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CONTENTS
P2 Report from Scientific Committee.....Dr. RSK Lo
P4 Symposium on Supportive Care for Renal Patients
P6 Spring Dinner of Hong Kong Society of Palliative Medicine & Hong Kong Hospice Nurses' Association
P8 Right to Die or Risk to Live.....Dr. YYW Mak
P10 Editors' Column.....Dr. DMW Tin
P11 Physician Assisted Suicide on air: Could it be right?.....Dr. DKS Au
P13 課程生哲學 eso.....李著人教授
P14 Is Euthanasia the Answer?.....Dr. CY Tin
P15 Palliative Care for Advanced Heart Failure: An Overview.....Dr. JSC Ng
P19 The Withdrawal of Non-Invasive Ventilation in a Patient with COPD and Transitional Cell Carcinoma.....Dr. A Mak
P24 Pain Management of Advanced Pancreatic Cancer: Local Experience in Caritas Medical Centre.....Dr. TWY Chen
P27 Palliative Sedation.....Dr. BCK Li
P29 Delirium in Palliative Care.....Dr. PKW Wu
P33 Education Seminars
P34 Membership Information
P36 Global Year Against Cancer Pain 2008 - 2009.....Dr. AGI Kwok
P37 News from Society for the Promotion of Hospice Care.....Ms Faye Chan

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特此鳴謝
The Symposium on Supportive Care for Renal Patients was successfully held on 11th January 2009. This was the first local symposium on palliative care for patients with end-stage renal diseases. It was a great experience to learn from our distinguished overseas speakers - Prof. Michael Germain and Prof. Edwina Brown. We also had local speakers to talk on a rich variety of topics, including data from local renal registry; symptom control in ESRD; the past, present and future of palliative care; experience of a local renal palliative care program; role of medical social worker in the program and the psychological distress in ESRD.

The symposium had attracted many workers from the fields of nephrology and palliative care. We are looking forward to more collaboration of different medical specialties to promote palliative care for non-cancer in Hong Kong.
香港紓緩醫學學會及香港善終護士學會
祝大家牛年……
THE DEATH OF CRAIG EWERT: REPERCUSSIONS & REFLECTIONS

RIGHT TO DIE OR RIGHT TO LIVE?

Dr. Yvonne Yi-Wood Mak
Council Member, Hong Kong Society of Palliative Medicine.
Correspondence: makyw@ha.org.hk

A documentary *Right To Die*, filming a gentleman who hastened his death by assisted suicide, was televised for the first time in December 2008. This had reignited the endless debate regarding issues of medically assisted death.

Craig Ewert, a 59 year-old American expatriate and retired university professor residing in the UK, was diagnosed with motor neurone disease in April 2006 and was given a life expectancy of two to five years. His disease progressed rapidly and within five months, he was wheelchair-bound and required artificial ventilation and tube-feeding at home. He paid Dignitas, a Swiss right-to-die organization which offers legal assisted suicide.

In September 2006, he flew to the Dignitas Clinic, a residential apartment in Zurich and was assisted to die by drinking a lethal dose of barbiturates. He died 45 minutes later with his wife by his side to say goodbye. He did not want his two children to be present, as he anticipated that it would be more difficult for him to go through with the act.

‘If I go through with it (assisted suicide), I die as I must at some point.
If I don’t go through with it, my choice is essentially to suffer, and to inflict suffering on my family, and then die.”

- Craig Ewert, a patient with motor neurone disease, December 2006 -
Excerpts from the documentary and the UK newspapers quoted Ewert's reasons for wanting assisted suicide:

“I am tired of the disease but I am not tired of living. I still enjoy life enough that I would like to continue but the thing is that I really cannot… If I opt for life then that is choosing to be tortured rather than end this journey and start the next one. I cannot take the risk… Let’s face it, when you’re completely paralysed and cannot talk, how do you let somebody know you are suffering? This could be a complete and utter hell…You can watch only so much of yourself drain away before you look at what is left and say, ‘This is an empty shell’… Once I become completely paralysed, then I am nothing more than a living tomb that takes in nutrients through a tube in the stomach. It’s painful…”

“I am dying. There is no sense in my trying to deny that fact. I truly expect that death is the end, that there is no everlasting soul, no afterlife. This is a journey I must make. At the same time I hope this is not the cause of major distress to my dear, sweet wife who will have the greatest loss as we have been together for 37 years in the greatest intimacy.”

