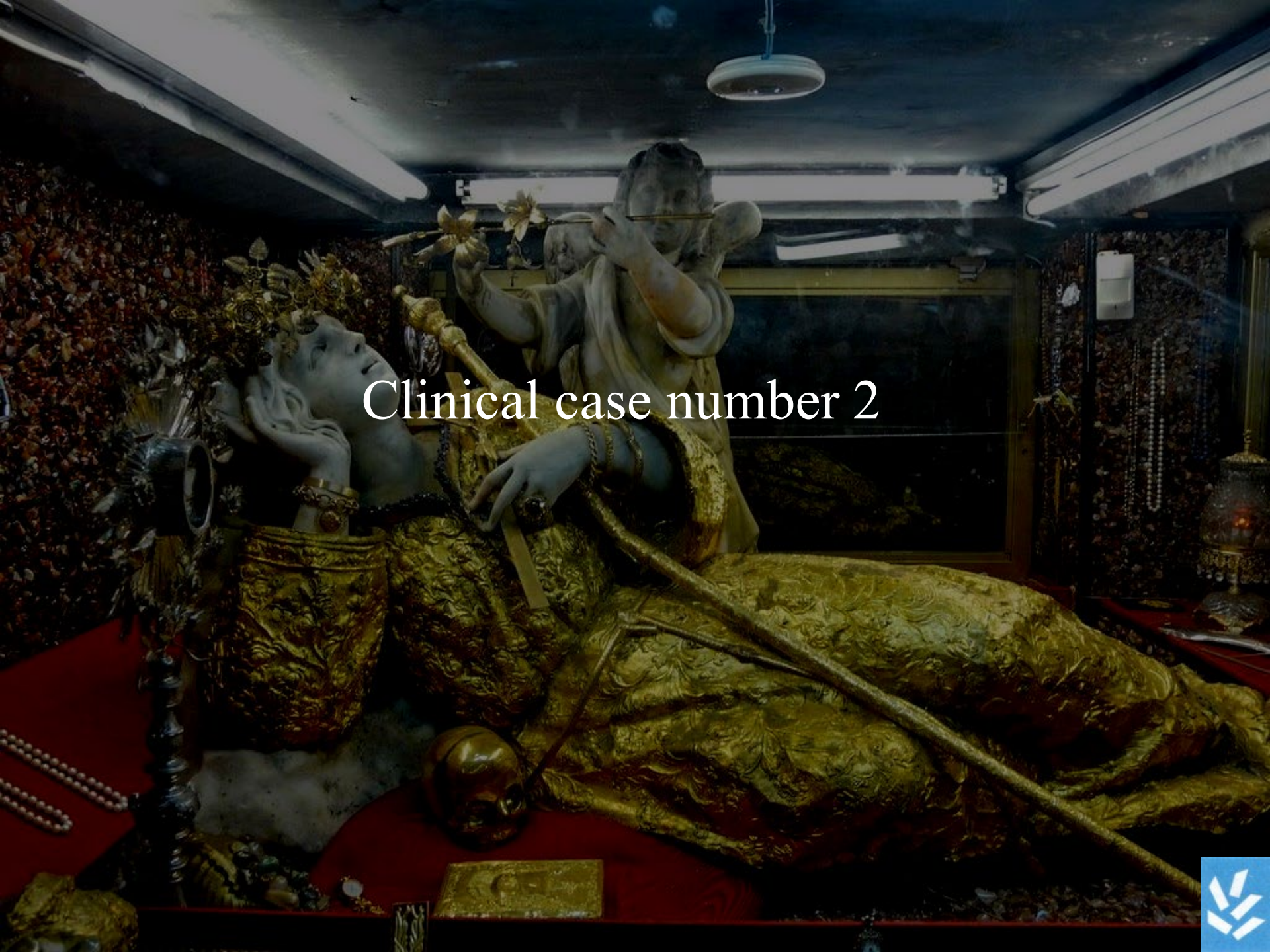
Anaesthetic and surgical teams met to decide about more intensive options, like endotracheal intubation, and transfer to an intensive care unit or a palliative care pathway. On day 9, after a family conference with the palliative care team, give the poor overall and short-term prognosis, palliative care-only measures were agreed.

