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Palliative Sedation: To sleep, perchance to dream?

**Queen's University Academic
Palliative Care Rounds
September 11, 2015**

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What is a good death?

- Theme that will weave throughout the weekly rounds in 2015 – 2016
- Focus of panel round on November 20 (Janeta Kobes)
- In 2016, Cheryl Cline will examine the pending situation in Canada regarding physician-assisted dying
- In April 2016, visiting speaker Stephen Jenkinson – provocative ideas and advice on how we (should) die

Goal of This Round

To discuss the use of sedation to manage symptoms and suffering in palliative care patients



Objectives for This Round

At the end of this session you will be able to:

- Define palliative sedation
- Discuss ethical principles relevant to palliative sedation
- State specific indications for palliative sedation
- Describe the application of palliative sedation



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No conflicts of interest

Except....

- I facilitate a one-hour session on Palliative Sedation at our twice-yearly 4-day course for family doctors and nurse practitioners – this needed updating
- I started to teach a seminar for the Palliative Medicine Fellows on this topic – I needed to think about it more
- Physician-assisted suicide/euthansia is on the horizon – much conflict lies ahead

Hamlet: Act III, Scene I, Lines 65-68

To sleep, perchance to dream—ay, there's the rub:

- Hamlet struggles with the thought that there may not be peace in death
- We use sedation to try to relieve intolerable suffering before death occurs

Patient Scenario #1

- 68 year old single woman – PPS 20%
- Metastatic colon cancer
- Steadily declining over 2 weeks - imminently dying
- Family & friends with her at home
 - Expressed wish to stay at home
- Agitated, incoherent, trying to get out of bed
 - Calling “help me, help me” “don’t leave me”
- Unresponsive to haloperidol & opioid rotation

What are the pros and cons of sedating her?

Terminology

- Terminal Sedation
- Total Pharmacological Sedation
- Sedation-induced Sleep
- Sedation in the Imminently Dying Patient
- Sedation for Intractable Distress of a Dying Patient
–(SIDDD Pat)
- Sedation for Intractable Distress in the Dying
- **Palliative Sedation**

Proportional Sedation

- Sedation that is proportional to the severity of the patient's symptoms
 - For symptoms with low suffering, low to moderate sedation may be enough
 - For severe suffering, total unconsciousness may be needed
- The lowest sedation is used to effect symptom control, preserving patient's consciousness

Definition – Palliative Sedation

- Deliberately inducing & maintaining deep sleep
- Not deliberately causing death
- In specific circumstances:
 - To relieve one or more intractable symptoms or profound anguish
 - When other interventions have failed or are not possible
 - When the patient is perceived to be close to death

Sedation for intractable distress in the dying – a survey of experts

- Postal survey
 - 61 selected palliative care experts
 - 87% response rate from 8 countries
 - Various practice settings
- 89% agreed sedation sometimes necessary
- 77% reported using it in prior 12 months



Sedation for intractable distress in the dying – a survey of experts

Reasons for sedation:

- Pain 20%
- Anguish 14%
- Respiratory Distress 12%
- Agitation/delirium/confusion 12%
- Fear/panic/anxiety/terror 10%
- Emotional/spiritual distress 10%

Sedation for intractable distress in the dying – a survey of experts

Medications used:

- Benzodiazepines - **midazolam, lorazepam**, diazepam
- Barbiturates - phenobarbital
- Neuroleptics - **methotrimeprazine**, chlorpromazine, haloperidol
- Anesthetic agents - propofol

Frequency of Use of Palliative Sedation – Systematic Review

- Range 14.6% – 66.7% of patients sedated in 11 studies
- Overall 34.4% of 1807 consecutive patients in 10 studies were sedated
 - 14.6% in a hospital
 - 66.7% in a hospice
 - 52.5% in a home care setting

Reasons for Palliative Sedation – Systematic Review

- Delirium 13.8% – 91.3%
- Dyspnea 8.7% – 63.0%
- Pain 9.5% - 49.2%
- Anxiety or psychological distress 6.0% - 40.0%

Survival with Palliative Sedation – Systematic Review

- No difference in median survival from admission between sedated and non-sedated patients
- Survival generally brief after initiation of sedation:
 - Muller-Busch (2003) - mean 63 hours (SD 58 hours)
 - Kohara (2005) – mean 3.4 days (max 11 days)

Patient Scenario #2

- 56 year old married man – PPS 40%
- Cardiac arrest with anoxic encephalopathy
- In acute care hospital for 6 months
 - Alternate place-of-care not available
- Progressive agitated delirium
 - Not controlled with neuroleptics/mood stabilizers
- Progressive difficulty swallowing

What are the pros and cons of sedating him?



