Potpourri of Palliative Care Pearls for Ob/Gyn Providers

Carolyn Lefkowits MD
University of Colorado
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Disclosures

- Vertex pharmaceuticals ad board

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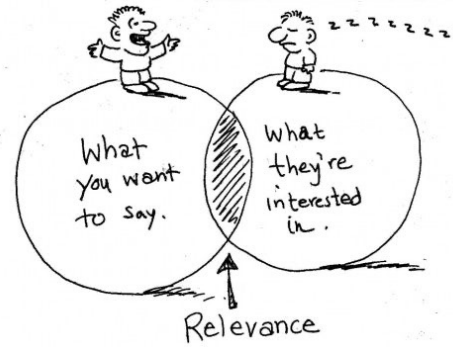

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Objectives

- Define palliative care and differentiate it from hospice care
- List the requirements for medical decision-making capacity
- Differentiate advance care planning from advance directives
- Utilize best case – worst case – most likely case framework for discussing prognosis
- Incorporate elucidation of patient values into shared decision-making
- Align post-operative opioid prescribing practices with national recommendations

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Outline

- What is palliative care?
- Advance care planning
- Complex communication
- Symptom management

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What is Palliative Care?

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

-Center to Advance Palliative Care (CAPC)

"an extra layer of support"

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Palliative Care vs Hospice

- Palliative care is **NOT** synonymous with end of life care or hospice
- Palliative care **CAN** be offered concurrently with curative intent therapy

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What services does palliative care provide?

- Assistance with Advance Care Planning
- Communication support - high stakes conversations
- Assessment & treatment of Symptoms
- Psychosocial, spiritual & bereavement support

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Primary vs. Specialty Palliative Care

PRIMARY PALLIATIVE CARE	SPECIALTY PALLIATIVE CARE
• Basic management pain & other physical symptoms	• Management refractory pain & other symptoms
• Basic management depression & anxiety	• Management complex depression, anxiety, grief, existential distress
• Basic discussions about: prognosis, goals of care, suffering, code status	• Conflict resolution regarding goals of care
	• Addressing cases of near futility

Quill & Abernethy NEJM 2013

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"He's our new Palliative Specialist!"

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Outline

- What is palliative care?
- Advance care planning
  - Capacity
  - ACP vs Advance directives
  - Code status
- Complex communication
- Symptom management

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Medical Decision-Making Capacity

What it is

- Temporal
- Situational
- Requirements
  - Understand relevant information about proposed evaluation/treatment
  - Appreciate their medical situation
  - Use reason to make a decision
  - Communicate a consistent choice

What it isn't

- Agreeing with our recommendation
- Making the same choice we think we'd make for ourselves
- Making what we or patient's friends/family consider a "good" decision

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Medical Decision-Making Capacity

Who determines it?

Any licensed physician

Options for next steps if concern for incapacity

- Obtain collateral information
- Consider family/care coordination meeting
- Communicate with PCP
- Consider consult – SW, psychology, palliative care

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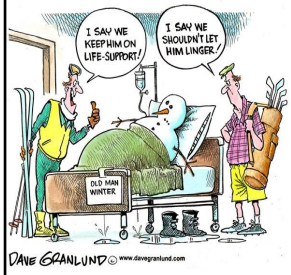
Advance Care Planning vs Advance Directive



Advance Care Planning (ACP): *process* that supports adults at any age or stage of health in understanding and sharing personal values, life goals and preferences regarding future medical care

Advance Directives (AD): *written statement* of a person's wishes regarding medical treatment

Sudore et al JPSM 2017

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3 Types of Advance Directives

1. Medical Power of Attorney: document in which a patient appoints someone to make decisions about her medical care if she cannot make those decisions
   - AKA MD POA, Durable POA for Healthcare (DPAHC), Healthcare Proxy
   - CO is an **all interested parties state**

2. Living Will: document in which a patient's wishes regarding administration of medical treatment are described if patient becomes unable to communicate

3. Physician Orders for Life-Sustaining Treatment (POLST): portable document of provider orders regarding patient preferences for resuscitation and other interventions
   - AKA MOLST, MOST, POST