Considering expected death was in the next 24 hours or less, the proposed to avoid transfer of someone with substantial distress or already sedated from one floor to another. Relatives and colleagues agreed.

Mercadante S., Villari P., David F. Palliative sedation outside a palliative care untit. BMJ Supportive and Palliative Care 2021

Morphine 10 mg/day and Midazolam 15 mg/day was started and NIV initially maintained. Subsequently an agreement was achieved between the palliative care team and care-givers, to discontinue palliative ventilation, maintain only morphine and midazolam infusion and add hyoscine butylbromide (60 mg/day) to prevent bronchial secretions. He died 4 hours after ventilator withdrawal without apparent suffering. Relatives were grateful for the communications about the rapid negative decline and process of care to limit the suffering of their loved one.

Mercadante S., Villari P., David F. Palliative sedation outside a palliative care untit. BMJ Supportive and Palliative Care 2021


Clinical case number 2

A man , in his 30s, diagnosed with advanced seminoma, was transferred as an emergency from day hospital to the oncological unit, for worsening conditions, weakness, confusion, limb oedema, and low platelet count.
Previous carcinomatosis and ascites were confirmed by a CT. Supportive therapy, platelet transfusion and albumine were given.

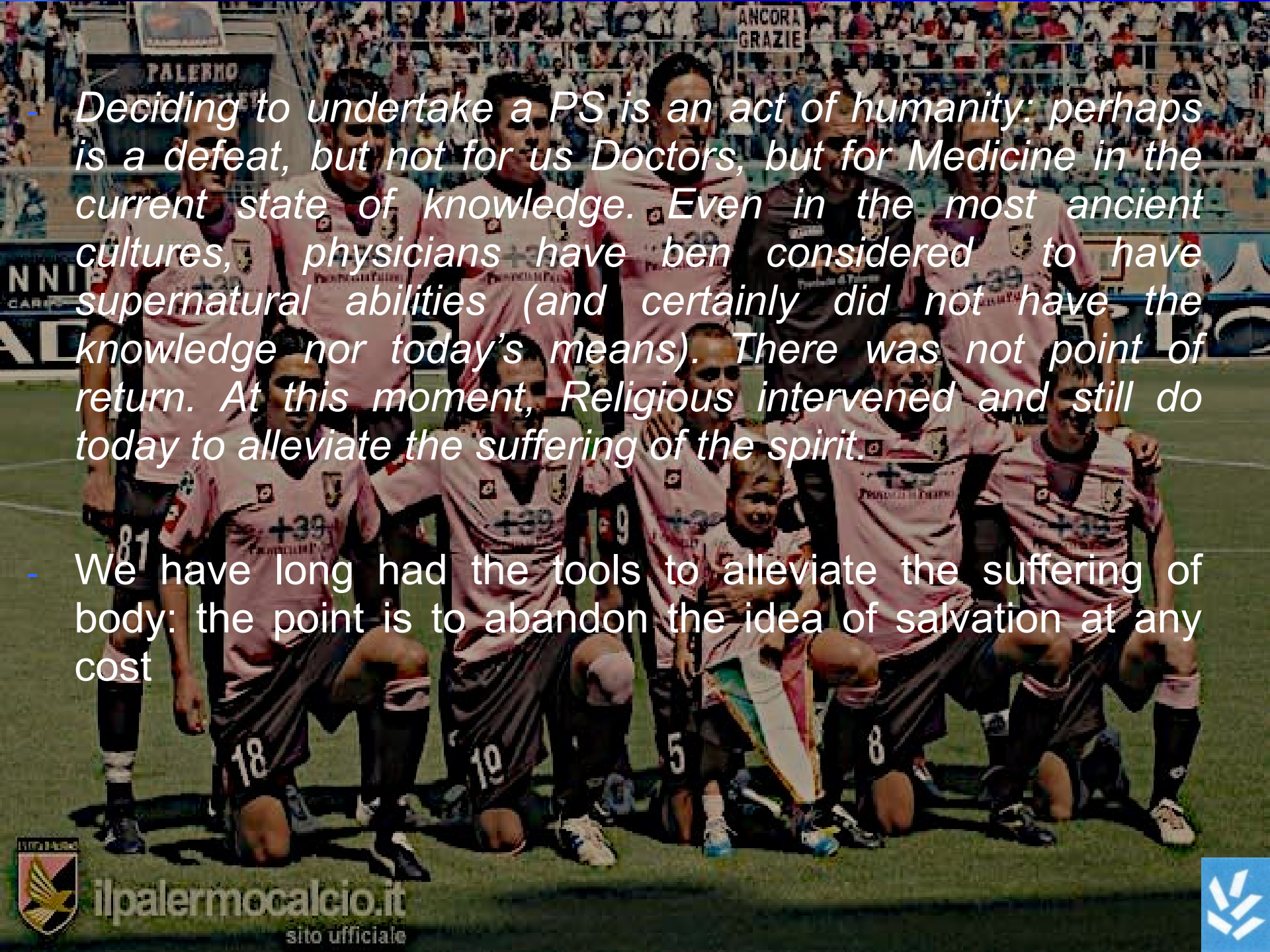
Afert consultation with the palliative care team for abdominal pain, intravenous morphine 60 mg/day and 10 mg as needed were prescribed after dose tritration test.
We discussed the short-term prognosis and the possible need to start SP due to the evident state of general suffering.

