Ente Ospedaliero Cantonale

Update: cure palliative

Dr.ssa med. Claudia Gamondi, Primario Clinica di Cure Palliative e di Supporto

- Proiezioni future
- Decisioni difficili
- Discussioni difficili

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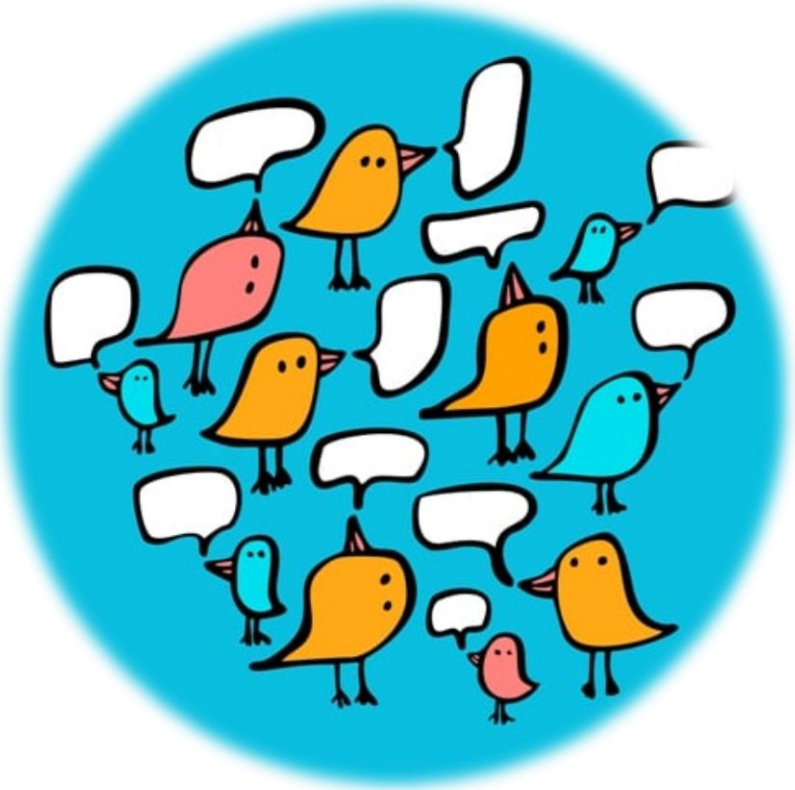

The escalating global burden of serious health-related suffering: projections to 2060 by world regions, age groups, and health conditions

Katherine E Sleeman, Maja de Brito, Simon Etkind, Kennedy Nkhoma, Ping Guo, Irene J Higginson, Barbara Gomes, Richard Harding

Summary

Background Serious life-threatening and life-limiting illnesses place an enormous burden on society and health systems. Understanding how this burden will evolve in the future is essential to inform policies that alleviate suffering and prevent health system weakening. We aimed to project the global burden of serious health-related suffering requiring palliative care until 2060 by world regions, age groups, and health conditions.

Methods We projected the future burden of serious health-related suffering as defined by the *Lancet* Commission on Palliative Care and Pain Relief, by combining WHO mortality projections (2016–60) with estimates of physical and psychological symptom prevalence in 20 conditions most often associated with symptoms requiring palliative care. Projections were described in terms of absolute numbers and proportional change compared with the 2016 baseline data. Results were stratified by World Bank income regions and WHO geographical regions.

Findings By 2060, an estimated 48 million people (47% of all deaths globally) will die with serious health-related suffering, which represents an 87% increase from 26 million people in 2016. 83% of these deaths will occur in low-income and middle-income countries. Serious health-related suffering will increase in all regions, with the largest proportional rise in low-income countries (155% increase between 2016 and 2060). Globally, serious health-related suffering will increase most rapidly among people aged 70 years or older (183% increase between 2016 and 2060). In absolute terms, it will be driven by rises in cancer deaths (16 million people, 109% increase between 2016 and 2060). The condition with the highest proportional increase in serious-related suffering will be dementia (6 million people, 264% increase between 2016 and 2060).

Interpretation The burden of serious health-related suffering will almost double by 2060, with the fastest increases occurring in low-income countries, among older people, and people with dementia. Immediate global action to integrate palliative care into health systems is an ethical and economic imperative.

