1.19 Pulmonary Disease

Key Points

1. Palliative evaluation includes assessment of physical, emotional, social, and spiritual suffering.

   Evaluate for uncontrolled physical symptoms such as dyspnea and asthenia; for emotional distress secondary to physical decline; social distress secondary to debility and need for additional support and services; and spiritual distress in the form of existential angst and hopelessness.

2. The palliative response includes managing symptoms, assisting with advance directive and hospice referral, and prognostication and truth-telling.

   Managing symptoms includes developing a plan of care to palliate symptoms unrelieved by disease-modifying treatment. Advance planning includes discussing choice of surrogate decision maker(s) and treatment preferences.

3. Prognostication and truth-telling is valuable to treatment process and to patient/family planning.

   Truth-telling about prognosis assists with symptom management, enables doctor/patient/family to access community resources, fosters preparing and planning care, and helps families avoid lurching from crisis to crisis.

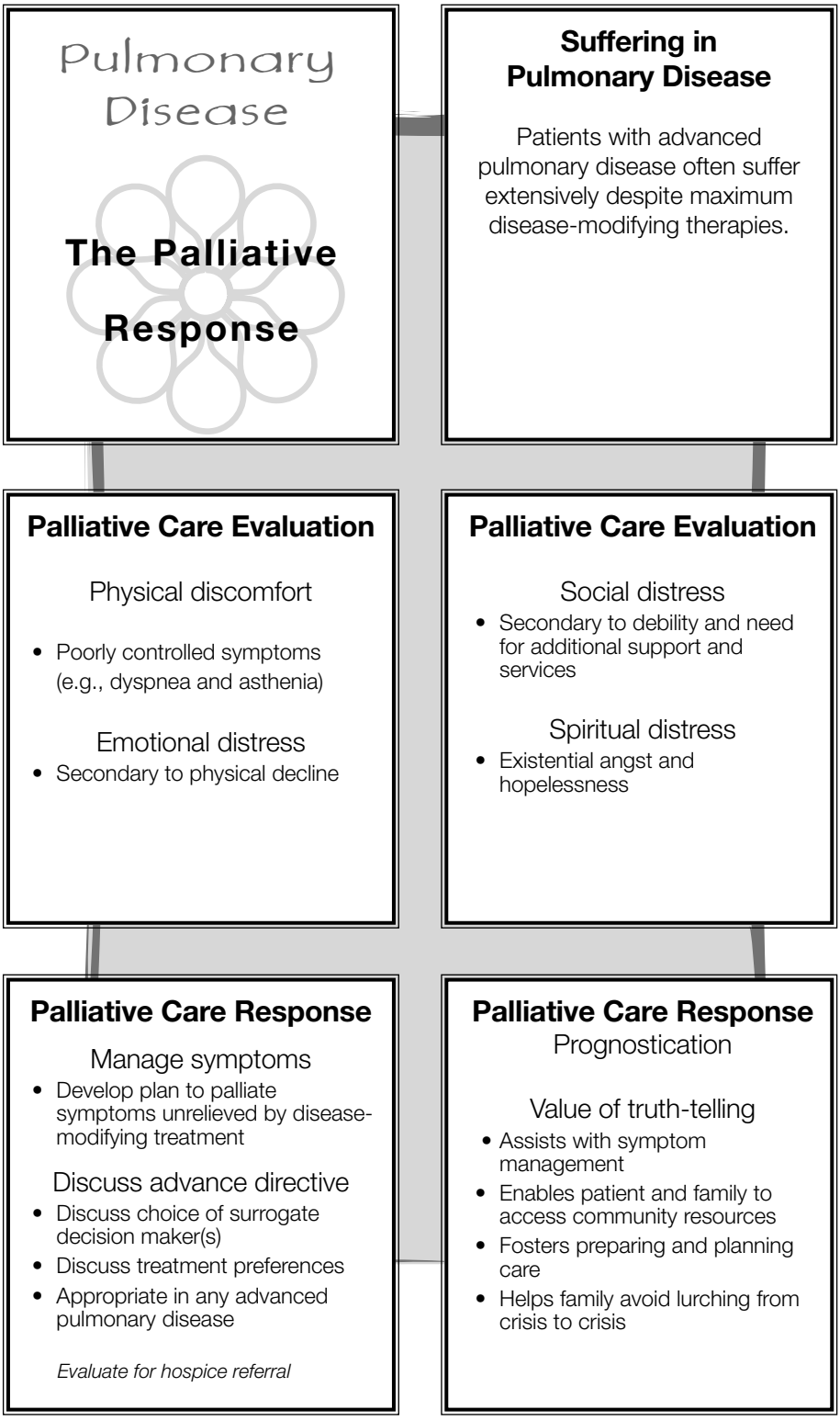
4. Disabling dyspnea is a marker for poor prognosis in advanced pulmonary disease.

   Disabling dyspnea is dyspnea at rest despite maximum medical management. Patients may be very limited (e.g., bed-to-chair or mostly bed confined), and other problems often present (e.g., cough, profound fatigue). Consider co-morbid illnesses.

