Welcome!

We will begin momentarily

Community-Based Primary Palliative Care Community of Practice Series 4

Pain Management in the Delirious Patient

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Nadine Gebara
Guest Speakers: Dr. Roger Ghoche
Date: January 22, 2025

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 and their families.

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.

Health Canada Santé Canada

LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Objectives of this Series

After participating in this series, participants will be able to:

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Pain Management in the Delirious Patient	January 22, 2025 from 12 to 1pm ET
Session 2	Communication: Part 1	February 26, 2025 from 12 to 1pm ET
Session 3	Communication: Part 2	March 27, 2025 from 12 to 1pm ET
Session 4	Palliative Care for those Living with Dementia	April 23, 2025 from 12 to 1pm ET
Session 5	AYA	May 28, 2025 from 12 to 1pm ET
Session 6	Gastrointestinal Symptoms in Palliative Care	June 25, 2025 from 12 to 1pm ET
Session 7	Interventions for symptom management; tubes and drains	July 3, 2025 from 12 to 1pm ET
Session 8	Intimacy and Sexually in Advanced Serious Illness	August 27, 2025 from 12 to 1pm
Session 9	Tissue Donation at End of Life	September 24, 2025 from 12 to 1pm ET
Session 10	Supporting Caregivers	October 29, 2025 from 12 to 1pm ET

Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting
- 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 to ask questions and add comments throughout the session.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **10 Mainpro+** credits.

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

Facilitator/ Presenter:

- Dr. Nadine Gebara: Nothing to disclose
- Dr. Roger Ghoche: Nothing to disclose

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content

Introductions

Facilitator:

Dr. Nadine Gebara, MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Panelists:

Dr. Haley Draper, MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Jill Tom, BSN CHPCN ©
Nurse Clinician for palliative Home Care
Mount Sinai Hospital, Montreal

Introductions

Panelists (continued):

Elisabeth Antifeau, RN, MScN, CHPCN(C), GNC(C)
Regional Clinical Nurse Specialist (CNS-C), Palliative End of Life Care
IH Regional Palliative End of Life Care Program
Pallium Canada Master Facilitator & Coach, Scientific Consultant

Thandi Briggs, RSW MSW, Palliative Care Coordinator
Ontario Health atHome | Santé à domicile Ontario

Claudia Brown, RN BSN, Palliative Care Coordinator
Ontario Health atHome | Santé à domicile Ontario

Rev. Jennifer Holtslander, SCP-Associate, MRE, BTh
Spiritual Care Provider

ECHO Support

Diana Vincze

Palliative Care ECHO Project Manager, Pallium Canada

Introductions

Guest Speaker:

Dr. Roger Ghoche, MDCM CCFP-PC, MTS
Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital- Montreal

Pain Management in the Delirious Patient

Session Learning Objectives

Upon completing the session, participants will be able to:

- Describe the challenges of pain assessment in delirious patients including recognizing non-verbal cues and understanding the impact of altered cognition on pain perception and expression.
- Implement effective pain management strategies for delirious patients

Outline

- Case intro
- First things first – what is delirium?
- What is the impact of delirium on patients and families?
- What does pain look like in a patient with delirium?
- How do we treat pain in a ~~human~~ mouse with delirium?
- Case progression

Case Intro – c/o Lindsey Gossip RN

Case of Mr. A. S.

- Patient is an 87-year-old man with pancreatic cancer. He lives at home with his wife in a condo. Prognosis less than 3 months.
- He has 2 children who live out of town.
- He has a pleurex which is drained 3 times a week by a homecare nurse.
- In the past week he has started developing new lower leg wounds, due to worsening edema and a recent fall. The nurse has been changing the dressings daily as they are getting soiled with serous fluid quickly.

Case Intro

Case of Mr. A. S.

- Mr. A. S. is having increased pain, however he is unable to explain where he has pain, and is having difficulty sleeping, particularly at night. He just can't seem to find the right position in bed and becomes frustrated he cannot get comfortable.
- He remains alert and oriented to place, name and time. He continues to get out of bed, but seems to have difficulty following commands and concentrating on tasks.
- The family has been giving him a small dose of dilaudid (0.5mg PO PRN) a couple of times per day to help with the pain, but it seems to have minimal effect. The nurse suggests to give the medication more regularly for a better effect.

Q: What are the 5 criteria for a diagnosis of delirium?

First things first

DSM V

- A disturbance of attention and awareness
- The disturbance develops over a short period of time, represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day
- An additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability, or perception)
- The disturbance in Criteria A and C are not better explained by something else
- There is evidence that the disturbance is caused by another medical condition

First things 4th

- **4AT - [the4at.com](the4at.com)**

1. Alertness
    - Normal = 0
    - Mild sleepiness for < 10 seconds after waking, then normal = 0
    - Clearly abnormal = 4
2. AMT4 – Age, date of birth, place, current year
    - No mistakes = 0
    - 1 mistake = 1
    - 2 or more mistakes = 2

First things 4th

- **4AT - the4at.com**

3. Attention - “Please tell me the months of the year in backwards order, starting at December”

    - 7 or more = 0

    - Starts but scores < 7 months/ refuses to start = 1

    - Untestable (cannot start because unwell, drowsy, inattentive)

4. Acute change or fluctuating course

    - No = 0

    - Yes = 4

First things 4th

- **4AT - [the4at.com](the4at.com)**

4 or above = possible delirium +/- cognitive impairment

1-3 = possible cognitive impairment

0-= delirium unlikely

First things 8th

Subsyndromal Delirium

- Defined as 1-3/8 of the following symptoms

1. Altered level of consciousness
2. Inattention
3. Disorientation
4. Hallucination
5. Delusion or psychosis
6. Psychomotor agitation or retardation
7. Inappropriate speech or mood
8. Sleep-wake cycle disturbance or **symptom fluctuation**

What is the impact of delirium on patients and their families?