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See Comment page e815

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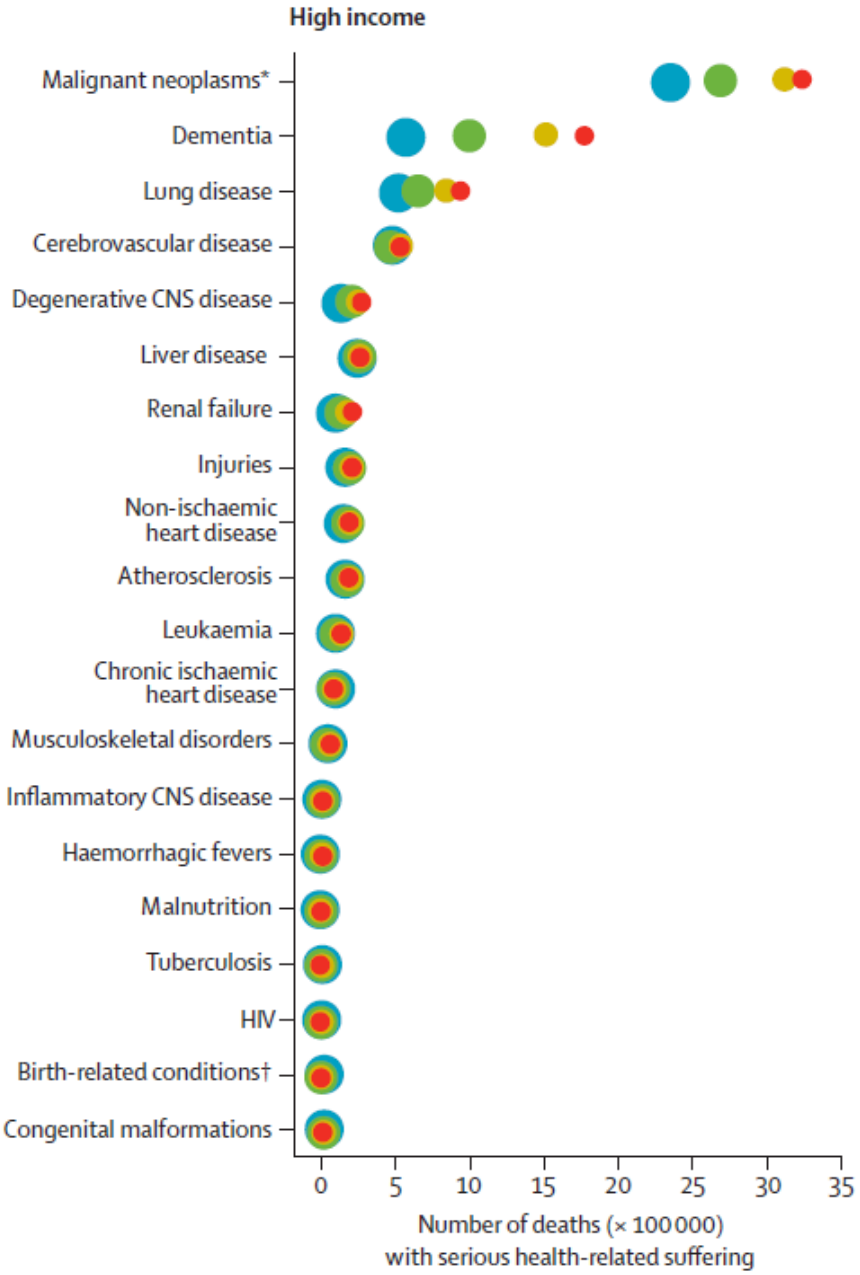
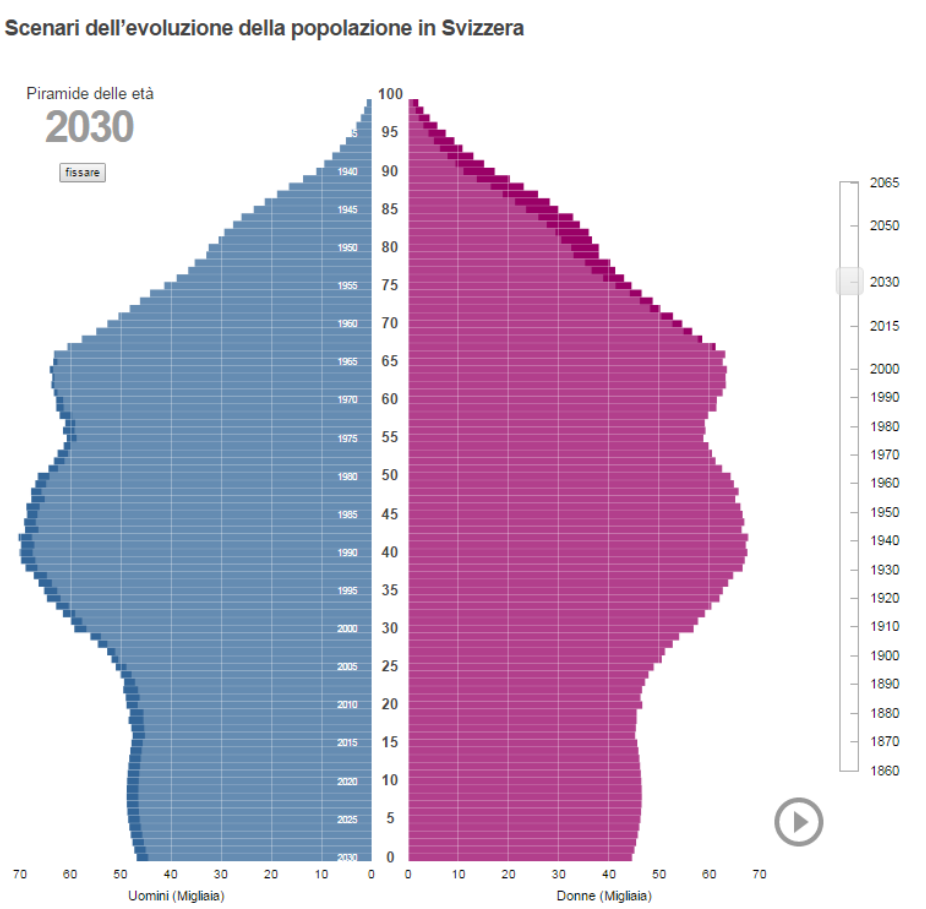
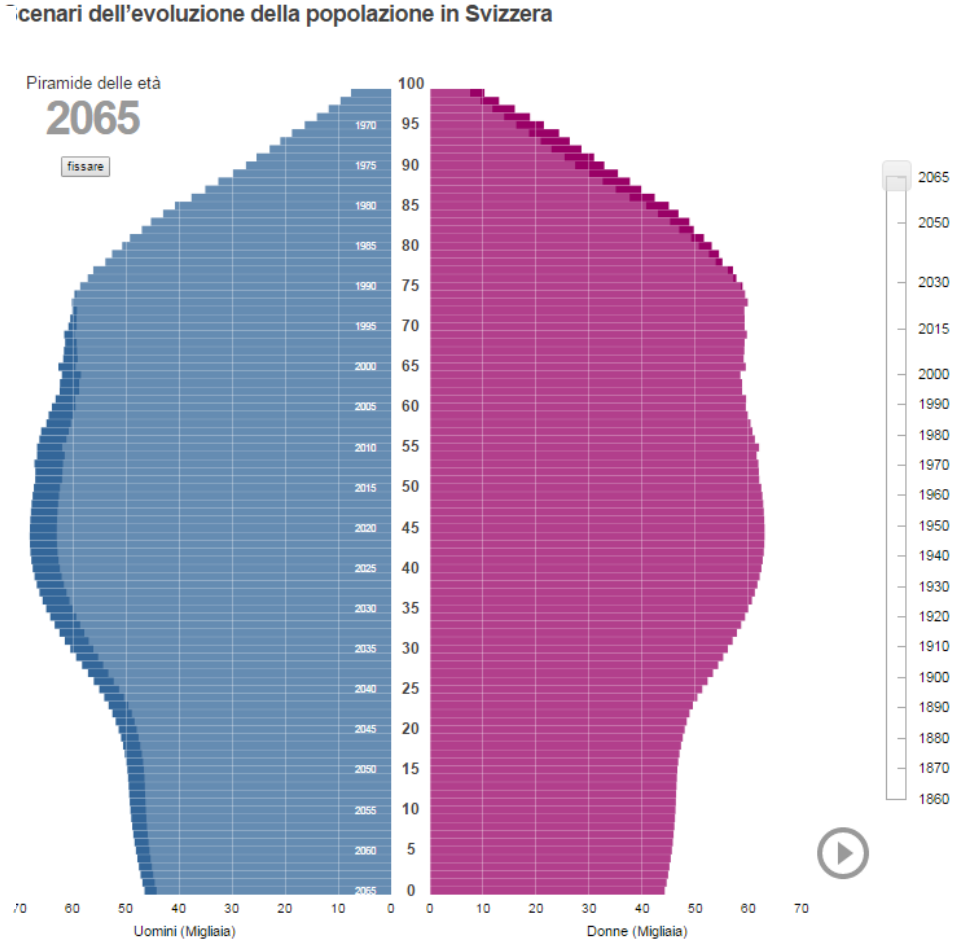