5. Functional markers for poor prognosis include multiple Emergency Room visits and hospital admissions, declining functional status based on assessment of activities of daily living (ADL), and inability to live independently.

6. There are five key clinical markers for poor prognosis in pulmonary disease:

   Weight loss greater than or equal greater than 10% of body weight over six months; resting tachycardia greater than 100 heart beats/minute; hypoxemia at rest despite supplemental oxygen, such as 21 NP; hypercapnia or pCO2 greater than or equal to 50mm HG; and evidence of right heart failure.


Pulmonary Disease
The Palliative Response
Suffering in Pulmonary Disease
Patients with advanced pulmonary disease often suffer extensively despite maximum disease-modifying therapies.
Palliative Care Evaluation
Physical discomfort
• Poorly controlled symptoms (e.g., dyspnea and asthenia)
Emotional distress
• Secondary to physical decline
Palliative Care Evaluation
Social distress
• Secondary to debility and need for additional support and services
Spiritual distress
• Existential angst and hopelessness
Palliative Care Response
Manage symptoms
• Develop plan to palliate symptoms unrelieved by disease-modifying treatment
Discuss advance directive
• Discuss choice of surrogate decision maker(s)
• Discuss treatment preferences
• Appropriate in any advanced pulmonary disease
Evaluate for hospice referral
Palliative Care Response
Prognostication
Value of truth-telling
• Assists with symptom management
• Enables patient and family to access community resources
• Fosters preparing and planning care
• Helps family avoid lurching from crisis to crisis

Aids to Prognostication

- Determining individual prognosis is difficult
- "Would I be surprised if this patient died in the next six months?"

yields more accurate answer than

"Will this patient die in the next six months?"

If you would not be surprised, assess for palliative care needs

Language Is Important

"Because of the severity of your lung disease, you and your family are eligible for the assistance of hospice at home"

is preferable to

"You have a prognosis of less than six months. Therefore, I am referring you to hospice"

Language Is Important

- "While no one knows how long anyone will live, there are certain signs that your lung disease is very severe and that time could be limited"
- "People are eligible for hospice when their illness is so severe that they might die in the next six months to a year"

Markers for Poor Prognosis

Disabling Dyspnea

- Dyspnea at rest despite maximum medical management
- Patients may be very limited (e.g., bed-to-chair or mostly bed confined)
- Other problems often present (e.g., cough, profound fatigue)
- Consider co-morbid illnesses

Poor Prognosis

Functional Markers

- Multiple Emergency Room visits
- Multiple hospital admissions
- Declining functional status (based on assessment of activities of daily living)
- Inability to live independently (necessitating move to live with family or in a residential care facility)

Poor Prognosis

Five Key Clinical Markers

1. Unintentional weight loss

- Greater than 10% of body weight
- Over six months

Poor Prognosis
Five Key Clinical Markers

2. Resting tachycardia

- Resting heart beat >100/minute
- Unrelated to recent breathing treatment
- Unrelated to atrial fibrillation
- Unrelated to MAT

Poor Prognosis
Five Key Clinical Markers

3. Hypoxemia at rest

- Despite supplemental oxygen, such as 2l NP, pO2 less than or equal to 55mm HG

4. Hypercapnia

- pCO2 greater than or equal to 50mm HG

Poor Prognosis
Five Key Clinical Markers

5. Evidence of right heart failure

- Physical Signs of RHF
- Echocardiogram
- Electrocardiogram

Palliative Care Evaluation
Indication

- Any combination of markers of poor prognosis warrants referral for palliative-care evaluation
- Not necessary or appropriate for patient to exhibit all markers to warrant palliative evaluation

Palliative Care Consult
Review of Contribution

- Unrelieved suffering
  Assess symptom control
  Assist to develop treatment plan that melds symptom management with disease-modifying treatment
- Goals of Care
- Advance care planning
- Assess for hospice referral

Palliative Care and Pulmonary Disease

Consult often and early.

Selected Readings

Symptom Frequency and Severity

Lutz, S., R. Norrell, C. Bertucio, L. Kachnic et al. "Symptom Frequency and Severity in Patients with Metastatic or Locally Recurrent Lung Cancer: A Prospective Study Using the Lung Cancer Symptom Scale in a Community Hospital." *Journal of Palliative Medicine* 4 (2001): 157–165.

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Gore, J. M., C. J. Brophy, and M. A. Greenstone. "How Well Do We Care for Patients with End Stage Chronic Obstructive Pulmonary Disease (COPD)? A comparison of Palliative Care and Quality of Life in COPD and Lung Cancer." *Thorax* 55 (2000): 1000–1006.

Skilbeck, J., L. Mott, H. Page, D. Smith, S. Hjelmeland-Ahmedzai, and D. Clark. "Palliative Care in Chronic Obstructive Airways Disease: A Needs Assessment." *Palliative Medicine* 12 (1998): 245–254.

Hospice Care

Abrahm, J. L. and J. Hansen-Flaschen. "Hospice Care for Patients with Advanced Lung Disease." *Chest* 121 (2002): 220–229.