Paramedic Community of Practice – Series 2

Pain and symptom management

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Diana Vincze, Pallium Canada
Presenter: Dr. Jitin Sondhi
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Territorial Honouring

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

Stay connected: www.echopalliative.com

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Project ECHO Palliative Care - Canada BY Pallium Canada

LEAP Paramedic

- Learn the essentials for providing a palliative care approach
- Ideal for Paramedics and Emergency Medical Service professionals

- **Key features:**
  - Created and reviewed by Canada's leading palliative care experts
  - Taught by local paramedic experts and experienced palliative care practitioners
  - Nationally recognized certificate
  - Evidence-based and case-based

Pallium Canada LEAP PARAMEDIC

Learn more about the course and topics covered by visiting

https://www.pallium.ca/course/leap-paramedic/

Introductions

Presenter:
Dr. Jitin Sondhi, MD, CCFP (PC), FCFP
Regional Clinical Co-Lead, Palliative Care, OH West
Adult and Pediatric Palliative Care

Panelists:
Kristina Anton, BScN, ACP
Paramedic Specialist, BC Emergency Health Services

Karen O'Brien
Frontline Paramedic since 1999, with a side of community paramedicine.
SWORBHP Associate Instructor
Pallium Facilitator

Stuart Woolley
Paramedic since 2003 in UK & Canada, current Paramedic Practice Leader in BCEHS leading Palliative Care, Low Acuity Patient management & Paramedic Specialist support.

Lisa Weatherbee
BN RN CHPCN©
Pallium Master Facilitator/Coach

Welcome and Reminders

- Please introduce yourself in the chat!
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function at any time to ask questions and add comments.
- Remember not to disclose any Personal Health Information (PHI) during the session.
- This session is being recorded and will be emailed to registrants within the next week.

Session Learning Objectives

Upon completing the session, participants will be able to:

- How to manage some common symptoms urgently in community (Pain, Nausea, Delirium)
- Identify Palliative Care Emergencies and option on how to manage them
- Awareness of pharmacological and non-pharmacological management of some symptoms.

Case-Based Discussion

CASE 1: Samantha

- A 58-year-old female with advanced metastatic breast cancer with known metastatic disease involving bilateral femurs, humerus, sternum and spine

- Has sudden onset of pain with recent changes in her quality of the pain

- Pages Palliative care team and Community Paramedicine is dispatched for rapid response

- What do you want to know?
- What will you do next?

Case 1: Samantha

O - Onset:

•When did the pain start?

- "The pain started about a week ago but has gotten much worse over the past few days."

•Was there a specific event that triggered it?

- "No specific event; it just gradually became more intense."

P - Provocation/Palliation:

•What makes the pain worse?

- "Any movement, especially when I try to stand or walk, makes the pain much worse."

•What makes the pain better?

- "Lying still helps a little, but nothing really makes it go away completely."

•Have any medications or treatments helped?

- "The pain medication I've been taking isn't helping like it used to."

Q - Quality:

•How would you describe the pain?

- "It's a deep, stabbing pain in my lower back that sometimes shoots down my legs. It feels like something is pressing on a nerve."

R - Region/Radiation:

•Where is the pain located?

- "The pain is mostly in my lower back."

•Does the pain radiate or spread anywhere else?

- "Yes, it radiates down both of my legs, especially the left one."

S - Severity:

•On a scale of 0 to 10, how severe is the pain?

- "It's around an 8 or 9 out of 10 right now."

•Has the pain changed in intensity over time?

- "It's definitely gotten worse over the past few days."

T - Timing:

•Is the pain constant, or does it come and go?

- "The pain is pretty constant, but it spikes when I try to move."

•When does the pain occur?

- "It's always there, but it's worse during the day when I try to be more active."

Case 1: Samantha

U - Understanding/Impact on You:

•What do you believe is causing the pain?

- "I'm not sure, but it feels different from the pain I've had before. I'm worried because it's affecting my ability to walk and even control my bladder."

•How is this pain affecting your life?

- "It's making it really hard for me to get around and do anything by myself. I'm also scared because I can't control my bladder very well."