- Strategic priorities
- Clinical priorities
- Health care facilities priorities

Scenari dell'evoluzione della popolazione in Svizzera





www.pallclick.ch

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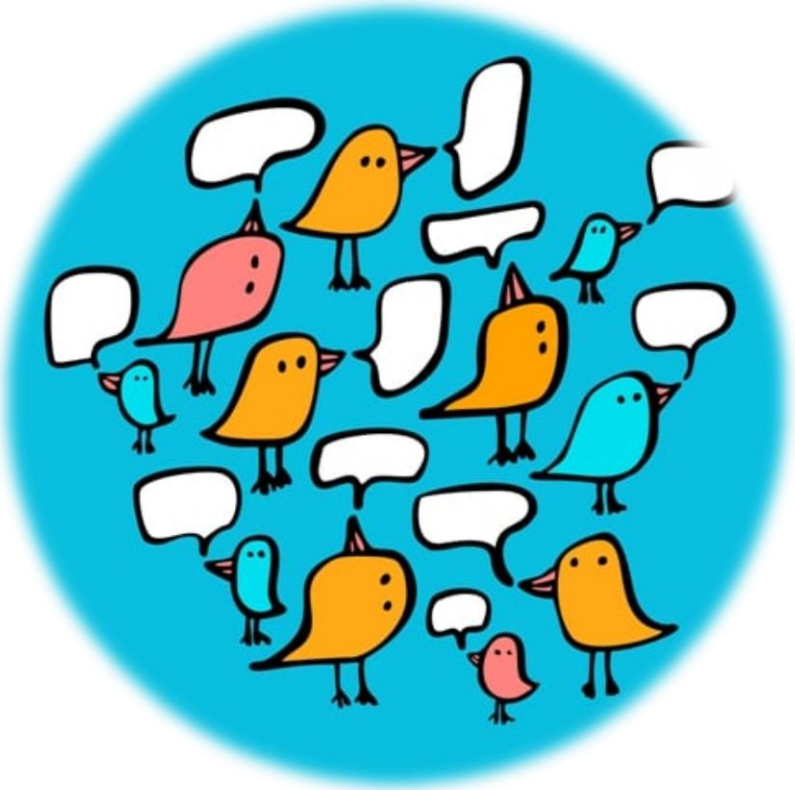
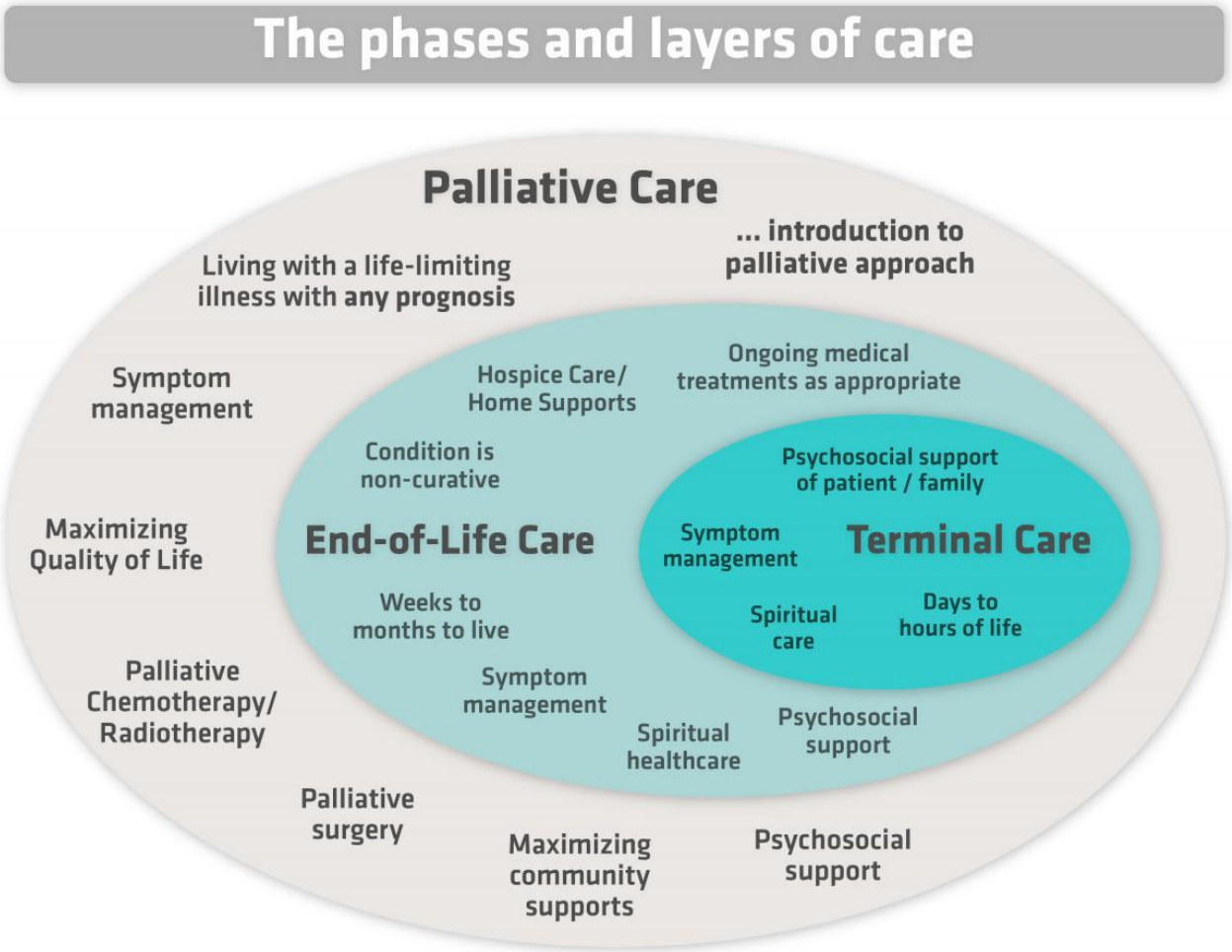


Recognizing and managing key transitions in palliative care



Recognising and managing key transitions in palliative care

Box 1 Supportive and palliative care indicators tool

(1) Ask

- Does this patient have an advanced long term condition, a new diagnosis of a progressive life limiting illness, or both? (Yes)
- Would you be surprised if this patient died in the next 6-12 months? (No)

(2) Look for one or more general clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% of the day) or deteriorating
- Progressive weight loss (>10%) over the past 6 months
- Two or more unplanned admissions in the past 6 months
- Patient is in a nursing care home or continuing care unit, or needs more care at home

Murray, *BMJ* 2010

Recognising and managing key transitions in end of life care

Transition 2: Is my patient reaching the last days of life?

Box 2 Clinical indicators for terminal care

Q1 Could this patient be in the last days of life?

Clinical indicators of dying may include:

- Confined to bed or chair and unable to self care
- Having difficulty taking oral fluids or not tolerating artificial feeding/hydration
- No longer able to take oral medication
- Increasingly drowsy

Murray, *BMJ* 2010

Q2 Was this patient's condition expected to deteriorate in this way?
Q3 Is further life-prolonging treatment inappropriate?

- Further treatment is likely to be ineffective or too burdensome.
- Patient has refused further treatment.
- Patient has made a valid advance decision to refuse treatment.
- A healthcare proxy has refused further treatment on the patient's behalf.

Q4 Have potentially reversible causes of deterioration been excluded?
These may include:

- Infection (eg, urine, chest, cholangitis, peritonitis, neutropenia)
- Dehydration
- Biochemical disorder (calcium, sodium, blood sugar)
- Drug toxicity (eg, opioids, sedatives, alcohol)
- Intracranial event or head injury
- Bleeding or severe anaemia
- Hypoxia or respiratory failure
- Acute renal impairment
- Delirium
- Severe constipation
- Depression