What is the impact of delirium on patients and their families?

Palliative Prognostic Index (PPI)

The PPI relies on the assessment of performance status using the Palliative Performance Scale (PPS, oral intake, and the presence or absence of dyspnea, edema, and delirium).

Performance status/Symptoms	Partial score
Palliative Performance Scale	
10–20	4
30–50	2.5
>60	0
Oral Intake	
Mouthfuls or less	2.5
Reduced but more than mouthfuls	1
Normal	0

What is the impact of delirium on patients and their families?

Edema	
Present	1
Absent	0
Dyspnea at rest	
Present	3.5
Absent	0
Delirium	
Present	4
Absent	0

What is the impact of delirium on patients and their families?

Scoring

PPI score > 6 = survival shorter than 3 weeks

PPI score >4 = survival shorter than 6 weeks

PPI score ≤4 = survival more than 6weeks

- Therefore, the new onset of delirium in a PC patient should initiate a serious illness conversation

What does pain look like in a patient with delirium?

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Review Article

Strategies for Pain Assessment in Adult Patients With Delirium: A Scoping Review

Dr. Thomas Fischer, MPH, Annmarie Hosie, PhD, Tim Luckett, PhD, Meera Agar, PhD, and Jane Phillips, PhD
Evangelische Hochschule Dresden (T.F.), Dresden, Germany; and IMPACCT—Improving Palliative, Aged and Chronic Care through Clinical Research and Translation (T.F., A.H., T.L., M.A., J.P.), Faculty of Health, University of Technology Sydney, Ultimo, Australia

What does pain look like in a patient with delirium?

- Conclusion: The current literature is insufficient to guide clinical practice

Q: How would you assess for pain in a patient with delirium?

What does pain look like in a patient with delirium?

What we know

- Opioid-induced neurotoxicity leads to increased pain, hyperalgesia and delirium
- Abbey Pain Scale and other tools can be used to assess pain in non-verbal patients with dementia
- Delirium fluctuates, and therefore the ability of the patient to use a 0-10 scale, for instance, will also fluctuate

What does pain look like in a patient with delirium?

Pain and delirium in people with dementia in the acute general hospital setting

Alexandra R. Feast[1], Nicola White[1], Kathryn Lord[2], Nuriye Kupeli[1], Victoria Vickerstaff[1,3], Elizabeth L. Sampson[1,4]

- Pain at rest → 3x more likely to have delirium
- 1/3 of patients with delirium unable to report whether they were in pain
- Presence of opioids NOT associated with increased risk of pain

What does pain look like in a patient with delirium?

The Impact of Delirium on the Circadian Distribution of Breakthrough Analgesia in Advanced Cancer Patients

Bruno Gagnon, MD, Peter G. Lawlor, MB, Isabelle L. Mancini, MD, Jose L. Pereira, MB, John Hanson, MSc, and Eduardo D. Bruera, MD

- Regular cancer-related pain – PRN doses mostly occur in the morning
- Delirium → PRNs mostly in the evening and at night

What does pain look like in a patient with delirium?

- Severe pain associated with delirium
- Opioids NOT associated with delirium

How do we treat pain in a ~~human~~ mouse with delirium?

THE EFFECT OF DOPAMINERGIC STIMULATION AND BLOCKADE ON THE NOCICEPTIVE AND ANTINOCICEPTIVE RESPONSES OF MICE*

F. CANKAT TULUNAY**, S.B. SPARBER and A.E. TAKEMORI

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Received 9 December 1974, revised MS received 4 February 1975, accepted 17 April 1975

The antipsychotic aripiprazole induces antinociceptive effects: Possible role of peripheral dopamine D_2 and serotonin 5-HT_{1A} receptors

Ana F. Almeida-Santos [1], Renata C.M. Ferreira [1], Igor D. Duarte, Daniele C. Aguiar, Thiago R.L. Romero *, Fabricio A. Moreira *

Department of Pharmacology, Institute of Biological Sciences, Universidade Federal de Minas Gerais, Av. Antônio Carlos 6627, 31270-901 Belo Horizonte, MG, Brazil

How do we treat pain in a human ~~mouse~~ with delirium?

- For gastroparesis treatment in the ED, Haldol vs. Placebo
  - 5.37 vs. 1.11 mean pain reduction
  - 2.70 vs. 0.72 mean nausea score reduction

How do we treat pain in a human ~~mouse~~ with delirium?

- For headache treatment in the ED, Haldol vs. Placebo
  - 4.77 vs. 1.87 mean pain reduction
  - 58.65% complete resolution of headache in the Haldol group

How do we treat pain in a human ~~mouse~~ with delirium?

- 2015 study of Palliative Care consults from 2011-2014
- Patients who were taking opioids but still had pain were offered very low dose Methadone + Haloperidol
- 43 patients were converted to this regimen
- Median Pain at week -1 = 5
- Median Pain at week 1 = 1
- Median Pain at week 2 = 0

Case based discussion

Case progression – c/o Lindsey Gossip RN

- In the following days the patient becomes more somnolent, is eating and drinking less, and becomes bedbound. The patient continues to have signs of pain (moaning, frowning, restlessness in bed) but Dilaudid does not seem to help.
- A dose of Haldol 0.5mg SC is given and patient settles down to sleep soon after. Haldol is ordered regularly and the Dilaudid is changed back to PRN. The patient becomes calmer and soon enters the actively dying phase. The patient then dies a day later at home, peacefully.

Discussion

Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- We hope to see you again at our next session taking place **February 26, 2025 from 12-1pm ET** on the topic of **Communication Part 1.**
- Thank you for your participation!

Thank You

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