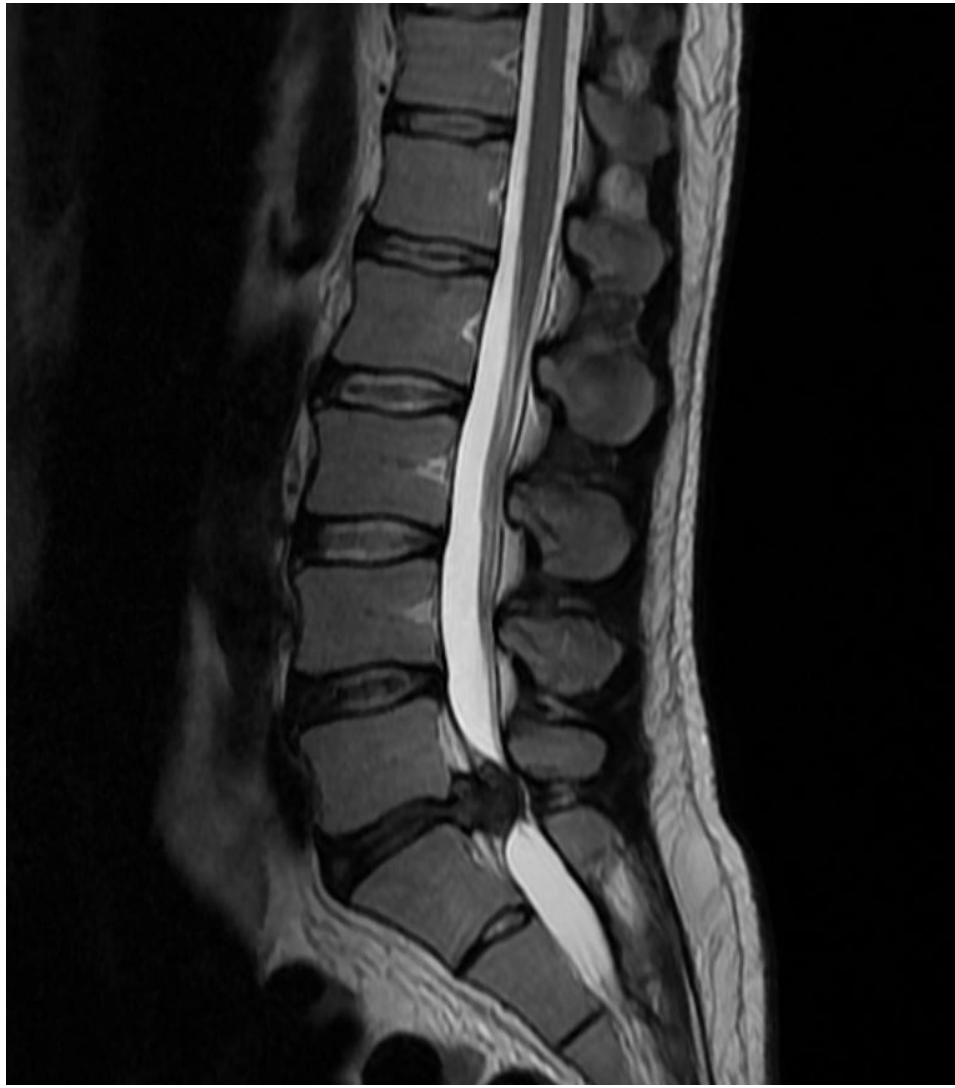
V - Values:

•What is your goal for pain management?

- "I want the pain to be more manageable so I can move around without so much difficulty. I'm also worried about these new symptoms and want to know what's causing them."

Case 1: Samantha

- Cauda Equina Syndrome: a serious neurological condition that occurs when the bundle of nerves at the lower end of the spinal cord, known as the cauda equina, becomes compressed. This compression leads to a range of symptoms, including severe lower back pain, sciatica, weakness or numbness in the legs, loss of sensation in the buttocks, inner thighs, and genital area (saddle anesthesia), and bowel or bladder dysfunction, such as urinary retention or incontinence. CES is a medical emergency requiring immediate diagnosis and intervention to prevent permanent damage, including paralysis or loss of bowel and bladder function.



Case 1: Samantha

- Emergency Imaging: MRI
- Surgical Decompression: Laminectomy
- Radiation Therapy
- Corticosteroids

CASE 2: Yadvinder

- A 70-year-old male with end-stage COPD and lung cancer, who is on home oxygen 3L
- Family calls 911 due to severe dyspnea
- 911 crew arrives on scene and patient refuses transfer to hospital and wants to feel better
- What do we do?

Case 2: Yadvinder

- Diminished breath sounds in right lung field
- Increased work of breathing noted
- No fever but has had purulent cough with hemoptysis.

- What are some possible concerns?
- What more would you want to know?

Case 1: Yadvinder

- Dyspnea can be multifactorial (Pulmonary, cardiac, systemic, psychological)
- Disease progression with pleural effusion
- Pneumonia
- Low hemoglobin due to underlying bleed (concerns for catastrophic bleed)

Case 2: Yadvinder

- Oxygen: adjust/increase flow rate
- Opioids: Hydromorphone 0.5mg sc with repeat doses if needed and plan to reassess current medications.
- Benzodiazepines: Clonazepam 0.5 to 1mg q6-8hr prn, Lorazepam 0.5mg SL q4h prn, Consider midazolam for intractable dyspnea or suspicion of terminal bleed.
- Bronchodilators: Salbutamol 2-4 puffs q2h prn

Case 3: Zaynab

- A 75-year-old female with advanced Alzheimer's disease and metastatic breast cancer
- Sudden onset of agitation, hallucination and restlessness
- Family unable to calm her down and contact EMS for assistance
- On arrival family requesting focus on home based care unless something suspected to be reversible
- What is happening?
- How would you assess?

