



Palliative Care & Prostate Cancer

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Palliative Care

- WHO Definition

“An approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention & relief of suffering by means of early identification.. and treatment of pain & other problems, physical, psychosocial & spiritual”

Palliative Care

- Focuses on the person & not the disease
- Can be used along with active disease management.
- Generalist palliative care is the responsibility of all HCPs.
- Specialist Palliative Care for patients with more complex needs

Specialist Palliative Care

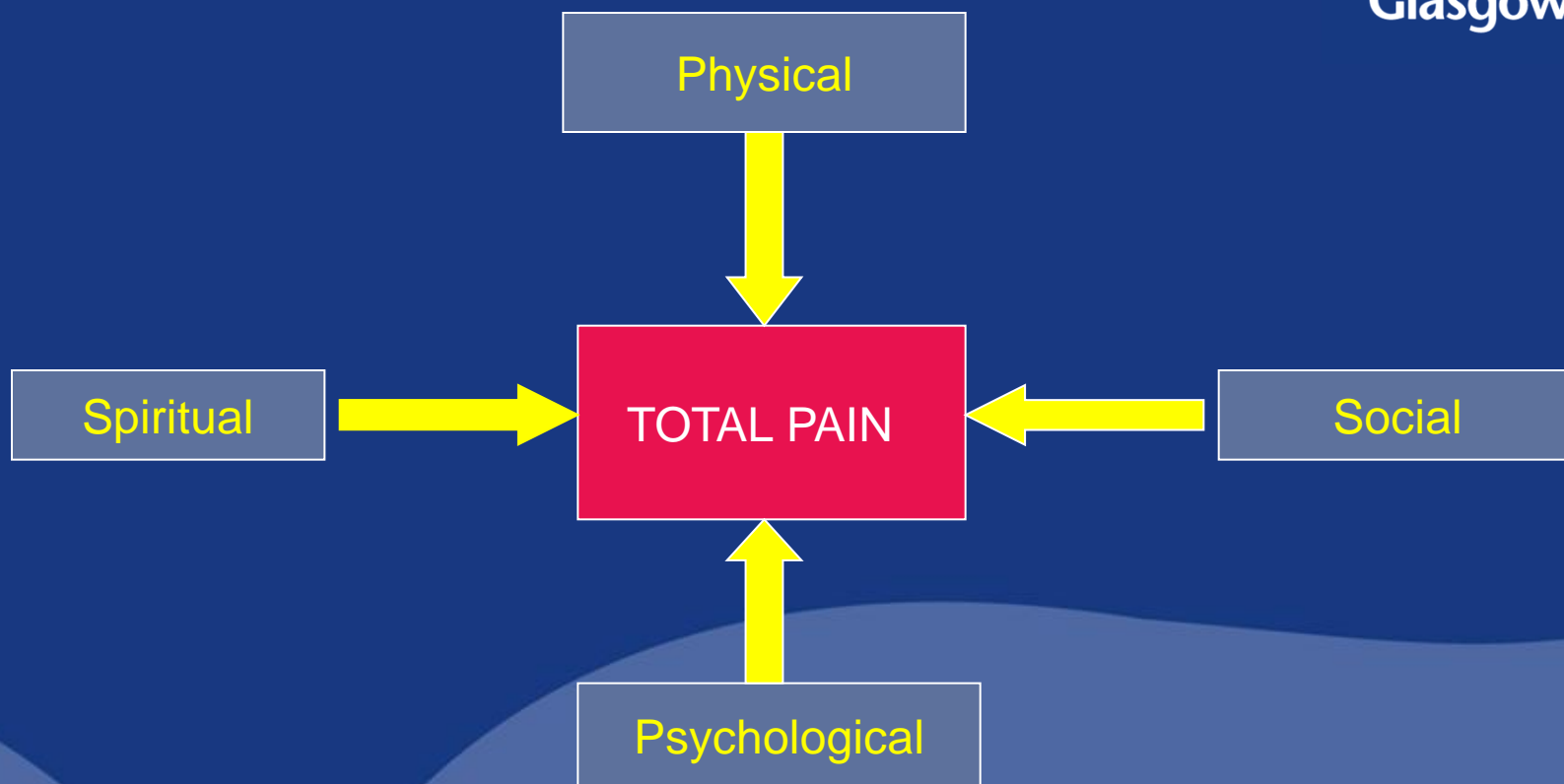
- Hospices
 - Inpatient
 - Outpatient Clinics
 - Day Services
 - Community specialist nurses
 - Bereavement
 - Child & Adolescent support
- Acute Hospital Specialist Palliative Care Teams

Palliative Care in Metastatic Prostate Cancer

- Pain
- Spinal cord Compression
- Social Aspects/ Supportive Care
- End of Life Care