“By this point, I have two choices, either go through with it or say, ‘I am too scared right now and I do not want to do it.’ If I do not go through with it, then my choice is to suffer and to enforce suffering on my family and then die in a way that is considerably more stressful and painful. I have death or I have suffering and death. This way makes a whole lot of sense to me…”

This documentary is powerful in supporting assisted suicide and thought-provoking too. One must not underestimate the power of the media and how the pro-euthanasia lobby is using this film as part of their political campaign. Given such a scenario, what would we choose? Do we really have that choice of deciding the manner and the timing of our own life and death?

In a secular society with a utilitarian and individualistic ethos, there is much emphasis on autonomy, control and self-determination. Ewert’s rationale for wanting assisted suicide seems to make perfect sense. If we could die peacefully with a lethal drink, perhaps we should, but is assisted suicide or euthanasia the only way of ensuring a peaceful death? If we could escape from suffering, perhaps we should, but is suffering always meaningless and should it not be embraced? Life comes with suffering and passion comes with pain, so does it mean that none of us should bother to live or love because we do not want to suffer? Do we only live and love for better but not for worse?
One could go on searching for the right answer. From a legal and medical perspective, however, medically assisted death is not the answer for the following reasons:

1. Patients who have a genuine desire for hastened death represent only a small minority in clinical practice.
2. There is a high prevalence of clinical depression in patients who desire hastened death.
3. The irreversibility of medically assisted death is dangerous as the will to live or die in the terminally ill is known to fluctuate during the course of illness.
4. The terminally ill or elderly are a vulnerable population. They often feel themselves as a burden and they could be compelled to die in order not to burden society. Particularly for the Chinese culture, Confucian philosophy views that a good society takes care of the vulnerable including the sick and that the sick elderly are not allowed to be seen as a burden. Legalizing medically assisted death on the grounds of burden could lead to moral disintegration.
5. The safeguards for protecting the vulnerable against coercion to die, screening for depression and exploring the genuine reasons for desiring death, are not safe or guaranteed.
6. Palliative care is not universally available or accessible for all patients with a progressive life-threatening disease, and even if it is so, its provision tends to focus on the terminal rather than the early phase of the disease journey, which overlooks the fact that patients at the time of diagnosis also have significant psychological distress, fears about their future disease trajectory and death.
7. Medical professionals focus more on the need to respect patient autonomy, assess mental competence for the patients’ requests for death, and determining legal guidelines than listening and understanding the patients’ inner world and genuine needs.
8. Medical students should not be trained to kill but to care when cure is no longer possible.

The real challenge is, as healthcare professionals, how do we respond when we are faced with a patient such as Craig Ewert, who gives an eloquent and seemingly logical reason for his death wish? Do we tell him that it is illegal locally but we would respect his choice of going to Zurich? Should we affirm the Dignitas Founder Ludwig Minelli’s suggestion that we should help to kill those who say they have had enough of an awful life and would like to leave? It is our moral duty to alleviate our patients’ suffering irrespective of the phase of their illness journey. Controlling suffering is a myth; we cannot control but relieve suffering to the best we can; we provide a holding environment to contain their suffering so that it becomes bearable. The holding environment enables the patients to have the opportunity to transcend their suffering into healing and to find meaning and personal growth. Suffering is a complex and multi-dimensional concept, going beyond the physical and functional to psycho-spiritual and existential concerns, understood within the context of the whole person.