Mercadante S., Villari P., David F. Palliative sedation outside a palliative care untit. BMJ Supportive and Palliative Care 2021

Doses of morphine were increased in the subsequent day while a further deterioration of the clinical status was observed.
On day 3 he was disoriented and agitated.
Afer a further conference, it was planned to strat a SP without transferring him to the palliative care unit, because of the critical condition.
Midazolam 30 mg/day with hyoscine butylbromide 60 mg/day and morphine 90 mg/day were prescribed. He die peacefully, witouth any sing of suffering after 8 hours.

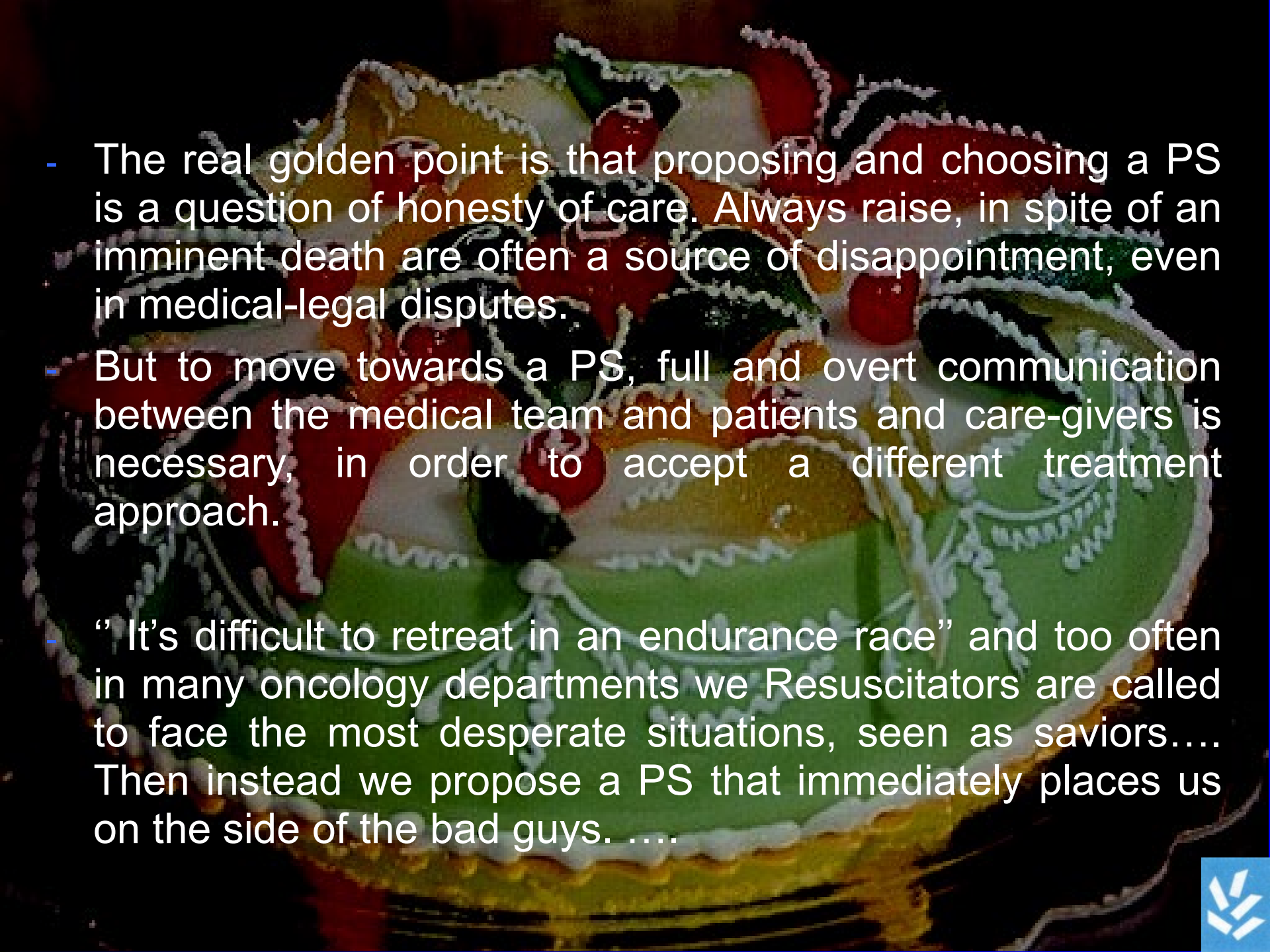
The relatives were satisfied with the decision to provide a timely SP in the last hours of life.

Mercadante S., Villari P., David F. Palliative sedation outside a palliative care untit. BMJ Supportive and Palliative Care 2021