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Code Status

Two flavors of code status discussions

1. Capturing pre-existing preferences (routine)
2. Broader discussion in context of prognosis, goals of care (prn)

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Routine Code Status Assessment Language

"I want to ask you something I ask all my patients. We don't expect this to happen during this hospitalization, but	**Normalize the ask**
have you ever thought about, if your heart or lungs were to stop working, you were unconscious and not breathing or heart not beating, so you had essentially passed away,	**In this circumstance, patient has essentially passed away**
Would you want your medical team to perform CPR in an attempt to bring you back or would you prefer to be allowed to pass peacefully"	**CPR as an attempt to bring patient back; include alternative to CPR**

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Critical for patients & families to understand:

in the absence of direction to the contrary,
the **default** in our healthcare system is
to proceed with **all available invasive interventions**

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Outline

- What is palliative care?
- Advance care planning
- Complex communication
  - prognosis
  - shared decision-making
- Symptom management

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Pro Gnōsis

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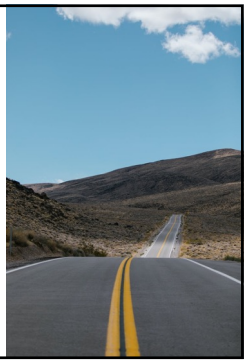
Prognosis = Future

- How long might I live?
- When can I leave the hospital?
- Will my pelvic pain ever go away?
- Will I always leak urine?
- Will I have another miscarriage?



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Structured Approach to Prognosis Discussion

- Name it → *"it sounds like you're wondering what to expect in the future"*
- Clarify the ask → *"what type of information about the future would be helpful?"*
- Framework for delivering prognosis
  - Best case
  - Worst case
  - Most likely case

Inability to make perfect predictions is not an excuse to avoid making any predictions

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Shared decision-making

"process in which clinicians and patients work together to make decisions … and care plans based on clinical evidence that balances risks and expected outcomes **with patient preferences and values**"

What it is **NOT**

- Giving patients a list of options and asking them to choose
- Shepherding patient toward the "right" option

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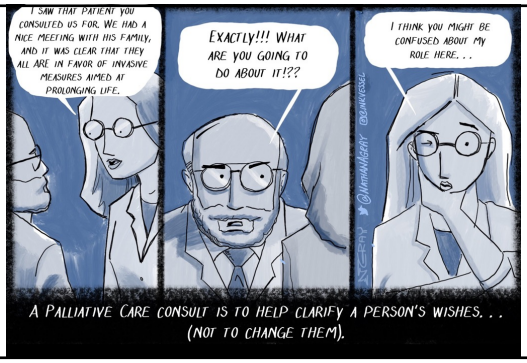

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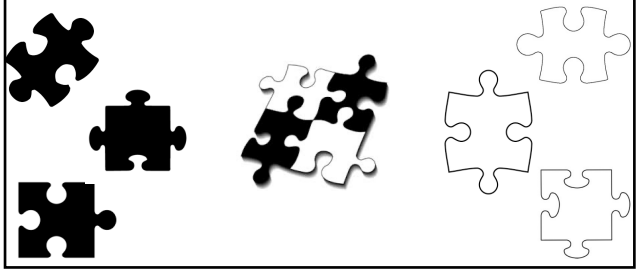
Shared decision-making: goodness of fit

Patient goals & values

Management options



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Exploring patient values/priorities

"Thinking about the future with [your pelvic pain] – what do you hope for most?"

"What bothers you the most about [your hot flashes]?"

"What do you enjoy doing that [your prolapse] interferes with?"

"Are there certain side effects that would be definitely unacceptable to you, where you would feel like the treatment was worse than the problem?"