Murray, *BMJ* 2010

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Murray, *BMJ* 2010

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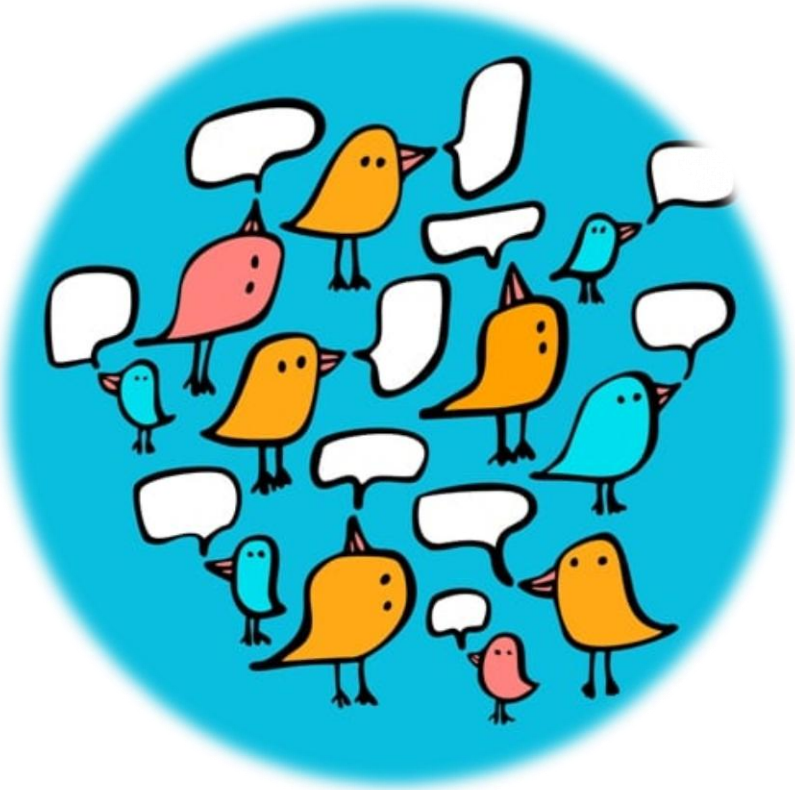


Deprescribing

«Reducing potentially inappropriate medications in palliative care cancer patients: evidence to support **deprescribing** approaches.»

Lindsay J et al, Support Care Cancer 2014; 22: 1113-1119

«Recommendations to support **deprescribing** medications late in life.»

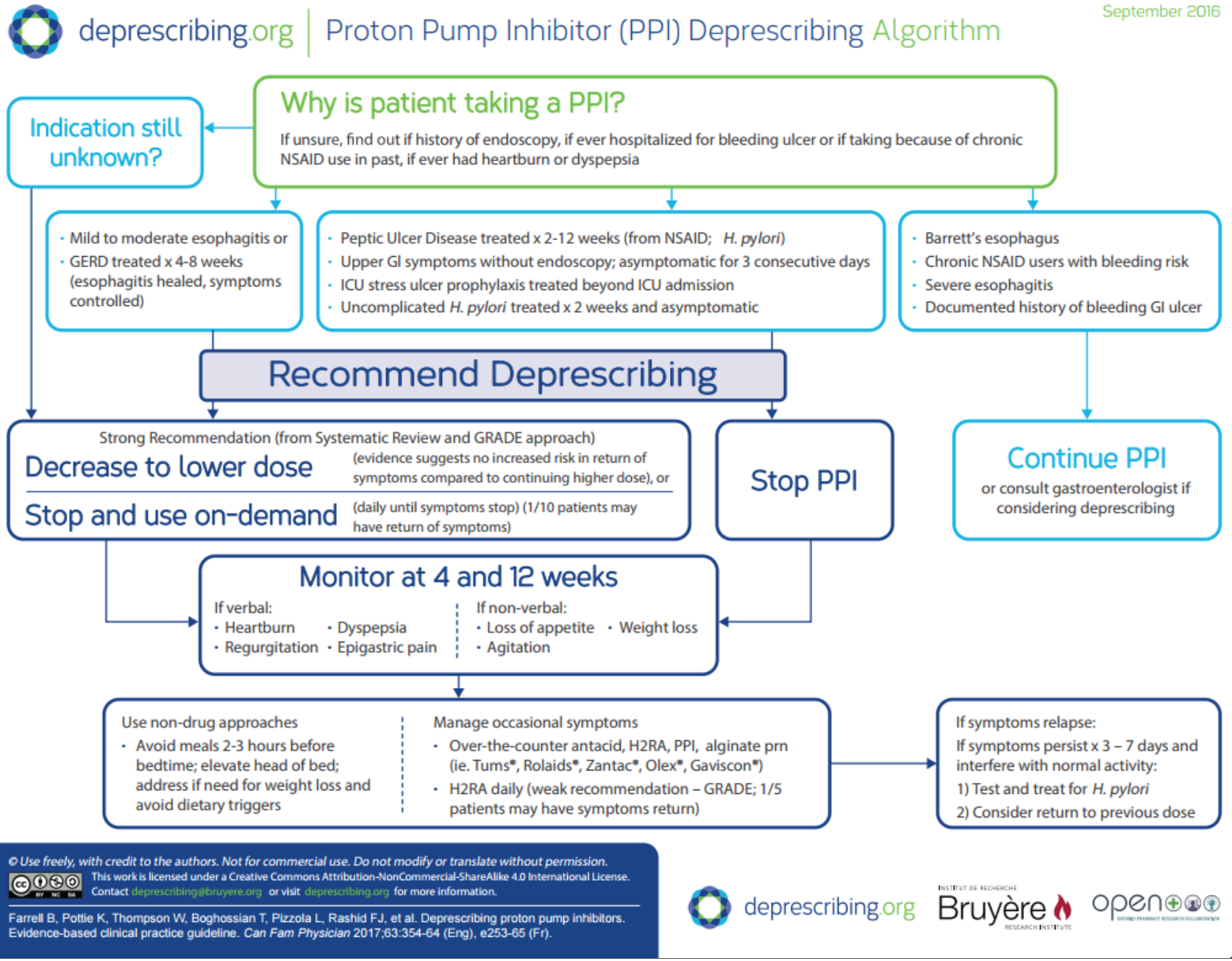
Todd A et al, Int J Clin Pharm 2015 (June 2015, epub ahead)

«The development and evaluation of an oncological palliative care deprescribing guideline: the **OncPal deprescribing guideline**.»