Imagine Craig Ewert is your patient... How would you respond? What thoughts are going through your mind? He has only been diagnosed with a life-threatening illness five months ago... Has he been referred to palliative care? Does he accept the diagnosis? Does he have clinical depression? What are his values and personal beliefs? Has he received counseling? Who has been advising him on his options? And who has been supporting him in his decision making? Is he really that terminal that he needs to die now? It is important to listen intuitively and empathetically, trying to read between the lines rather than taking his words at face value. It is necessary to acknowledge the suffering that Craig is going through, spending time to understand his personhood, teasing out the meaning of his every word and exploring in depth his inner world. If we examine Craig’s verbatim carefully according to a framework of (i) the reality, (ii) perception of current suffering for self and significant others, (iii) anticipation of the future, (iv) desires and (v) holding environment and connectedness, it helps to identify his underlying concerns and direct further in-depth exploration:

(i) Craig is aware of the rapid progression of his disease and the inevitability of death.
(ii) Suffering is multi-dimensional: his loss of body image and not just physically but also the loss of sense of existence with a sense of uselessness being totally dependent upon his wife; he sees himself as a burden to his wife; he cannot enjoy life.
Craig has many anticipatory fears: fear of future suffering for self and his wife, anticipating his future as a lifeless body, torture and utter hell.

Craig desires relief of suffering for himself and for his wife, not to burden his family and the desire to be understood.

His wife provides his holding environment with intimacy but nothing is mentioned about their support network and their children are not present.

From this framework, Craig’s anticipatory fears and support network become apparent areas that warrant deeper exploration, explanation and reassurance. Has he witnessed other patients’ dying trajectory? Has anyone explained that he could come off his ventilator whenever he wanted to and be supported by good palliative care when he was dying so that he would not suffer symptoms such as dyspnoea and choking? Has anyone discussed advanced care planning to ascertain his wishes when he can no longer communicate? What is the support network for him and his family? Apart from his physical and functional concerns, there are many existential aspects that could be addressed to facilitate transcendence of his current suffering.

At a macro level, how should policy makers, medical educators and society respond? Policy makers need to recognize and reinforce palliative care as a standard of good quality care for patients with progressive life-threatening illness, particularly in providing symptom control, psychosocial counseling and existential care. Palliative care can be integrated into non-cancer specialties that deal with life-threatening illnesses at an early phase of the disease journey. Undergraduate medical training could include more emphasis on whole person care and medical humanities to allow better understanding of the patient’s illness experience, thus improving the quality and art of medicine. Public education on life and death would help to promote a positive and healthy attitude to facing crises and caring for the sick. We all have a part to play, as everyone has the right to live, whatever the circumstances.

I end this article with some life-affirming words from Morrie Schwartz, also a retired professor who suffered from amyotrophic lateral sclerosis, but died a natural death at home in the presence of his immediate family:

“on’t stay pre occupied with your body or illness. ecogni e that your body is not your total self, only part of it.”

“I am an independent person, so my inclination was to fight all of this being helped from the car, having someone to dress me. I felt a little ashamed, because culture tells us we should be ashamed if we can’t wipe our own behind… ‘ orget what the culture says’… I began to enjoy my dependency… I revel in it… It is like going back to being a child again… e all know how to be a child. It’s inside all of us… It’s just remembering how to enjoy it.”

“oppel imagined the two men together one day, one unable to speak, the other unable to hear… ‘ e will hold hands… And there’ll be a lot of love passing between us… we’ve had thirty five years of friendship. You don’t need speech or hearing to feel that.’”

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Physician assisted suicide on air: Could it be right?

Dr. Derrick KS Au,
Hospital Chief Executive, Kowloon Hospital & Hong Kong Eye Hospital.
Correspondence: ksau@ha.org.hk

The Dignitas Clinic in Switzerland assists both Swiss and foreign patients to commit suicide. People in support of this service would prefer to call it ‘assisted dying’. More than 100 UK citizens who gone to Switzerland to die with such assistance. They are often accompanied by their relatives. Assisting others to commit suicide is a criminal offence in UK, but so far there have been no prosecutions of the relatives. Responding to the case of 23 year-old rugby player Daniel James, who died in Switzerland in this manner, the Director of Public Prosecutions remarked that prosecuting his parents would not be in the public interest.

