

## Journal Watch

### Differing Management of People with Advanced Cancer and Delirium by Four Sub-Specialties.

Presented at: Journal Club, TPCU, 14<sup>th</sup> Jan 2009, by Rebekah Gilbert  
 Reference: M Agar; DC Currow; J Plummer; R Chye; B Draper.  
 Palliative Medicine 2008; 22: 633-640

Abstract: Delirium is prevalent; 28-48% in advanced cancer, up to 90% in last days. Maintaining lucidity has been identified by patients and families to be as important as good pain control.

Question: how does the management of delirium in patients with a diagnosis of metastatic cancer differ between specialties that may treat such patients?

Method: Used postal survey with two vignettes to ask physicians from palliative medicine, medical oncology, geriatrics and psychogeriatrics about their management decisions in patients with delirium.

Physicians were chosen from databases held by the learned colleges.

| <u>Personal Details</u>                  | <u>Questions</u>             |
|--|------------------------------|
| Age                                      | Location                     |
| Gender                                   | Usual assessment             |
| Specialty                                | Investigations               |
| Years in this specialty (<10, >10 years) | Use of non-pharmacological   |
| Frequency of delirium (<=5, >5 per week) | Symptoms requiring treatment |
| Location                                 | Pharmacological treatment    |
|  | Dosing schedule              |

#### Case vignettes:

- 62 yr woman. Met breast Ca. Bone, single lung. Ambulant, living at home, supportive family. Hormonal treatment only. Routine visit. 3 day h/o confusion. Nil else.
- 84 yr man. Met small cell lung. Liver and bone. No anti cancer treatment possible. Progressive agitation and confusion. Prognosis days.

#### Results:

Response rates: Palliative – 38%, Med Onc – 24%, Geriatrics – 33%, Psychoger – 26%  
 (Total 30%, total number 270/918)

Med Onc – no community practice

Pall Med – 67% no inpatient practice

| Case One (Case Two) | Med Onc | Psychogeri | Geriatric | Pall Med |
|---------------------|---------|------------|-----------|----------|
| Consider home Rx    | 35 (50) | 72 (56)    | 35 (67)   | 69 (69)  |
| No investigations   | (47)    | (54)       | (47)      | (41)     |
| U+E/FBC/ Ca/LFTs    | 92 (20) | 90 (6)     | 85 (15)   | 77 (15)  |
| Urine C+S           | 85 (25) | 92 (34)    | 93 (28)   | 76 (22)  |
| Oxygen Sats         | 77 (33) | 44 (29)    | 61 (29)   | 55 (37)  |
| TFTs                | 13 (0)  | 41(0)      | 28 (0)    | 8 (0)    |
| CT head             | 49 (2)  | 18 (0)     | 38 (0)    | 10 (0)   |
| CXR                 | 55 (5)  | 54 (3)     | 67 (8)    | 13 (0)   |

|                    |               |              |              |              |
|--------------------|---------------|--------------|--------------|--------------|
| Empirical Therapy  |               |              |              |              |
| Antibiotics        | 16            | 3            | 5            | 4            |
| IVT                | 39            | 3            | 27           | 10           |
| O2                 | 39            | 3            | 16           | 12           |
| Pharmacological Rx | 31            | 44           | 30           | 77           |
| Non pharm Rx       | 62            | 97           | 90           | 85           |
| What pharm?        |               |              |              |              |
| Neuroleptic/ Benzo | 79/21 (23/77) | 95/5 (72/28) | 98/2 (69/31) | 97/3 (62/38) |

Other options – Lumbar Puncture/Electroencephalogram/arterial blood gases chosen by none

### Investigations

Case 1: median number investigations PM =5; others =7

Medical oncologists most likely to investigate (significant for O2 saturations and CT head, Palliative Medicine least likely to investigate (significant for chest X-Ray and Urine culture and sensitivity)

No significant differences in case 2

### Empirical Therapy

Medical Oncology more likely to use Antibiotics IVT and O2

Palliative Medicine more likely to use symptomatic therapy

### Dosing of symptomatic therapy

Haloperidol starting dose 0.25 – 25mg/24h max 0.5 – 120mg/24h

Midazolam starting dose 0.5 – 30mg/24h max 10-150mg/24h

### Other

4.8% geriatricians and 9.4% psychogeriatricians added opioids to the management of delirium in the last days of life

### Strengths:

- Anonymous survey of current practice
- Ability to be honest.
- Looked at some of the specialists most likely to be involved
- Created a Baseline to direct further education, research or audit

### Weaknesses:

- Not clear whether all eligible physicians or a subset of them were contacted.
- Appears that choices were given regarding treatment options ( no free text – may have limited responses)
- Would have liked to see General practitioners and Internists responses
- Vignettes are not real life and neither is a piece of paper – the answers may not reflect what actually happens in practice.
- Low response rate – respondent bias difficult to assess.

### Relevance to Practice:

- Informs practice as to the variability of current management of delirium and questions our own management.

- Helps to understand other specialties point of view