"[Given what I've told you so far about our treatment options], what factors might be most important to you in choosing between those options"

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Shared decision-making: make a recommendation

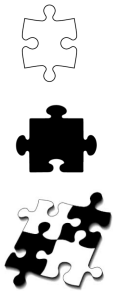
"Given what we've discussed about options for management

COMBINED WITH

what you've told me about your values and priorities

I'D RECOMMEND

[whatever management path you recommend]"



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Outline

- What is palliative care?
- Advance care planning
- Complex communication
- Symptom management
  - General pearls
  - Opioids

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Symptom management pearls

1. Good symptom management starts with good symptom assessment
2. Try to identify etiology of symptom and treat to etiology
3. A constant symptom should be treated with a constant (scheduled) medication
4. Avoid two prn medications for the same indication
5. When assessing efficacy, focus on function

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Four Pillars of CO's CURE

1. Limiting opioid usage
2. Using alternatives to opioids (ALTOs) for the treatment of pain
3. Implementing harm reduction strategies
4. Improving treatment and referral of patients with opioid use disorder (OUD)

https://cha.com/wp-content/uploads/2021/05/CURE_ACOG_final.pdf

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CO's CURE Best Practices

Work with patients to establish realistic goals and expectations for management of pain

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Opioids for Post-operative Pain

Goals for treating acute post-op pain

- Provide adequate pain control: **focus on function!**
- Minimize morbidity
- Return patients safely to opioid independence/baseline use
- Prevent misuse & diversion

"I wish I could tell you we'll be able to get you pain free. Our goal is to get the pain to a place where it's tolerable enough that you can do the things you need to go in order to get better, like eat, sleep and walk"

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CO's CURE Best Practices

Establish standard prescribing practices and default limits for post-operative opioid prescribing

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Case: 45yo P2 pre-op for TAH/BS for 24 week fibroid uterus

- PMH/PSH tobacco use, obesity, no prior surgeries
- SHx married, lawyer
- Current meds: none

How many tabs of 5mg oxycodone would you anticipate prescribing for her at discharge?

1. 0
2. 10
3. 15
4. 20
5. 30

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Recommendations for Post-op Opioid Prescribing*

	Overton et al JACS 2018 (Hopkins)	Michigan Opioid Prescribing Engagement Network (OPEN)	Colorado's CURE
MIS or vaginal hysterectomy	0-10	0-15	0-15
Abdominal hysterectomy	0-20	0-20	0-20
Diagnostic laparoscopy			0-10
H/S D&C			0

*number of tabs 5mg oxycodone or equivalent

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CO's CURE Best Practices

Order a bowel regimen to prevent Opioid Induced Constipation (OIC) in pts receiving opioids unless contraindicated

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CO's CURE Best Practices

Opioids are NOT recommended as first line analgesia for the following conditions

- Chronic Pelvic Pain
- Endometriosis
- Dysmenorrha
- Dyspareunia
- Ovarian cysts
- Vulvodynia
- 1st trimester miscarriage
- Pain after uncomplicated vaginal delivery

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What percentage of Ob/Gyns report prescribing opioids for endometriosis?

1. 5%
2. 10%
3. 25%
4. 50%

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Opioids for Chronic Non-Malignant Pain

Percent prescribing opioids by indication (n=179 ob/gyns)

- Ovarian cysts 30%
- Endometriosis 24%
- Chronic pelvic pain unknown cause 18%

Madsen et al Green Journal 2018

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CO's CURE Best Practices

Tramadol is not a safe opioid. It carries significant side effects and has been associated with significant rates of long-term opioid use

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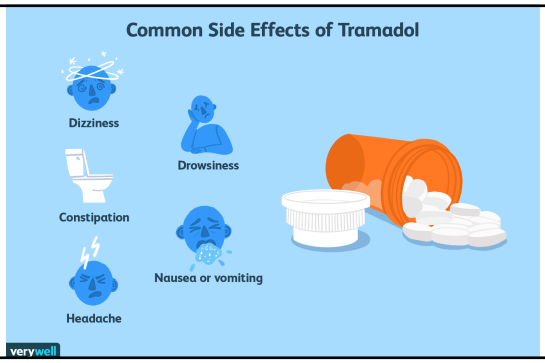

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CO's CURE Best Practices

Avoid or limit if avoidance is not possible prescription or co-adminstration of opioids with barbiturates, benzos, gabapentinoids and other CNS depressants

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Opioids
and
Benzodiazepines
The New FDA Black Box Warning

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Please identify one thing you learned that you might apply in your clinical practice

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Questions?

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