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OUR MISSION

Hospice of the Western Reserve provides palliative and end-of-life care, caregiver support, and bereavement services throughout Northern Ohio. In celebration of the individual worth of each life, we strive to relieve suffering, enhance comfort, promote quality of life, foster choice in end-of-life care, and support effective grieving.

THE DOCTOR IS IN

The Importance of Palliative Care for the Oncology Patient

BY KATHERINE H. EILENFELD, DO

The diagnosis of cancer is arguably one of the most difficult pieces of information our patients will ever receive. They hear the dreaded C-word and simply shut down. It is at these moments that their physicians have the distinct opportunity to guide the future of their patients’ care in a significant way.

Cancer and its treatments can cause a variety of unwelcome symptoms and side effects. National organizations that specialize in cancer care are recognizing the importance of addressing these issues head-on. The idea of aggressively managing patient symptoms during the pursuit of cure is not a new one, but has undergone a transformation in the last decade. Palliative care – sometimes now referred to as supportive care – is aimed at relieving these symptoms and side effects.

But it’s not all about prescriptions. Palliative care focuses on the whole person and aims at supporting patients on an emotional, physical, social and spiritual level from the time of diagnosis, through treatments, and beyond.

In oncology, palliative care should co-exist alongside the testing, imaging, surgery, radiation, and chemotherapy from the very beginning. Organizations like the UH Seidman Cancer Center are realizing its utility and benefit for enhancing quality and complete patient-centered care. This includes navigating the healthcare system, prognostication, guidance with complex treatment choices, goals of care – including advance directives – and supporting the patient into their next step of life.

In the setting of end-of-life for the cancer patient, palliative care can transform into hospice care which aims to not only relieve pain and other distressing symptoms but also to affirm the life of that patient while empowering and preparing them and their family for disease progression and death.

Dr. Eilenfeld, Director of the Palliative Care Consult Service at St. John Medical Center, recently completed a fellowship in hospice and palliative medicine at MetroHealth Medical Center. Board certified in internal medicine, she practices with Westshore Primary Care in Westlake, and is a Clinical Assistant Professor at the Ohio University Heritage College of Medicine.

Editor’s Note: This column features perspectives from guest physicians. Submissions are welcome. Send column ideas to: lhenrichsen@hospicewr.org.

BY THE NUMBERS • Percentage by Primary Diagnosis

Cancer remains the leading diagnosis of hospice patients.
From our Chief Medical Officer

**OUR FIRST QUARTER EDITION** takes an in-depth look at palliative and end-of-life care for cancer patients. In addition to maintaining effective strategies for symptom control, emotional, spiritual and psychosocial support are critically important for cancer patients and their families as the disease progresses.

National Healthcare Decisions Day (April 16) provides a reminder not only to the consumers of healthcare—but also to those of us who are providers—about the critical importance of educating our patients and their families about advance directives.

Although it’s admittedly a difficult conversation to have, discussing advance directives earlier in the course of the disease allows the patient and family to put a plan into place that provides greater autonomy and peace of mind during possible periods of incapacity and toward the end of life.

Physician barriers to completing an advance directive include lack of time and discomfort with the topic. On the patient’s part, lack of knowledge, fear of burdening family and a desire to have the physician initiate the discussion are common. Once the advance directive is complete, vague language, issues with the proxy decision-maker, and subsequent accessibility of the advance directive can present additional obstacles.

Overcoming these barriers depends on effective communication at multiple visits and allowing the patient to ask questions. Involving the family or a proxy early and over time can help the process. It may be helpful to integrate discussions at selected stages of the patient’s life, and to revisit these decisions as his or her health status changes.

Y our partner in care,

**Charles V. Wellman, MD**

**Dr. Charles Wellman**
Chief Medical Officer
Hospice of the Western Reserve

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**RESEARCH CORNER**

**Hospice of the Western Reserve Supports KSU Research Study**

BY DENISE SHEEHAN, PH.D.
COLLEGE OF NURSING, KENT STATE UNIVERSITY

Dr. Denice Sheehan and her research team at Kent State University College of Nursing recently completed a study, “Strategies to Help Adolescents with a Parent in Hospice,” funded by the National Institute of Nursing Research. The interdisciplinary team—Murray Mayo, Ph.D, RN; Claire Draucker, Ph.D, RN, FAAN; Grace Christ, Ph.D./DSW; Kim Heim, MSN, RN, FNP-BC; and Stephanie Parish, MAT, BS are grateful to the families and staff members for their time and effort in making this study possible.