Pain Assessment

- Pain history
- Functional effects
- Psychosocial aspects
- Assessment tools



Pain Management



- 1. Explanation**
- 2. Modification of disease process**
 - Surgery
 - Radiotherapy
 - Chemotherapy/ Hormonal therapy
- 3. Non-pharmacological measures**
 - TENS
 - Heat/ Acupuncture
- 4. Lifestyle modification**
 - Immobilisation
 - Wheelchair/ walking aids

Radiotherapy

- Simple
- Reasonably quick (10days – 6 weeks)
- Relatively few side effects – Nausea, Diarrhoea
- Single treatment effective but 4 or 5 if weight bearing bone or nerve compression
- Can re-treat after 3-4 months

Pharmacological Measures

- WHO Ladder
- Principles
 - By the ladder
 - By the clock
 - By mouth
 - Individualise treatment
 - Attention to detail

WHO Analgesic Ladder



Step 3

**Opioid for
Mod/severe pain
+/- non opioid
+/- adjuvant**

Step 2

**Opioid for mild-moderate pain
+/- non opioid
+/- adjuvant**

Step 1

Non-opioid for mild pain +/- adjuvant

Step 3 Opioids

- **Morphine** First choice
- **Oxycodone**
- **Hydromorphone**
- **Buprenorphine** Transdermal patches
Renal Failure
- **Fentanyl** Renal failure
Transdermal patches
- **Alfentanil** Renal Failure
Parenteral
- **Methadone** Specialist use

Commencing Morphine

- Immediate release preparation 4hourly & as required e.g. Sevredol 5mg 4hourly & PRN
- Breakthrough dose equivalent to 4 hourly dose (1/6th total daily dose)
- Once stable convert to long acting opioid 12 hourly (divide 24 hour dose into 2)
- Prescribe regular laxative
- Prescribe anti-emetic at least as required.

Adverse effects of Opioids



- Common Initial
 - Nausea & Vomiting
 - Drowsiness
- Common Ongoing
 - Constipation
- Occasional
 - Dry mouth
 - Sweating
 - Itch
 - Opioid Toxicity – Hallucinations, Myoclonus & Peripheral shadows
- Rare
 - Respiratory depression
 - Psychological dependence

Special Considerations



Opioid Toxicity

- Check renal function
- May need to switch opioid

Renal Failure

- Avoid morphine
- May be able to use oxycodone/ hydromorphone
- Alfentanil, Fentanyl & Buprenorphine safest

Adjuvant Analgesics

- **NSAIDS** Bone/ inflammatory pain
Avoid in renal failure
- **Corticosteroids** Nerve root compression
- **Anticonvulsants** Neuropathic pain
Gabapentin/ Pregabalin
- **Antidepressants** Neuropathic pain
Mostly TCAs (Amitriptyline)
Newer SSRI & SNRIs
- **NMDA blockers** Ketamine & Methadone
- **Interventions** Nerve block
Epidural/ Intrathecal analgesia

