

Editorial Reflections
Could We Be Over Treating Some of Our Patients?

December 1998

Dr. Robin Fainsinger

*Associate Professor, Division of Palliative Medicine, University of Alberta
Palliative Care Director, Royal Alexandra Hospital, Edmonton*

The Edmonton Palliative Care Program has been at the forefront in challenging established palliative care/hospice practice, and suggesting new innovations and approaches. We have emphasized the need for better assessments. We have incorporated the Edmonton Symptom Assessment System (1), The Edmonton Staging System for Cancer Pain (2), the Mini-Mental State Examination (3), and other assessments into our daily practice. We have suggested alternative viewpoints on a number of issues including dehydration (4), oxygen use (5), opioid (6) and adjuvant analgesics (7). Our numerous publications have bolstered our arguments, and sometimes convinced practitioners in other centers, of our viewpoint.

However, there is a need for caution and an awareness of "the law of decreasing returns." We have advocated for hydration in the terminally ill, and data published from the tertiary palliative care unit (PCU) in Edmonton shows hydration of 70% of patients at the end of life (8). However this patient population represents a highly selected group on higher average opioid doses than in other environments, both in our region and as seen by many of our national and international colleagues (9, 10). It would be arrogant to claim that those who promote the lack of need for hydration at the end of life are always wrong. Many patients on smaller opioid doses or few other medications, will have a lesser risk of opioid and other pharmacological toxicities in the presence of dehydration and renal failure. Judicious decreases or discontinuation of medications, may prevent many problems and avoid the need to hydrate in some patients. These are unanswered questions that require further clarification. We need to ensure everyone (including those working in Edmonton), understand that we are not necessarily claiming that everyone needs to be hydrated all of the time.

A similar issue exists with the use of opioid rotation or sequential drug trials. Although we publish results of the benefit of changing opioids in the highly selected patient population on the tertiary PCU (11) these results do not necessarily apply to other settings. In addition it is likely that if the first opioid change brings limited or no results, it is probable that subsequent changes are even less likely to be effective.

Our close attention to patient assessment and investigation of symptomatic patients, may often result in the diagnosis and management of complications that would have been left untreated in other settings. We are convinced of the value of better assessments and management of problems such as dehydration, delirium and opioid toxicity. Despite our convictions, we do need to be cautious not to take these approaches to extremes. However, there are other areas such as the use of antibiotics for infection, and anticoagulation for deep vein thrombosis and pulmonary embolus, that are also potentially troublesome. Unpublished data from our group reveals that we have moved away from predominantly prescribing oral antibiotics to an increasing dependence

on an array of intravenous antibiotics. A review of 50 consecutive patients dying on the tertiary PCU showed that 46% received antibiotics in the last week of life. 24% of patients were still on an antibiotic when they died. We have also embraced the use of low molecular weight heparin (12) for the advantage over the monitoring required for regular heparin or Coumadin. We need to question whether our patients have better outcomes from these interventions, before they become an established part of our practice.

If we do not remain vigilant in our management of palliative care patients we run the risk of crossing the line to excessive treatment. This then becomes part of accepted, unquestioned, routine practice. We need to challenge our own practice far more stringently than any potential critics. If we do not, our reputation will suffer, and more importantly, so will our patients.

References

1. Bruera E, Kuehn N, Miller MJ, Selmser P, MacMillan K. The Edmonton symptom assessment system (ESAS): A simple method for the assessment of palliative care patients. *J Palliative Care* 1991; 7(2):6-9.
2. Bruera E, MacMillan K, Hanson J, MacDonald RN. The Edmonton staging system for cancer pain: Preliminary report. *Pain* 1989; 37:203-209.
Bruera E, Miller L, McCallion J, MacMillan K, Krefting L, Hanson J. Cognitive failure in patients with terminal cancer: A prospective study. *J Pain Symptom Manage* 1992; 7(4):192-195.
3. Fainsinger RL, Bruera E. When to treat dehydration in a terminally ill patient? *Support Care Cancer* 1997; 5:205-211.
4. Bruera E, de Stoutz N, Velasco-Leiva A, Schoeller T, Hanson J. The effects of oxygen on the intensity of dyspnea in hypoxemic terminal cancer patients. *The Lancet* 1993; 342:13-14.
5. Pereira J, Bruera E. Emerging neuropsychiatric toxicities of opioids. In: AG Lipman, ed. *J Pharm Care in Pain and Symptom Control - Innovations in Drug Development, Evaluation and Use*. New York: The Haworth Press, Inc., 1997; 5(4):3-29.
6. Oneschuk D, Bruera E. The 'dark side' of adjuvant analgesic drugs. *Progress in Palliative Care* 1997; 5(1):5-13.
7. Fainsinger RL, MacEachern T, Miller MJ, Bruera E, Spachynski K, Kuehn N, Hanson J. The use of hypodermoclysis (HDC) for rehydration in terminally ill cancer patients. *J Pain Symptom Manage* 1994; 9(5):298-302.
8. Hawley P, Forbes K, Hanks DW. Opioids, confusion and opioid rotation. *Palliative Medicine* 1998; 12:63-64.
9. Fainsinger RL, Toro R. Opioid confusion and opioid rotation. *Palliative Medicine* 1998; 1998; in press.
10. de Stoutz ND, Bruera E, Suarez-Almazor M. Opioid rotation (OR) for toxicity reduction in terminal cancer patients. *J Pain Symptom Manage* 1995; 10(5):378-384.
11. Johnson MJ. Problems of anti-coagulation within a palliative care setting: An audit of hospice patients taking warfarin. *Palliative Medicine* 1997; 11:306-312.