On 19 February 2009, a multiple sclerosis patient Debbie Purdy claimed partial victory after the Court of Appeal in London rejected her case. Ms Purdy had sought to establish whether her husband would be prosecuted if he helps her travel abroad to die assisted, in a country like Switzerland, where assisted dying is legal. The appeal judges ruled that she was not legally entitled to such advance guidance. To Ms Purdy and advocates of euthanasia and assisted suicide, the ruling was nonetheless perceived as encouraging – the Appeal Court had not ruled that relatives should be prosecuted if they assisted with such suicide arrangement.

Legalisation of ‘assisted dying’ is on the agenda in the UK. In May 1996, the House of Lords blocked an Assisted Dying Bill by just 148 to 100 votes after much public debates. Recently, Private Members of the Scottish Parliament attempted to put up a similar bill, proposing to give terminally ill patients the right to assisted suicide.

To this date, PAS remains highly controversial, but the tide of public opinion seems to be slowly shifting in its favour, at least in the UK. It must be a matter of time that a case like Craig Ewert would eventually prop up to stir a storm.

Mr Ewert was a patient completely paralysed with motor neuron disease and dependent on non-invasive ventilator. In September 2006, he died in Dignitas Clinic after drinking a mixture of sedatives and using his teeth to turn off his ventilator. Canadian director John Zaritsky had documented his assisted dying process in his film Right to Die, and the process was broadcast live on Sky TV last year, with pre-announcement. New internet media like the YouTube helped disseminate the clip to wide audiences all over the world.

Critics branded this Sky TV programme as just another “Reality TV” stunt. Was it just “Reality TV”? Reality TV is a new genre of programs that features ordinary people in non-script scenarios, often monstrous or extreme in nature. The audience gets entertained by seeing the actions and responses of unpaid participants in treacherous contests or humiliating “coaching”.

Strictly speaking, the film Right to Die does not fall into the category of Reality TV programmes. However, they do have some similarities.

Lady Finlay, a professor of palliative care, said of the SkyTV programme, “This programme is broadcasting something which is very private, which is someone dying and which is illegal in this country.”
The Death of Craig Ewert: Repercussions and Reflections

Here is the commonality between such pre-announced broadcast of assisted suicide and other Reality TV programmes: Both make voyeurism-like invasion of privacy possible. Indeed, seeing private life (and dying in this case) under extreme condition is an important part of the attraction.

Television Features Editor Michael Deacon strongly disagreed. He argued his case from the point of presenting all the facts for the public to judge: “Ewert’s assisted suicide upset some. And indeed it was an upsetting film. But that was no reason to remove it from our screens. If we are to have a serious debate about assisted suicide we must look at all the facts. And that means looking at some things we might rather not see.”

Mary Ewert, wife of Craig Ewart for 37 years, confirmed that it was their wish to bring this dying process to the public. She told the Telegraph newspaper, “The film is a wonderful tribute to my husband. I have absolutely no regrets about agreeing to leave the camera rolling as Craig died. It’s what we both wanted…If this film gets people thinking about death and talking about it, that’s all that Craig would have wished.” The intention was clear: Craig and Mary both wish the filming would get the public to think and talk about this death. Privacy was not their concern. They wanted to make a statement, and to stir public debate. They very much achieved the goals.

Could it be right in this case to broadcast the suicide act? It did have the consents from the patient and his relative. The broadcast probably did serve the purpose of generating public debates and making a statement. The question is, does the end justify the means? Take a different scenario, a depressed person out of job wishes to film his suicide to make a statement of protest against an unjust society, would the end also justify filming his suicide?

The pro-PAS camp should have no shortage of arguments to defend the broadcast. Assisted dying in the terminally ill person, unlike the suicide of a depressed unemployed worker, is not merely an act of political protest; the film was meant to lay the facts open for the public. It could help overcome social taboo regarding death and dying.

In reality, the nature of the film is probably somewhere in between (protest / advocacy vs. facts / taboo-breaking). A documentary with such strong ideology and advocacy cause can hardly be a mere piece of fact-recording documentary. The filming of Craig’s final moments puts the case of assisted suicide in the best of lights, reassuring viewers that there is nothing to be afraid of. It is persuading, not just recording or reporting.