Case 3: Zaynab

- Delirium
  - Disturbance in Attention
  - Develops over a short period of time
  - Change in Cognition
  - Related to general medical condition
- Differentiate between dementia and depression

The diagnosis of delirium by CAM requires the presence of BOTH features ***A*** and ***B***		
C A M Confusion Assessment Method	**A.** **Acute onset** and **Fluctuating course**	Is there evidence of an acute change in mental status from patient baseline? Does the abnormal behavior: ➢ come and go? ➢ fluctuate during the day? ➢ increase/decrease in severity?
	B. **Inattention**	Does the patient: ➢ have difficulty focusing attention? ➢ become easily distracted? ➢ have difficulty keeping track of what is said?
	AND the presence of EITHER feature *C or D*	
	C. **Disorganized thinking**	Is the patient's thinking ➢ disorganized ➢ incoherent For example does the patient have ➢ rambling speech/irrelevant conversation? ➢ unpredictable switching of subjects? ➢ unclear or illogical flow of ideas?
	D. **Altered level of consciousness**	Overall, what is the patient's level of consciousness: ➢ alert (normal) ➢ vigilant (hyper-alert) ➢ lethargic (drowsy but easily roused) ➢ stuporous (difficult to rouse) ➢ comatose (unrousable)

Adapted with permission from: Inouye SK, vanDyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright © 2003, Hospital Elder Life Program, LLC.

Please see the **CAM Training Manual**, available at http://www.hospitalelderlifeprogram.org/private/cam-disclaimer.php?pageid=01.08.00

Case 3: Zaynab

- Causes of Delirium (PINCH ME)
  - Pain
  - Infection
  - Nutrition
  - Constipation
  - Hydration
  - Medications
  - Environment, Endocrine and Electrolytes

Case 3: Zaynab

- Non-pharmacological
  - Gentle, repeated reassurance
  - Reorientation
  - Reduce stimulation (low lighting, low noise)
  - Avoid physical restraints

- Pharmacological
  - Haloperidol 0.5mg to 2mg sc q1h prn (may need higher doses)
  - Methotrimeprazine 6.25mg sc q2h prn
  - Midazolam 1mg to 5mg q15 to 30min (moderate to severe)
  - May consider infusion (palliative sedation) if severe and not responding to above

Case 4: Xiu

- A 55-year-old female with advanced ovarian cancer undergoing palliative chemotherapy
- Experiencing intractable nausea and vomiting that has persisted for several days
- Despite taking prescribed oral antiemetics, she is unable to keep any medication or food down, leading to severe dehydration and weakness.
- Her son contacts paramedics as she is now unable to get out of bed due to fatigue and ongoing vomiting.
- What will you do?
- What is going on?

Case 4: Xiu

- Causes of Nausea
  - Constipation
  - Medications
  - Treatment (Chemo, Rad)
  - Autonomic neuropathy
  - Primary and metastatic abdominal disease
  - Metabolic causes (hypercalcemia, uremia, hyponatremia)
  - Malignant bowel obstruction
  - Increased intracranial pressure
  - Anxiety
  - Infection

Case 4: Xiu

- 1st line:
  - Metoclopramide 10mg QID sc/PO
  - Domperidone 10mg TID PO (Max)
- 2nd line:
  - Haloperidol 0.5mg to 1mg PO/SC q4h prn
  - Ondansetron 4 to 8mg (ODT)
  - Methotrimeprazine 5 to 10mg sc q4h prn
- 3rd line:
  - Dexamethasone 2mg to 4mg PO/SC
  - Canabinoids

Case 4: Xiu

- Other interventions:
  - IV hydration
  - Can consider lab work (non urgent)
  - Management of anxiety (benzos)

Case 4: Xiu

- 5 days later
  - now reports persistent abdominal pain, bloating
  - Increased pain
  - Has recurrent nausea and emesis
- What more do you need to know?

Case 4: Xiu

- Malignant Bowel Obstruction:
  - Surgery (if appropriate)
    - Resection
    - Stenting
    - Colostomy
    - Venting gastrostomy (PEG)
  - Nasogastric tube
  - Medical management:
    - Octreotide 100mcg sc TID
    - Dexamethasone 4 to 10mg sc BID
  - IV hydration and fluids
  - Pain control

Session Wrap-Up

- Please fill out our feedback survey! A link has been added to the chat.
- Help us spread the word! A copy of our flyer for this COP has also been added to the chat.
- Thank you for your participation!

Thank You

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