Lindsay J et al, Supp Care Cancer 2015; 23: 71-78

CONCLUSIONI:

- PIMs: «Potentially Inappropriate Medicines»: una categoria di farmaci che si può definire
- PIMs e polypharmacy sono un problema frequente in pazienti onco in palliazione
- Il buon senso non basta per gestire sospensione farmaci, soprattutto per medici «titubanti»
- **«OncPal Deprescribing Guideline»:** strumento validato, utile e pratico


deprescribing.org | Proton Pump Inhibitor (PPI) Deprescribing Algorithm
September 2016
Why is patient taking a PPI?
If unsure, find out if history of endoscopy, if ever hospitalized for bleeding ulcer or if taking because of chronic NSAID use in past, if ever had heartburn or dyspepsia
Indication still unknown?
• Mild to moderate esophagitis or
• GERD treated x 4-8 weeks (esophagitis healed, symptoms controlled)
• Peptic Ulcer Disease treated x 2-12 weeks (from NSAID; H. pylori)
• Upper GI symptoms without endoscopy; asymptomatic for 3 consecutive days
• ICU stress ulcer prophylaxis treated beyond ICU admission
• Uncomplicated H. pylori treated x 2 weeks and asymptomatic
• Barrett's esophagus
• Chronic NSAID users with bleeding risk
• Severe esophagitis
• Documented history of bleeding GI ulcer
Recommend Deprescribing
Strong Recommendation (from Systematic Review and GRADE approach)
Decrease to lower dose (evidence suggests no increased risk in return of symptoms compared to continuing higher dose), or
Stop and use on-demand (daily until symptoms stop) (1/10 patients may have return of symptoms)
Stop PPI
Continue PPI
or consult gastroenterologist if considering deprescribing
Monitor at 4 and 12 weeks
If verbal:
• Heartburn • Dyspepsia
• Regurgitation • Epigastric pain
If non-verbal:
• Loss of appetite • Weight loss
• Agitation
Use non-drug approaches
• Avoid meals 2-3 hours before bedtime; elevate head of bed; address if need for weight loss and avoid dietary triggers
Manage occasional symptoms
• Over-the-counter antacid, H2RA, PPI, alginate prn (ie. Tums®, Rolaids®, Zantac®, Olex®, Gaviscon®)
• H2RA daily (weak recommendation – GRADE; 1/5 patients may have symptoms return)
If symptoms relapse:
If symptoms persist x 3 – 7 days and interfere with normal activity:
1) Test and treat for H. pylori
2) Consider return to previous dose
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This work is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.
Contact deprescribing@bruyere.org or visit deprescribing.org for more information.
Farrell B, Pottie K, Thompson W, Boghossian T, Pizzola L, Rashid FJ, et al. Deprescribing proton pump inhibitors. Evidence-based clinical practice guideline. Can Fam Physician 2017;63:354-64 (Eng), e253-65 (Fr).
deprescribing.org
Bruyère RESEARCH INSTITUTE

«Deprescribing»: Dal buon senso all'evidenza scientifica

Box 2. Barriers to deprescribing[1,2,8,9]

- Limited time.[1]
- Lack of clarity over whose role it is to deprescribe.[8]
- Concern regarding stopping medications initiated by specialists.[1]
- Uncertainty regarding the ongoing benefits of medications.[1]
- Concern over drug withdrawal effects.[2]
- Uncertainty regarding the timing of deprescribing discussions when goals of care are unclear.[1]
- Concern from healthcare professionals that patients may feel they are 'giving up hope'.[9]
- Reluctance from patients to change medications.[2]