For the study, 30 adolescents, 20 well parents and 11 ill parents from 26 families were interviewed. Of the six families who were contacted to participate in a second interview after the death of a parent, all readily agreed. Grandparents participated if they were currently parenting the adolescent.

The team identified the following findings:

- Adolescents manage their lives by dwelling in their “well world” (school, friends, work) where they can live without constant reminders of the parents’ illness, and by spending time and helping their parents when they feel able.
- Parents help their adolescents by informing them about the illness in ways they can handle, by encouraging them to pursue their normal activities, and by spending time with them.
- Adolescents tend to spend more time being with, and caring for, their ill parent as the illness progresses.
- Parents and adolescents seem to differ on their views of how health care professionals might be helpful: Adolescents do not view them as sources of support, whereas parents believe the professionals may serve as a resource to the adolescents, at least after the death. Adolescents and their parents negotiate adolescent caregiving roles while supporting typical adolescent activities to maintain normalcy.

Drs. Sheehan and Mayo recently presented the findings about the way adolescents interact with healthcare providers to the care teams at Hospice of the Western Reserve. The study’s findings have also been presented at regional and international conferences and published in professional journals.

Editor’s Note: Dr. Sheehan is the principal investigator for the “Strategies to Help Adolescents with a Parent in Hospice” study. Dr. Sheehan reached out to Hospice of the Western Reserve to conduct her study. All of the data were collected from patients and families between December 2010 and August 2012.

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**Hospice teams benefit from cancer training**

Hospice of the Western Reserve’s education team and a transdisciplinary panel of experts conducted specialized cancer training for more than 700 members of its clinical care teams. The session was held at the nonprofit agency’s headquarters and teleconferenced to all of its sites.

The training explored some significant trends, including a rise in younger cancer patients with young children who are living with their parents. Many of these younger patients have a more aggressive form of cancer and die quickly, leaving families with grief issues and concerns. Hospice can help by addressing issues like anticipatory grief, and by connecting the family with bereavement support and community resources.

Since the Northern Ohio region is home to two major tertiary cancer centers, a vast number of treatment modalities and clinical trials are available to cancer patients. So, the session also covered the need for additional ongoing education to more effectively address post-treatment symptomology.

Additional disease-specific training sessions are planned for this year, including one which will offer a more in-depth look at COPD, its differentials and causes.
new treatments, but we must look not only at the medical community which is groomed to save lives, not escape death, which is not possible. I have watched history. We have come to believe that our goal is to respect for human life and the dignity of each person.

Clinical Connections interviews Marlene Oliver, BSN, RN-BC, CHPN, Palliative Care Coordinator at St. John Medical Center, about the mission that motivates her.

Q: Tell us a little about the history of palliative care at St. John Medical Center, and your role.
A: When I started with St. John Medical Center, one of the floors I managed delivered inpatient chemotherapy. As a hospital certified by the Commission on Cancer, we adhere to their program standards which require that every patient diagnosed with cancer have palliative care. The renewal of the accreditation as a cancer center by the Commission on Cancer ignited my journey toward certification in Hospice and Palliative Nursing.

Q: What is the overarching philosophy of the program?
A: The philosophy reflects the mission of our organization, which is rooted in a deep reverence and respect for human life and the dignity of each person.

Q: Why is such a program important?
A: The advent of immunizations, surgeries, antibiotics, and technologies in medicine, such as ventilators, place non-medical families in the position of making medical decisions for the first time in history. We have come to believe that our goal is to escape death, which is not possible. I have watched families struggle to try to decide when medicine has gone far enough, with little help from a medical community which is groomed to save lives, not speak of death. Medicine will continue to develop new treatments, but we must look not only at that we can; we must evaluate if we should impose these treatments.

