

# Sedation in Palliative Care

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You deserve tomorrow.



- Incidence
- Definition of sedation
- Conditions for sedation
- Guidelines for sedation
- Practice and outcomes of sedation
- Issues that require further consideration

- 1994, Ventafridda study of home care patients citing 53% had sedation at the end of life
- Wide variation incidence 15% - 67%
- Differing terms.....
- Differing approaches:
  - Level of sedation
  - Temporal nature
  - Indications and methods

*Ventafridda 1994, Muller-Busch 2003,  
Vitetta 2005, Maltoni 2012*

# Differing terms....

- Sedation
- Terminal sedation
- Controlled sedation
- End of life sedation
- Total pharmacological sedation
- Sedation for intractable distress in a dying person
- ‘Palliative sedation’



# Differing approaches

- Confusion about what is sedation:
  - Mild sedation excluded in some studies
  - Included in others
  - Not explicitly defined in a number
- Level of sedation (mild or conscious sedation vs deep sedation)
- Temporal (Intermittent/temporary/respite/night vs continuous)
- Medications used
- Target symptoms

*Morita et al 2002*

# Towards standard language

- Systematic review of all studies including use of sedative medications or intention to reduce consciousness
- Sedation includes 2 core factors
  - The presence of severe suffering refractory to standard palliative management
  - The use of sedative medications with the primary aim to relieve distress

*Morita et al 2002*

# Towards a definition

Degree of sedation	Mild	Maintain consciousness
	deep	Almost or complete unconsciousness
Duration	intermittent	Provide some periods when patient alert
	continuous	Alter patient consciousness until death
Pharmacological property of medications	Primary	Achieved by sedative medications not proven to effectively palliative underlying distress
	Secondary	Reduced consciousness results from medications effective for palliation of underlying distress
Target symptoms	Based on standard diagnostic criteria	
Target Populations	Physical conditions described using validated methods Eg. Performance status, prognostic scores	

# Levels of Sedation:

## Claessens 2011

Level of Sedation	Description
Mild-intermittent	Intermittent, mild reduction consciousness, still reacts to stimuli
Mild-continuous	Continuous, mild reduction consciousness, still reacts to stimuli
Deep-intermittent, non acute	Intermittent reduction of consciousness to treat a non acute refractory symptom: patient is unconscious
Deep-intermittent, acute	Intermittent sedation to unconsciousness to treat acute refractory symptom
Deep-continuous, non acute	Deep-continuous sedation for a non acute symptom: patient is unconscious
Deep-continuous, acute	Deep-continuous sedation for an acute symptom ( eg. Haemorrhage), patient is unconscious



# Definition of Palliative Sedation

Palliative sedation ... is the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health care providers.

*Cherny et al European Association for Palliative Care recommended framework for the use of sedation in palliative care. Pall Med 2009*

# Unpacking this definition - Intractable Suffering:

## ➤ Intolerable

- Determined on basis of patient evaluation, or if impossible, proxy judgements in collaboration with families and staff



*Cherny & Portenoy 1994, Morita 2002*



.... AND

➤ Refractory

- “all other possible treatments have failed, or it is estimated by team consensus, based on repeated and careful assessments by skills experts, that no methods are available for alleviation within the time frame and risk-benefit ratio that the patient can tolerate”

*Cherny & Portenoy 1994, Morita 2002*

... AND

➤ Goal

- To relieve the burden of suffering



# Why do we need guidelines ?

## ➤ Potential adverse outcomes and risks of sedation:

- Impairment, loss of ability
- Family distress
- Paradoxical agitation
- Risk of hastened death \*

## ➤ Problem practices

- Abuse (intention is to hasten death) – xs dose, no symptoms
- Injudicious use of palliative sedation
- Injudicious withholding of palliative sedation
- Substandard clinical practice of palliative sedation

*EAPC 2009*

# EAPC framework for procedural guidelines 2009

1. Recommend pre-emptive discussion of the role of sedation in EOL care and contingency planning.
2. Describe the indications in which sedation may be considered:
  - intolerable distress due to physical symptoms/refractory
  - Continuous deep only if very terminal stages
  - Transient or respite sedation may be indicated earlier
  - Occasionally consider for severe nonphysical symptoms

# Nonphysical refractory symptoms (special precautions)

- Different because:
  - harder to establish are truly refractory
  - Dynamic and changeable with adaptation common
  - Standard treatment has low intrinsic morbidity
  - Not necessarily indicating far advanced disease