Thompson, 2019

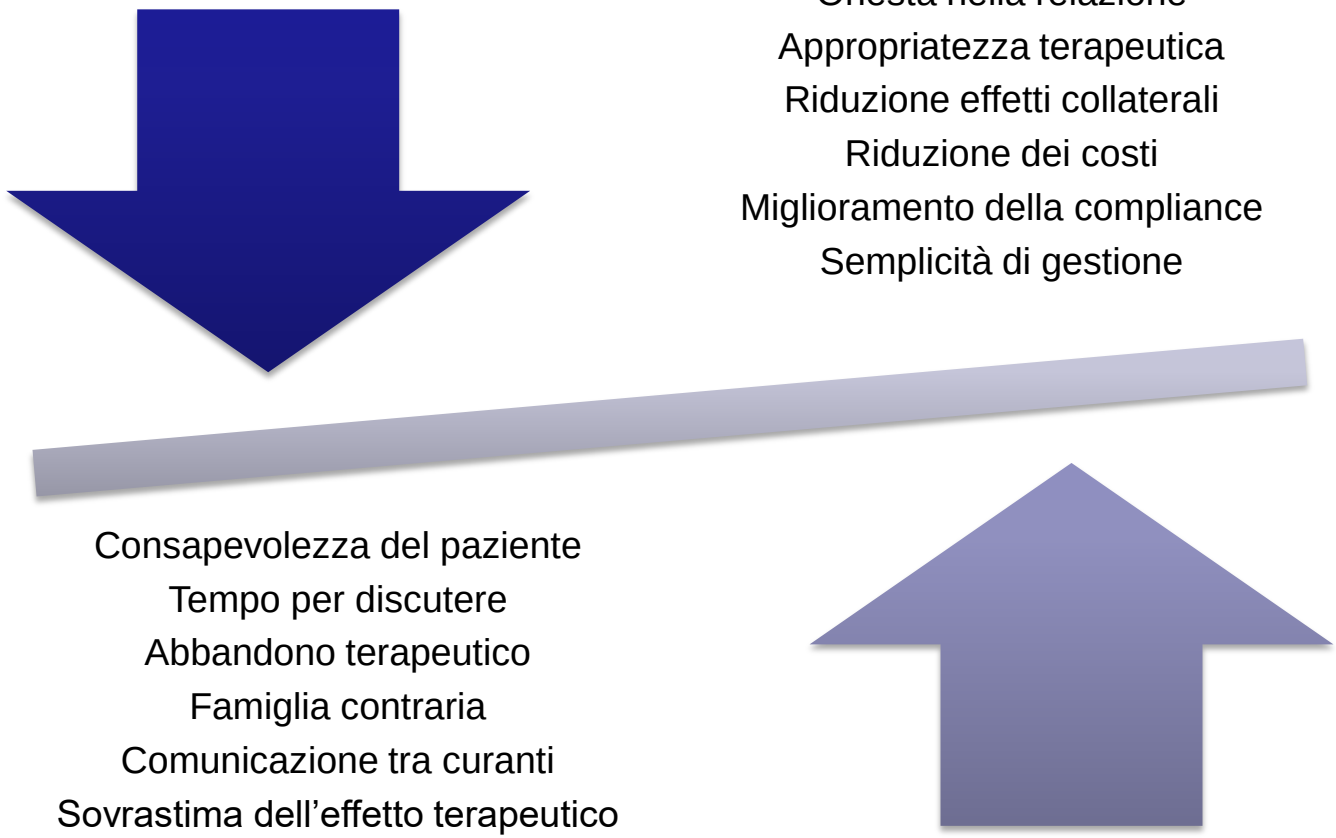
Table 1. The OncPal deprescribing guideline.

Class of medication	Medication	Situations of limited benefit
Aspirin	Aspirin	Primary prevention
Lipid lowering medications	Statins	All indications
	Fibrates	
	Ezetimibe	
Blood pressure lowering medications	ACE inhibitors	Mild to moderate hypertension
	Sartans	Secondary prevention of cardiovascular events
	Beta blockers	Management of stable coronary artery disease
	Calcium channel blockers	
	Thiazide	
	Diuretics	
Anti-ulcer medications	Proton pump inhibitors	All indications unless recent history of gastrointestinal bleeding, peptic ulcer, gastritis, GORD, or the concomitant use of NSAIDs and steroids
	H2 antagonists	
Oral hypoglycaemics	Metformin	Mild hyperglycaemia (prevention of diabetic complications)
	Sulfonylureas	
	Thiazolidinediones	
	DPP-4 inhibitors	
	GLP-1 analogues	
	Acarbose	
Osteoporosis medications	Bisphosphonates	All indications except hypercalcaemia
	Raloxifene	
	Strontium	
	Denosumab	
Vitamins	n/a	All except treatment of low serum concentrations
Minerals	n/a	All except treatment of low serum concentrations
Complementary therapies	n/a	All indications

Adapted with permission from Lindsay J, Dooley M, Martin J *et al.* The development and evaluation of an oncological palliative care deprescribing guideline: the 'OncPal deprescribing guideline'. *Support Care Cancer* 2015;23:71–8.

ACE = angiotensin-converting enzyme; DPP-4 = dipeptidyl peptidase-4; GLP-1 = glucagon-like peptide-1; GORD = gastro-oesophageal reflux disease; NSAIDs = nonsteroidal anti-inflammatory drugs; n/a = not applicable.

Come decidiamo?



Onestà nella relazione
Appropriatezza terapeutica
Riduzione effetti collaterali
Riduzione dei costi
Miglioramento della compliance
Semplicità di gestione

Consapevolezza del paziente
Tempo per discutere
Abbandono terapeutico
Famiglia contraria
Comunicazione tra curanti
Sovrastima dell'effetto terapeutico

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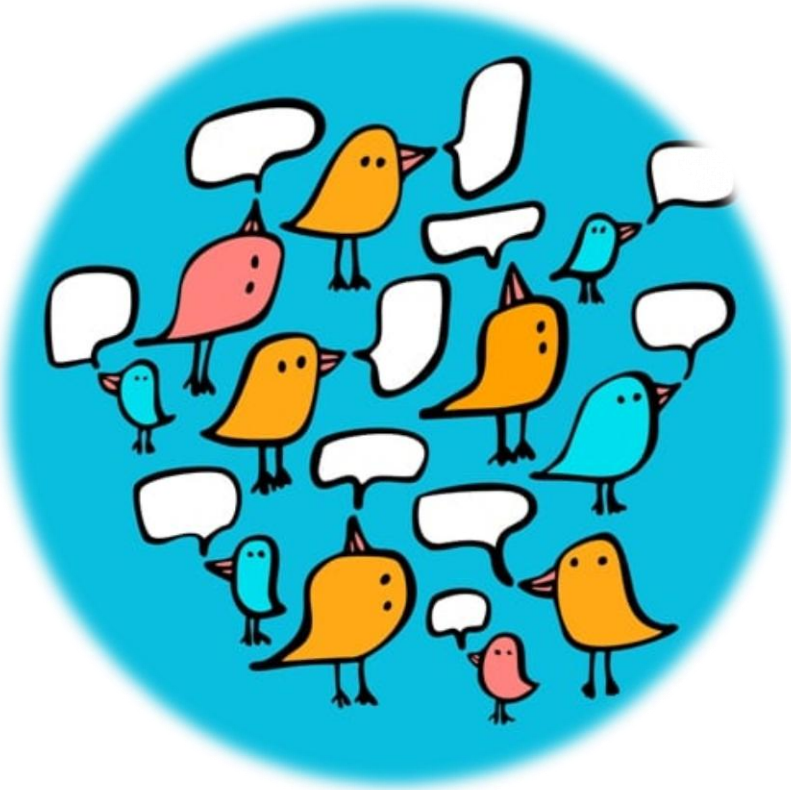