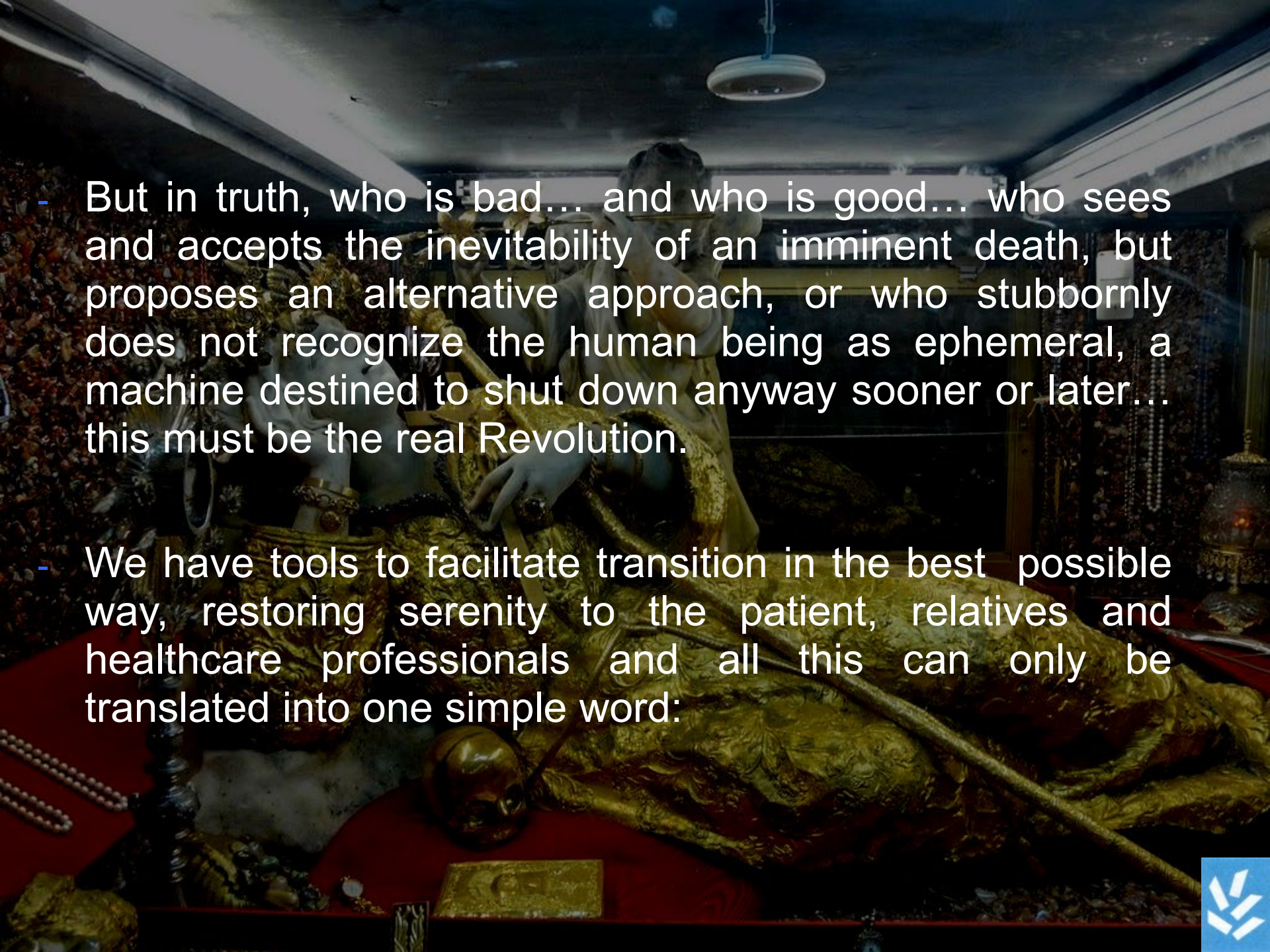
- *Deciding to undertake a PS is an act of humanity: perhaps is a defeat, but not for us Doctors, but for Medicine in the current state of knowledge. Even in the most ancient cultures, physicians have ben considered to have supernatural abilities (and certainly did not have the knowledge nor today's means). There was not point of return. At this moment, Religious intervened and still do today to alleviate the suffering of the spirit.*

- We have long had the tools to alleviate the suffering of body: the point is to abandon the idea of salvation at any cost



- The real golden point is that proposing and choosing a PS is a question of honesty of care. Always raise, in spite of an imminent death are often a source of disappointment, even in medical-legal disputes.
- But to move towards a PS, full and overt communication between the medical team and patients and care-givers is necessary, in order to accept a different treatment approach.

- '' It's difficult to retreat in an endurance race'' and too often in many oncology departments we Resuscitators are called to face the most desperate situations, seen as saviors…. Then instead we propose a PS that immediately places us on the side of the bad guys. ….



- But in truth, who is bad… and who is good… who sees and accepts the inevitability of an imminent death, but proposes an alternative approach, or who stubbornly does not recognize the human being as ephemeral, a machine destined to shut down anyway sooner or later… this must be the real Revolution.

- We have tools to facilitate transition in the best possible way, restoring serenity to the patient, relatives and healthcare professionals and all this can only be translated into one simple word:


Grazie