

Palliative Care Tips

Palliative Care Tips - Edited by Yoko Tarumi, MD. Royal Alexandra Hospital. Original Contributor: Peter Lawlor, MD, Doreen Oneschuk, MD. Tertiary Palliative Care Unit, Grey Nuns Community Hospital. - Issue #21 (Collect them all) (Fully revised and issued February 2007)

Palliative Sedation: When considering this practice, it is strongly recommended to consult the Regional Palliative Care Program. PLEASE SEE CHA CLINICAL PRACTICE GUIDELINE:

<http://www.palliative.org/PC/ClinicalInfo/Clinical%20Practice%20Guidelines/PDF%20files/3A6%20Palliative%20Sedation%20and%20Addendum.pdf>

- A process of inducing and maintaining deep sleep in order to relieve **refractory symptom** in the palliative care setting when the patient is actively dying (days to a week of life expectancy).
- Although “terminal sedation” has long been used to describe this practice, **Palliative Sedation** is thought to be a more appropriate term due to the possibility of misinterpreting the intention of sedation as being “termination of life”.
- **Refractory symptom** is a condition where all other possible treatments have failed and no methods are available for alleviation of the symptom within the time frame and risk-benefit ratio that the patient can tolerate based on repeated and careful assessments by skilled experts as well as based on the team’s consensus.
- Various levels and durations of sedation have been described in the literature; however considering the presence of refractory symptoms and proximity of death, it is best to limit Palliative Sedation to deep and continuous sedation. This reflects our current clinical practice.
- Ethical Validity of **Palliative Sedation** as a possible life-shortening process: recent evidence does not demonstrate any shortening of survival in appropriately selected patients who received Palliative Sedation. It should be emphasized that the intention of this practice is exclusively to relieve the refractory symptoms for those who are actively dying.
- **Palliative Sedation** does not refer to temporary sedation (respite sedation), such as for patient whose expected prognosis is longer than a week, and who require sedation until ongoing treatment takes effect (such as response to treatment for hypercalcemia, treatable infection, etc.).

Questions that need to be answered prior to considering sedation

- has a thorough assessment been conducted to identify and treat reversible problems?
- have appropriate consultations been made with palliative care and other specialists?
- have non-pharmacological approaches been maximized, eg, distraction or relaxation techniques in the case of anxiety/dyspnea?
- have other pharmacological treatments been maximized, eg, appropriate titration of opioids in the case of dyspnea or appropriate dosing of neuroleptics for delirium?
- have the goals of sedation been established and agreed upon the patient and/or family and multi-professional caregivers?
- has DNR status been established based on an informed decision making process for the patient and/or

family?

- has all the process above been documented?
- has temporary sedation been considered? Consider, if necessary, in the event of potentially reversible delirium, and while awaiting the outcome of interventions aimed at reversal.

Pharmacological approach for Palliative Sedation: PLEASE SEE CHA CLINICAL PRACTICE GUIDELINE:
<http://www.palliative.org/PC/ClinicalInfo/Clinical%20Practice%20Guidelines/PDF%20files/3A6%20Palliative%20Sedation%20and%20Addendum.pdf>

- Administer a loading dose of midazolam 2.5-5 mg sc
- Start midazolam infusion at 1mg/hour sc, titrate till patient becomes deeply sedated enough to be comfortable
- The midazolam infusion can be titrated up/down every 5-10 minutes as needed.

REMEMBER: For referrals, questions, or telephone consultations call 496-1300 weekdays and weekends