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Ethical Principle Relevant to Palliative Sedation

Principle of Double Effect

Good effect = relieve suffering Bad effect = cause death

Four Conditions:

1. Nature of the act must be good
2. The good effect, not bad effect, must be intended
3. The bad effect must not be the means to the good effect
4. The good effect must outweigh bad effect

Patient Scenario #3

- 45 year old married woman with 2 children – PPS 50%
- Metastatic cervical cancer to bones
- Prognosis can be a few months
- Strong family support
- Intractable 9/10 neuropathic pain in pelvis and legs
- She asks, “Put me to sleep, please.”

What are the pros and cons of sedating her?



Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- For the use of sedation continued until patient's death
- Indicated only for refractory *and* intolerable suffering
- All other available treatments must have been considered, offered, continued or declined
- For existential symptoms alone, use only in rare cases of severe distress

Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- For the patient who cannot communicate preferences, discussion must occur with the substitute decision maker
- Consider CPST only in the last 1-2 weeks of life
- If longer survival is possible:
 - Consider nutrition and hydration during sedation
 - Consider intermittent sedation – lightening the sedation after a previously determined time

Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- Sedation should be titrated to relieve suffering
- Lower the patient's consciousness only to the point needed to relieve suffering
- There should be no intention to cause complete loss of consciousness, although this may occasionally be necessary

Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- Monitor for relief of suffering, level of consciousness and side effects (respiratory, skin breakdown, aspiration)
 - Suggested monitoring every 20 minutes until adequate sedation then 3 times daily
 - Frequency depends on place of care
 - No need to monitor vital signs in last few days of life
 - Consider dose reduction if side effects occur

Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- Occasionally review the decision to use CPST with family, team and, if possible, patient
- Used in this way, no evidence that life is shortened

Canadian Framework for Continuous Palliative Sedation Therapy (CPST)

- Benzodiazepines or sedating antipsychotics used most often
 - Midazolam
 - Methotrimeprazine
 - Barbiturates
 - Propofol
- **Do not use** opioids or haloperidol as the sedating agent
 - Continue opioids for symptom management



Determinants of Decision to Sedate

Are the symptoms refractory/intractable?



Definition of Intractable/Refractory

Three attributes:

1. Aggressive efforts short of sedation fail to relieve
2. Additional treatments cannot provide relief
3. Additional therapies are associated with excessive or unacceptable morbidity & are unlikely to provide relief in reasonable time



Determinants of Decision to Sedate

Have all possible interventions been considered?



Courtesy of the Robert Pope Foundation



Determinants of Decision to Sedate

What about existential distress?



Existential distress

- Death anxiety
- Meaning of life
- Grief resulting from loss
- Loss of control
- Loss of dignity



Determinants of Decision to Sedate

Is the patient “close to death”?





Supportive Therapy with Sedation

Nutrition and hydration?



Medications Used for Palliative Sedation

- Midazolam - most commonly used
 - Rapid onset benzodiazepine
 - Route IV or SC
 - Starting dose 0.5 - 1 mg/hour and 1 - 5 mg prn
 - Usual effective dose 1 - 20 mg/hour

Medications Used for Palliative Sedation

- Lorazepam
 - Intermediate-acting benzodiazepine
 - Route IV or SC
 - Starting dose 0.05 mg/kg q2-4h by intermittent bolus

Medications Used for Palliative Sedation

- Methotrimeprazine
 - Phenothiazine
 - Route IV or SC
 - 12.5 – 25 mg stat then 50 – 75 mg continuous infusion (presumably per day)
 - Usual effective dose 12.5 – 25 mg q8h and q1h prn or up to 300 mg/day continuous infusion

Patient Scenario #4

- 72 year old married man – PPS 50%
- Recent diagnosis of advanced lung cancer
- He decided against antineoplastic treatments
- Admitted to hospital with weakness
 - No pain or dyspnea
- Very anxious - expresses a wish to die
- Requests sedation

What are the pros and cons of sedating him?

Does Palliative Sedation Present an Ethical Dilemma?

YES

- Significance of intent
- Control of psychological/existential suffering
- Potential for abuse

Does Palliative Sedation Present an Ethical Dilemma?

NO

- Supported by ethical principles if combined with informed consent
- Address potential for abuse with guidelines
- The best alternative to manage intractable suffering

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