Q: Is there an educational process for physicians in the hospital setting?
A: Much of the angst is decreasing as physicians are seeing the benefit for both themselves and their patients. Every physician wants to alleviate suffering. Palliative care decreases the suffering of the patient, a win for everyone. As part of health care reform, physicians are being asked if their patients spend an unusually high number of days in an acute care setting. Palliative care is effective in reducing these days, because it is so individualized in the plan of care. It reduces re-admissions.

Q: What are some ways the program improves quality of life for the patient and his/her family?
A: It is more often the symptoms that bring the patient to the ER, not the actual disease. When a patient receiving treatment for cancer, for example, develops nausea and vomiting after treatment, aggressive management of this symptom will get the patient back on track sooner to complete chemo.

Q: How can the program serve as a bridge to hospice for patients who are coping with serious chronic illness?
A: When no more treatment options are available, being candid allows patients and families to make plans, get closure, achieve goals they would otherwise not address under the illusion that they may improve. All of these things enhance the quality of life.

Q: Do you anticipate a growing need for palliative care?
A: Undoubtedly. We are just capturing the tip of the iceberg right now. As this specialty establishes its roots in medicine, patients and families will be asking for palliative medicine in the same manner they ask for a cardiologist when they have a heart attack.

Q: Anything you would like to add?
A: I am proud to work at St. John Medical Center where they take risks for our patients by being at the forefront of providing Palliative Care at the community hospital level. This is yet another accolade to the gold standard we set and achieve throughout our hospital.
Effectiveness of Antiemetic Drugs Requires Correct Clinical Presentation

BY DR. WAYNE H. GRANT, PHARM.D
CLINICAL PHARMACIST, HOSPICE OF THE WESTERN RESERVE

The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology establish recommendations for our current care. Clinicians must know the past chemotherapy/radiotherapy treatment timeline. This will allow the clinician to know if the patient is having breakthrough, delayed or refractory nausea/emesis. Categorically, antiemetic drugs control nausea and vomiting; however, they will only work with the right clinical presentation.

Patients who enter hospice often present after not tolerating the most recent oncological offering. The mechanism of delay-nausea (>24 hours) involves stimulation of neuroreceptors other than serotonin. Dopamine mediations dominate this type of nausea. This leads to the benefit seen with phenothiazines (chlorpromazine, promethazine) and butyrophenone (haloperidol). The use of 5HT-3 antagonists, such as ondansetron, is not beneficial in this phase of emesis control as it lacks dopaminergic activity. The use of other drugs - such as dexamethasone, metoclopramide, droperidol and olanzapine - may provide relief.

<p>| Legend: D2 or D2DA (dopamine 2) antagonists, CTZ (chemoreceptor trigger zone), VC (vomiting center), SHT3 (serotonin) antagonists, EPS (extrapyramidal symptoms), HA (headache) |</p>
<table>
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<th>Drug(s)</th>
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<td>Drug(s)</td>
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<td>EPS, dyskinesia, sedation</td>
<td>EPS, dyskinesia, sedation</td>
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<td>Xerostomia, sedation, blurred vision</td>
<td>Weight gain, mood change, metabolic change</td>
<td>Nausea, diarrhea</td>
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Intractable nausea and vomiting represents a substantial source of physical and psychological distress for patients and caregivers. As the oral route of administration becomes limited to non-existent, medication choices are scarce. Attempting rectal administration of various medications becomes an appropriate route for some medications; unfortunately infusion therapy may be required. The use of a subcutaneous continuous haloperidol infusion may provide the relief these patients deserve.

Marijuana is thought to control nausea/emesis through inhibition of endorphins, suppression of prostaglandin synthesis. However, if using cannabinoids, consider their ability to inhibit the metabolism of medications by affecting hepatic enzymes or slowing gastric emptying time, which may lead to changes in absorption of oral medications.

Interactions:
- SSRIs - can lead to manic episodes (fluoxetine)
- Anticholinergics, α-agonists - can lead to tachycardia and hypertension
- Antipsychotics - decreased effectiveness, increased risk of EPS (CYP1A2)

Understanding the pathology and associated pharmacology will aid in developing a plan of care which successfully addresses these distressing symptoms.