Palliative Care Update

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Palliative Care Update

• Where is palliative care
  • What are we dying from and where?
  • Trends for the future
  • Trends in palliative care service development

• Symptom control updates
What are we dying from?

Figure 2: Number of deaths from top five leading causes, 2015 to 2017

England and Wales

- Dementia and Alzheimer disease (F01, F03, G30)
- Ischaemic heart diseases (I20-I25)
- Chronic lower respiratory diseases (J40-J47)
- Cerebrovascular diseases (I60-I69)
- Lung cancer (C33, C34)

Number

- 2015
- 2016
- 2017
Where are we dying?
What percentage of adult admissions to acute hospitals are patients in their last year of life?

1. 5-10%?
2. 10-20%?
3. 20-30%?
4. 30-40%?
Imminence of death amongst hospital inpatients  

Clark 2014

- Census of 25 Scottish hospitals
- Of 10,743 inpatients, 28.8% died within one year
The future palliative care population

Etkind 2017
By 2040, the biggest cause of death is predicted to be:

1. Any cancer?
2. Any organ (heart, lung, renal and kidney) failure?
3. Dementia?
4. Accidental?
Trends in palliative care service development

• Advance Care Planning
• Overlap with frailty
• Supportive Care

"Duirte me leat go raibh me breoite"
The impact of advance care planning in hospital (N= 309)

• Ability to adhere to end of life wishes (85% vrs 30%)
• Reduction in intervention (0 vrs 4 ITU deaths)
• Improved patient and family satisfaction
• Reduced stress, anxiety and depression in surviving relatives
• No difference in mortality

Detering BMJ 2010
“...no-one really seemed to appreciate that Mum was dying...I do wish that Mum had remained at home with some support from Dad and I, and she had not had the time in hospital. It was a confusing and stressful time for us all”.
Predicted vrs observed survival

Disease trajectories

Cancer

Organ failure

Dementia/frailty
Overlap with frailty

Retrospective comparison of frail inpatients over 80

- 50% likely to die within a year

Death on admission associated with:
- More than 2 admissions in last 12 months
- Dementia diagnosis > 3 years
- Care home resident

Hyatt et al 2018
Supportive care in cancer

Prevention and management of adverse effects of cancer and its treatment

MASCC Strategy 2019
What has been demonstrated for supportive care in cancer?

1. Only improved patient experience / quality of life
2. Improved patient experience and increase in overall healthcare costs?
3. Improved patient experience and reduction in overall healthcare costs with no impact on survival?
4. Improved patient experience and reduction in overall healthcare costs with increased survival?
Supportive care

• Improved patient experience / quality of life
• Reduction in overall healthcare costs (primarily through reduction in emergency/unplanned admissions to hospital)
• Reduction in the need for aggressive interventions in the last days / weeks of life
• Survival benefit (12 weeks)

Temel NEJM 2010
What’s new in symptom control?

• WHO analgesic ladder
• Opioid induced constipation
• Hyperactive delirium in palliative care
WHO analgesic ladder

Codeine requires P450 CYP2D6 for conversion to morphine
Genetic variation in expression of CYP2D6
Can replace “second rung” with 2.5 – 5mg oral IR morphine 4hrly or 10-15mg SR bd with good pain relief

Caraceni Lancet Oncol 2012

Figure 1. The World Health Organization analgesic ladder for treating cancer pain
Naloxegol for opioid-induced constipation

- Oral peripherally acting selective \( \mu \)-opioid antagonist
- NICE approved for non-laxative responsive opioid-induced constipation
- 25 mg naloxegol more effective than placebo (44.4\% vs 29.4\%; \( p=0.001 \))

Chey et al NEJM 2014

Contraindicated in GI, ovarian or peritoneal malignancy, presence or risk of GI obstruction, concurrent treatment with VEGF inhibitors
Hyperactive delirium in palliative care

- Treatment of reversible causes
- Antipsychotic medication where patient at risk

- DB RCT N=247 palliative care patients
- Risperidone, Haloperidol, Placebo

Agar et al JAMA 2017
Which treatment for hyperactive delirium was most effective?

1. Haloperidol?
2. Risperidone?
3. Both Haloperidol and Risperidone equally
4. Placebo?
Hyperactive delirium in palliative care

• Delirium scores higher in risperidone (p=0.02) and haloperidol (p=0.009) arms than placebo

• Haloperidol and risperidone group had higher incidence of extrapyramidal side effects

• Placebo group survived longer than haloperidol group ((hazard ratio, 1.73; 95% CI, 1.20-2.50; p=0.003)

Agar et al JAMA 2017
“Millions long for immortality who don't know what to do with themselves on a rainy Sunday afternoon.”
Susan Ertz