Review

OPEN ACCESS

CPR decision-making conversations in the UK: an integrative review

Charlie C Hall,[1] Jean Lugton,[2] Juliet Anne Spiller,[2] Emma Carduff[3]

PFC preferences	Opportunities/Shape of future care
▶ Initiation of discussion by someone trusted with an existing relationship ▶ Not necessarily just doctors—role also for nursing and AHP teams	▶ Proactively seeking out opportunities in community by GPs and nursing teams (eg, posthospital discharge[27]) ▶ Proactive use of tools in hospital and community (such as the SPICT tool[48]) to identify patients who would benefit from ACP discussions, followed by targeted outreach by familiar medical/nursing team ▶ Improving electronic communication between primary and secondary care teams regarding existing ACP/DNACPR discussions: use of electronic Palliative Care Summaries (such as the eKIS[44] ▶ Empowering and encouraging all clinical staff to develop communication skills and mandatory training to encompass ACP/DNACPR discussions. ▶ Development of specific ACP nursing roles to lead and educate rotating staff within individual wards/units/GP practices ('Link' nurse roles in hospital wards to interact with palliative care teams where needed for advice, GP practice 'ACP outreach' roles to monitor patients requiring ACP follow-up at regular practice meetings)
▶ Most want family involved ▶ Some fear burdening family members	▶ Development of support roles in acute settings following ACP discussions and to identify follow-up conversations needed ▶ Integration of ACP screening questions at specialist outpatient clinic (eg, chronic disease/oncology) where frequently patients have established trusted relationships. ▶ Initiating ACP discussions can be enabling for patients/families, especially in diseases such as MND[29] ▶ Incorporation of 'What (and who) matters to me' section in to any ACP created with helpful descriptions such as 'Would *'always/prefer/not wish'*.... Mr/Mrs X, Tel.... to be involved in decisions about my care'
▶ When? Timing of discussion needs to be individualised and early in illness ▶ Where? Not during acute admissions, dislike of busy wards (vulnerability impacts on decision making)	▶ Development of national processes to improve consistent awareness of good practice approach to such discussions (eg, http://www.ReSPECTprocess.org.uk)[12] and incorporation of these conversations in to routine ACP planning ▶ Prioritising person-centred quiet areas in workplaces/wards for discussions ▶ Routine patient ACP information gathering on ALL admissions to hospital: Checking electronic information summaries,[44] legal (welfare/financial/combined) guardian/power of attorney, next of kin, 'What/Who matters to me'?, advance statement/living will to aid in ACP discussions
▶ Delivery: Individualised, honest, straightforward, empathetic language. Avoiding vague terms. Consider level of education/literacy. Include discussion about QOL	▶ Development of a consistent approach to communication skills training dealing with issues around ACP/DNACPR conversations embedded within medical and nursing education curricula; from undergraduate/preregistration level and throughout generalist/specialist careers. Greater understanding and embedding of health literacy approaches and resources within acute and community care settings


Palliative
Care
body
mind
spirit
dignity
comfort
chaplain
communication
autonomy
choices
Respect
disease
end of life
person—centered
partnership
moral
celebrate
Resolution
nursing
support
pain management
decision—making
family
spiritual
care

Corso di Cure Palliative Generali per Medici

FORMAZIONE CONTINUA

- Area economia e diritto
- Area lavoro sociale
- Area sanità
  - Clinica generale e Gestione sanitaria
  - Cure palliative
  - Riabilitazione
  - Physiotherapie Graubünden
- Formazione su misura
- Catalogo offerta formativa
- Sede e contatti

Corso di cure palliative generali per medici

Le cure palliative rappresentano un tema di salute pubblica importante e complesso, sia quelle generali prodigate dalla maggior parte dei professionisti della salute, sia quelle specialistiche riservate a particolari categorie di pazienti.
Una delle sfide del futuro è la diffusione dell'approccio palliativo nelle cure domiciliari, nelle case anziani e negli ospedali a beneficio dei pazienti affetti da malattie cronico evolutive, con particolare attenzione alle malattie non oncologiche.

La strategia nazionale e la strategia cantonale in materia di cure palliative emanata dall'Ufficio del Medico Cantonale in Ticino mettono l'accento sulla formazione del personale curante.
Per rispondere a questa richiesta, la Scuola universitaria professionale della Svizzera italiana (SUPSI), in collaborazione con l'Ordine dei Medici del Canton Ticino e la Clinica di Cure Palliative dell'Istituto Oncologico della Svizzera Italiana (IOSI), offre un corso specifico di cure palliative generali, adattato ai bisogni dei medici attivi nelle specialità coinvolte.

Obiettivi

Il corso ha lo scopo di fornire e affinare gli strumenti necessari a riconoscere e curare i pazienti meritevoli di cure palliative a un livello non specialistico.

ISCRIZIONE

- Iscrizione online

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