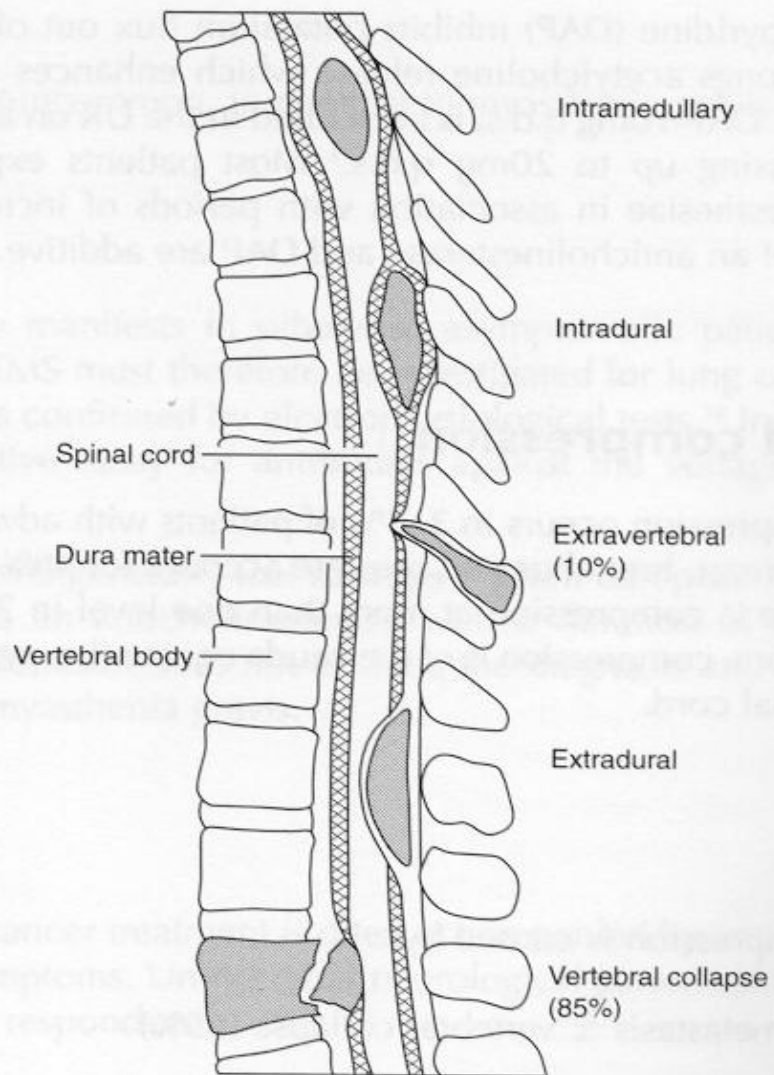
Bisphosphonates

- Zoledronic acid is only one licensed in prostate cancer
- IV infusion every 4 weeks
- Proven to reduce skeletal events by 36%
- Improves pain control
- Used in England & Wales but not SMC approved so used on named patient basis.
- Caution with renal impairment

Spinal Cord Compression



- Relatively common in prostate cancer
- Can have profound consequences for patients
- Vast majority due to vertebral metastases +/- vertebral collapse compressing the cord
- Most common in thoracic spine.
- Cauda Equina compression if below L2





Features

- Pain (>90%)
 - Back pain
 - Radicular pain
- Weakness (>75%)
 - Can be rapidly progressive
 - May have gait disorder
 - “Going off legs”
 - Difficulty getting up from chair
- Sensory Loss (>50%)
 - May be patchy
 - Sensory level
- Sphincter Dysfunction (>40%)
 - Bladder – retention/ loss control
 - Constipation

Management

- Lie patient flat
- High dose steroids (Dexamethasone 16mg)
- MRI
- Radiotherapy Urgent referral
5 fractions
- Surgery Laminectomy & Decompression
Rapid neurological deterioration
Single vertebra
Previous XRT

Spinal cord Compression Prognostication



Poor prognostic signs

- Severe leg weakness at presentaion
- Sphincter dysfunction
- 94% ambulatory patients remain mobile after XRT
- 13% paralysed patients able to ambulate post XRT

Supportive Care

- “Chronic illness” model
- Aim to enable patients to live with the disease
- Multidisciplinary care
- Remember carers – elderly & vulnerable
- Financial considerations
- Place of care

Multidisciplinary Team

Hospital

- Urologist
- Oncologist
- CNS
- Palliative Care Team
- Physio
- OT
- Chaplain

Community

- GP
- District Nurse
- Community Palliative Care CNS
- Hospice staff
- Home carers
- Community OT

Financial help

- **Disability Living Allowance**
 - <65
 - Need help with personal care
 - Care & Mobility components
 - “Special rules”
- **Attendance Allowance**
 - >65
 - Need someone to help look after patient
 - Physical &/ or mental disability
 - “Special Rules”
- **MacMillan Grant**
 - Low income
 - One off payment up to £300

Caring for Patients at End of Life Challenges



- Ascertaining preferred place of care
- Recognising end of life & communicating with patient & family
- Providing preferred place of care
- Meeting needs of dying patients in somewhere other than preferred place of care e.g. acute hospital.
- Dignity
- Loss of control
- Carer fatigue – elderly carers

End of Life Care Gold Standards Framework



- Identify patients in need of palliative care
- Assess needs
- Agreed management plan discussed regularly as a team
- List of tasks
 - Communication
 - Coordination
 - Control of symptoms
 - Continuity of care
 - Continued learning
 - Carer Support
 - Care of the dying pathway

End of Life Care Liverpool Care Pathway



- Need to recognise patient is in last few days of life
- Aims to transfer hospice model of care into other settings
- Set of aims dealing with physical needs but social & religious needs also addressed
- Aids decision making process
- DNACPR is documented
- Symptom control algorithms aid prescribing for EOLC
- Can be modified according to the clinical environment

End of Life Care Prescribing



Pain

- Morphine SC as required
- Morphine via CSCI

Distress

- Midazolam SC as required & can add to CSCI

Nausea

- Levomepromazine for distress & nausea

Secretions

- Hyoscine Hydrobromide or Butylbromide PRN
- Can add to CSCI

National Strategy



Scotland

- Living & Dying Well Oct 2008
- NHS Boards use it to plan & develop services

England & Wales

- Department of Health End of Life Care Strategy

Questions?