# Nonphysical refractory symptoms, therefore... (special precautions)

- Use only for patients with advanced disease
- Refractory only with repeated and skilled psychological specialist assessment - formed relationship, following trials of routine therapy
- Consideration by multidisciplinary case conference including psychiatry, chaplaincy, ethics
- If appropriate (rare) use on respite basis (6-24 hrs)
- Only use continuously if repeated respite trials have been performed



# EAPC Framework continued

## 3. Describe the evaluation and consultation procedures

- evaluation (hx, disease status, potentially treatable cause, prognosis, capacity)
- multi-professional PC input



#### 4. Specific consent requirements if non-critical situation:

- general condition, treatments tried, rationale and aims for sedation
- methods, anticipated effects, risks
- medical and nursing care during sedation, outcomes if sedation not performed
- commitment to ongoing care and pt well being
- d/w family present if possible, legal proxy if patient not competent.



“...in the case of terminally ill patients who have no advanced directive and no health-care proxy and who are in severe distress whilst actively dying provision of comfort measures (including if necessary the use of sedation) is the ‘standard of care’ and should be the default strategy for clinical treatment decision.”

# EAPC framework continued

5. Indicate the need to discuss the decision-making with the patient's family
6. Selection of sedation method : In general the level of sedation should be lowest necessary to provide relief of suffering.
  - Unless emergency - trial intermittent or mild sedation first
  - ? down titrate -- re-establish lucidity/evaluate symptoms.
  - Continuous deep sedation first if:
    - suffering intense / refractory
    - Death within hours – few days anticipated
    - Patients wish is explicit
    - end of life catastrophic event.

## 7. Detail dose titration, patient monitoring and care

- Severity of suffering vs level of consciousness vs adverse effects of sedation - monitored
- Doses ↓ ↑ to palliation of suffering palliated with least suppression of conscious levels / AEs
- Document reasons for changes and response
- Consider monitoring:
  - if short term intermittent then sedation level, HR, BP, O2 sat.
  - If goal comfort, monitoring is of comfort
- Maintain humane dignified care as before

## 8. Guidance for decisions regarding hydration and nutrition and usual medications

- Decision about ANH is independent of decision regarding sedation (individual, informed by patient and family wishes, treatment aim)
- Palliative medications should continue.

## 9. Care and information needs of family

## 10. Care for health professionals

# What do we do in practice?

- Belgium: 266 patients followed, 7.5% palliative sedation.
- Started mean 2.5 days before death
- Patients: PPS 40, GCS 15 ie bed bound, extensive disease, normal conscious state
- Average 5 symptoms, most prevalent
  - Pain
  - Fatigue
  - Depression
  - Drowsiness
  - Loss of well being

*Claessens et al. JPSM 2011*

- 40% started as mild continuous sedation, 40% as deep sedation
  - Nb 45% changed and almost all of these went from mild to deep indicating titration against symptoms
  - Of those who did not change sedation form, started 2 days before death and 73% was deep sedation
- All patients gave consent.

*Claessens et al. JPSM 2011*



## Authors concluded:

- Exceptional when suffering refractory
- For patients near the end of life
- Consensual process



*Claessens et al. JPSM 2011*

# Palliative Sedation and Survival

- 10 retrospective or prospective non-randomised studies
- 621/1807 (34%) consecutive patients were sedated (15-67%)
- Reasons for sedation:
  - Delirium (range 14-91%)
  - Dyspnoea (range 9-63%)
  - Pain (10-49%)



*Maltoni et al J Clin Oncol 2012*

- Mean duration of sedation (0.8-12.6 days)
- Midazolam most common drug prescribed in 9/10
  - Psychotropic drugs frequent , often in conjunction with BZDs
- Proportional sedation most common, few sudden deep sedation
- Survival from time of admission to PCU :
  - Sedated range 7-36.5 days, non sedated range 4-39.5 days
  - No significant difference between 2 groups

*Maltoni et al J Clin Oncol 2012*

# Summary

- Palliative sedation involves:
  - Refractory symptoms
  - Goal is relief of symptoms
- Should adhere to guidelines when instituting
- Requires detailed attention to assessment, relief and level, as well as deep reflection on intention
- Should be proportional
- Should be consensual (pt, family, team)
- Requires careful attention to family and staff as caregivers

# Issues that require further consideration

- How we decide what is refractory – role of patient vs. role of physician
- Refractory physical symptoms versus refractory psychological symptoms - we regard them differently, yet linked.
- Issues around consent
- Family?
- Raise early enough – reassure, enable consent
- ? ANH



# Cases

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