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Current issues in palliative care: third national conference

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ABSTRACT – This recent conference provided an all-round review of the current issues to be considered in palliative care. A list of the top 10 points that one hospital physician found most useful is presented.

KEY WORDS: advance care planning, opioid analgesics, palliative care

This conference covered many aspects of palliative care, with topics ranging from opioid switching to hope. In the author's opinion, the top 10 points from the conference are as follows:

1 There are still no firm rules on pain control. There is no definite way of converting from one opioid to another, or one route to another. The World Health Organization pain ladder is easy to follow but is outdated and does not have sufficient evidence to support it.
2 When a patient's pain just simply cannot be managed, consider opioid (morphine) resistance or opioid-induced hyperalgesia. Methadone is useful for the former but requires careful titration. Buprenorphine is useful for the latter. Check for and correct low magnesium levels. Testosterone replacement in opioid-induced hypogonadism might also help. Watch out for studies on the genetics of morphine resistance. That may help reduce some of the current guesswork.
3 Selective serotonin receptor inhibitors and gabapentin may be useful for itch and cough. Paroxetine appears to have the most number of studies supporting its use here. Those worried about its recent negative press may be reassured that sertraline has also been found to be helpful. Start low – lower then the usual minimum dose – and go slow.
4 A 24-hour subcutaneous infusion of frusemide up to a maximum dose of 120 mg (the most the syringe driver will take) may help alleviate distress in patients dying of heart failure.
5 Advance care planning is not necessarily as easy or as good as it sounds on paper. No one can ever really imagine what the future is going to hold. Neither is promising all patients that they can die at home, if that is what they choose, a good idea. The system cannot support everyone this way. How one dies is more important to where one dies. Be wary of simply aiming to fill the next set of boxes/standards coming from the top down.
6 Patients with motor neuron disease rarely die from choking. Some patients need to be reassured about this as they may choose to give up sooner because of this frightening thought. With good palliative care, the more common symptoms, such as pain and dyspnoea, can be controlled.
7 Patients suffering from heart failure need to be consulted with early as many will die suddenly. Therefore, they and their families need to be given the time and opportunity to prepare for this, if it is at all possible. Make plans with those who have implantable cardioverter defibrillators.
8 Hope matters.
9 It is sometimes useful to challenge patients' beliefs. Cognitive behavioural therapy (CBT) helps. It sounds fairly easy, but one must be trained. There are now brief courses for 'non-psychologists' to train as CBT 'first-aiders' and more. However, on-going practice and supervision is required if one chooses to take this up. An easier option would be to ask for help.
10 Kids still need to be kids, regardless of their prognosis.

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