

On the Horizon...

A Physician's Newsletter on End-of-Life Care

Winter 2001

New Treatments for Hospice Patients

From the December, 2000, *American Journal of Hospice & Palliative Care*, on "Methylphenidate for Depression in Hospice Practice" by Jade Homs, MD, Cleveland Clinic. This case reports of Ritalin use in 10 patients with depression and advanced cancer. Using doses of 5 to 10mg BID, all these patients had improvement in their depression, appetite, concentration, and fatigue with little side effects. Three other studies with its use in advanced cancer also demonstrated 50 to 90% of patients had some improvement in symptoms, usually within 2 to 5 days, with few serious side effects even in the very elderly. This medicine probably should be thought of more often to help improve the quality of life of hospice patients.

Improving the quality of life for hospice patients

From same journal, an article by Dr. Nabeel Sarhill, et. al, Cleveland Clinic was a case report on "Nebulized Hydromorphone for Dyspnea in Hospice Care of Advanced Cancer." They reported on one patient who was tried on nebulized sterile Dilaudid for management of terminal dyspnea. A 4mg dose with 2cc of sterile water in a nebulizer produced almost immediate relief of this patient's symptoms. This was the first report using Dilaudid this way. There have been a number of studies using inhaled morphine for dyspnea, with mixed results, likely because it may induce bronchospasm unless albuterol is used prior. This may be another treatment that can be used for this very discomforting symptom in terminal hospice patients. ■

Conference—"Caring for Families At the End of Life"

The second annual fall conference of the Cancer Wellness Center will be held on Friday, April 20th, 2001, at the American College of Chest Physicians in Northbrook. Timothy Quill, MD, a leading figure in the death with dignity movement, will be keynote speaker, and 6 hours of CME credits will be available for physicians. For more information, contact the Cancer Wellness Center at 847-509-9595. ■

- To make a referral to Horizon Hospice, call Liz Carney, Admissions Coordinator, at 312/733-8900.
- Questions or comments on newsletter contents? Call editor Melanie Kubale at 312/733-2233 or e-mail to mkubale@horizonhospice.org
- Visit the "Physician's Guide to Hospice" page on our website at www.horizonhospice.org.

Teamwork

Dr. Marschke's Message

Sometimes we physicians tend to forget the ability of other healthcare workers to help our patients overcome their physical symptoms. After all, who is better at taking care of a patient's pain or vomiting than a doctor? What could be better for severe pain than the right dose of a narcotic medication?

Teamwork is better—as working in hospice has taught me. Our care team includes nurses, home health aides, social workers, chaplains and volunteers, all of whom can contribute insights for determining treatment. Helping a person overcome pain and suffering, especially at the end of life, involves so much more than just adding another medication. For example, consider the symptom of pain. There is so much more to pain than just the physical nerve irritation.

We know from medical research that emotional factors like depression or loneliness factor into how a person experiences pain. Fear and anxieties can create their own pain, and socio-economic factors may play a role. Some people will try to hide their pain, not wanting to trouble or burden their family. Many cultures, as well as the urban poor, may feel distrustful of the medical hierarchy and reluctant to report symptoms.

The three hospice patients profiled below illustrate the complexity of devising effective treatment, and how a teamwork approach can make a real difference.

Pain = Fear

One gentleman, in his 50s with metastatic cancer, told me he was in severe pain—rating it a 7 or 8 on a 10 point-scale. It was a vague pain, all over, off and on, with no relation to any activity. He was already on pain medications and they were not effective at all. As we talked more, he began to describe to me an overwhelming fear of dying. He was afraid of what was out there after this life. My response was to ask our chaplain to see him as soon as possible. After their visit, I know that this man's pain lessened, and he eventually died comfortably without more narcotics.

Family Anxiety

Our team treated an elderly woman with ovarian cancer. She was from a poor family and had several daughters and lots of grandkids, all crammed into a small apartment. She was confined to a small room and very depressed. She would get panicky and have bouts of vomiting that were hard to control no matter what medication we tried, and we tried about ten different ones. Her daughters feared losing their mother, and would often take her into the ER during these panics. Our social worker and nurse both spent many hours with this family addressing their fears, letting them vent about this situation. Over time, this patient and family became more accepting of the situation. The ER visits and vomiting gradually subsided and the woman eventually died peacefully at home. Our bereavement team then stepped in to help the daughters through the funeral and then adjusting to going on without their mother.

Self-Image Adjustment

A young man with intestinal lymphoma entered into our hospice program with severe diarrhea and abdominal pain. This was a very neat, organized, and outgoing gentleman who had reconciled himself to the fact that he was dying. However, his diarrhea with incontinence and diaper use became a great cause of distress. He came to the point of thinking he would rather end his life than go on. Through a team effort that included our nurse, chaplain, social worker, and many hours of home health aide supervision, along with a more aggressive systemic approach to his symptoms, we were able to control the diarrhea and pain and help him work through his anxiety and mortification. He once again started to value his remaining time, and the suicidal ideation disappeared without resorting to a stay in a locked psych floor.

Yeah Team

Facing one's own mortality is fraught with emotional, cultural, and spiritual issues. Involving the hospice team from the start of each patient's care makes the physician's job more focused and thus more effective. The physical symptoms in patients at the end of life many times do not have an isolated etiology and are all wrapped in emotions. Relying on the expertise of team members who are trained and experienced in dealing with all the aspects of what patients and their families are going through helps immensely in *palliating* their symptoms. Foregoing the team approach would certainly result in far greater suffering. I am one doctor who is tremendously grateful for teamwork.



*Michael Marschke, MD
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