

***Clients across the life span:
effective pain management
at end of life.***

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Case Description:

- Case #1
- 6 year old male diagnosed with Leukemia.
- Multiple chemo regimens for 1 year with poor response and disease progression.
- Family (Mom and Dad, no siblings)

Initial consult/contact Case 1

Bone marrow transplant. (allogenic with non related donor) at large mid-western university health center

- Pain issues
- Nurse's role

Plan for pain management:

- Client reluctant to express symptoms
- Assessment – client able to state he had pain but intensity not rated
- Pain medication- able to administer only after negotiation with Mom
- Mom's fears
 - Addiction
 - Deterioration and death of child

Positive outcomes Case #1

One day I was in the room doing cares, and he was playing with mom and during a moment, when it was quiet in the room, he looked up at his mom and said, "Mommy, you know dying is not a bad word"

In hallway, nurse provided mother with psychological support to acknowledge son's statement.

Pain well managed with appropriate medication doses administered to minimize suffering.

- He died 2 days later.

Recommendations

- Assessment of parental concerns related to end of life care and pain medications
- Provide psychological support early in process to parents whose children are terminal
- Provide education and psychological support to parents to discuss death with their children and provide comfort care at end of life

Case Description

- Case #2: 21 year old male c/o lethargy, flu like symptoms. After consultation and labs, diagnosed with aggressive Leukemia
- Allogenic stem cell transplant with sibling match
- Anticipated long term pain issues

Initial consult/contact

- Pain description, location, intensity
- Initial pain regimen
- Nurse Consultant involvement
- Challenge was staff nurse's failure to administer prescribed doses of Dilaudid (hydromorphone).

Positive outcomes:

- Patient discharged to home on Hospice with Dilaudid (hydromorphone) PCA pump
- Client has progressive weakness and limited ability to use extremities & unable to self-administered medication through pump
- Family used PCA to administer medication
- On final visit, patient able to converse and died peacefully.

Recommendations:

- Nursing staff inappropriately limited medication for fear of addiction
- Nursing staff needed education on difference between addiction and need for increasing pain medication for progressing disease
- Continued education needed for safe, effective pain management at end of life

Introduction

- 51 y/o female admitted with intractable pain on October 1.
- Leiomyosarcoma of right buttock with metastases to hip, pelvis, lumbar and thoracic spine, and femur.
- Receiving morphine 500mg/hour at home.
- Increased to 580mg/hour had seizures.
- Started on Dilantin (Hydrocodone)
- Other meds: Flexeril, Decadron, and Valium

Hospital Course

- Attempted Dilaudid, but ineffective
- Duragesic patch 150mcg/hr placed, Morphine 50 mg q 15 minutes, Valium 10 mg q 2 hours (20 mg)
- Restarted Morphine 500mg/hr on Oct 2, titrated to 1355mg/hr 0525 Oct 5.
- "Yelling out in pain"
- Pain Management Consult obtained

Intervention

- By 1000 Oct 5, Morphine at 4500 mg/hr.
- Patient continued to yell out in pain and have seizures.
- Meds: Versed 6 mg IV q 6 minutes
Valium 20 mg q 15 minutes
- “Palliative Sedation” protocol
 - Thiopental started at 20mg/hr at 1200, titrated q 5 minutes until coma induced.
 - Time of death-1559, thiopental at 250mg/hr.

Reflection

- Family relieved by death
- Made statement that they wish we could have done this earlier.
- Personal feelings around what I had done.
- Personal feelings of relief.

What could have been done differently?

- New types of neuropathic meds available
- More aggressive with dilaudid titration
- Earlier palliative sedation initiated
- Other thoughts?

Case #3: Description

- Patient is an 84 year old African-American female (MMB)
- Diagnosis of breast cancer with metastasis to the base of the skull.
- Rarely out of bed to a chair
- Reports severe head/neck pain; moderate constipation; and mild fatigue
- Dislikes taking pills of any kind. Problems with adherence imperil optimal symptom management

Identification of Pain Syndromes

- Musculoskeletal pain related to diminished activity and prolonged bedrest.
- Skeletal pain r/t metastatic disease process
- Facial nerve impingement r/t cervical lymphadenopathy.

Exploring Options in Support of Patient Preferences

- Analgesic relief: PO (liquid, tablet); transdermal; long-acting and/or short-acting.
- Consideration of adjuvants: risks for elderly and difficulties associated with titration.
- Alternatives preferred by MMB: Cutaneous therapies, music therapy and meditative power of prayer.
- Postural change
- Optimal pain relief **requires** prevention and/or management of side-effects.

**Prevention and/or Management
of Side Effects & Sequelae**

- Constipation
- Fatigue/lethargy
- Somnolence
- Confusion
- Sad/Depressed/
Response to a shrinking world
- Skin care á la MMB

Goals of Care

- Patient-family synchrony
- Timing is everything
- Advance Directives:
Old wine new bottles