Even then, it may be argued that there is nothing wrong with ideology or cause-driven documentaries. We are in a pluralistic society. Conflicting values and perspectives should all enjoy freedom of expression.

Could the live broadcast of the assisted suicide of Craig Ewert’s be right? It could, but I would submit that, in balance of probability, it wasn’t. PAS is a complex issue with ethical, legal, medical, and social dimensions. It cannot be fairly treated by the documentation of a single ‘he died willingly and peacefully’ case. One particular case of affectionately produced and enthusiastically broadcasted PAS may seem innocuous, or may even be ‘touching’ to some viewers; whether the ramifications of legalising PAS can be appropriately comprehended and discussed with such sensational means is doubtful. The ‘slippery slope’ of PAS is real. Craig Ewert was not even a terminally ill patient. Frail and vulnerable non-terminally ill patients do not fare well if and when PAS becomes an ‘easy way out’ for health care professionals, the patients and their family. Even for the terminally ill patients, the Sky TV broadcast of Craig Ewert’s assisted suicide might well be doing them a ‘disservice’. Further to her remark on the SkyTV programme and privacy quoted above, Professor Finlay said, “I think it also perpetuates a myth that, somehow, to have a good death you have to end your own life and that is just completely untrue.” Indeed, once PAS becomes a ‘quick-fix’, the norms and values of health care will shift, and good quality palliative care is unlikely to be pursued with patience.

NO SHORT CUT!
安樂生・安樂死

可以看到（Craig Ewert）在瑞士選擇了安樂死的最終決議，即時令我感到震驚，腦海中浮現數年前在電視新聞上看到一幕嚴重的火警，當時有一位女子被困在十數層窗外等待求援，現場的人都以為很快就會得到救援，但過了二十多分鐘，該女子最終抵不住高溫及濃煙，無奈從高處躍下當場死亡。現場的市民均掩面痛哭，令我至心痛的。兩件事件感觸，兩樣活生生生命在你面前結束，實在不好受，好生離，要很久才平靜下來。

一個是想他人達致他的生命，而一個是想他人在達致自己的生命時，兩個都是一個強烈的對比，但何為會這樣想起來我已解釋不了。以前我不曾經經歷過他們想活，又或經歷過後，對生命有另一種結論。這片段一直衝擊我的思想，把再一次反思生命的價值。也令我回首想起當年的創傷後，也想達致結束生的行為。

二十四年前被救出在醫院的時候，本要接受終身監禁的事件，當時的我內心有放棄自己的想法，無容縈覆，面對病魔每一天的折磨，家人的怒容苦臉，面對摸索不前的步伐，面對自己薄弱的求生意志及低落的情緒，這些因素最終初期所面對困難的刺激，尋死仿似是唯一一條解脫的路。

可知道生命走到今天這階段，要我來一個緋聞，我會這樣想，我好興奮沒有走上那條不歸的路，我亦希望我的家人看見我今天是人生。在當年的痛苦難過時，所以我更興奮沒有要求我親人幫助我解決我的困苦。而要他們變成撲火手，救我不肯面對困難，而要他們可能背上一生內疚。

可以有選擇安樂死的權利，算是幸運還是不幸？在現今香港的社會中，像我們這一個類的病人，並沒有選擇的機會，但想深一層探討一條合法的路線，讓我們走上一條永遠沒有選擇的路線，這是對我們最好的辦法嗎？還是在剎那甚至摧毀我們的將來呢？

雖然由溫室毒至死亡只是短短三分鐘的過程，卻是一個命運的決定，看去他的家人會放看著一分一秒地倒數著親人的離去，我的心感到無比的痛苦。然而，病者家屬在尊重病者的情願下讓他在自己的手中離去，這纔是真正尊重生命的做法嗎？意願真的能夠凌駕在生命的道路上嗎？

在我這二十四年全職經驗中的分享，我們只要得到適當的支援和同路人的協助及鼓勵，再配合社會上的康穢資源及先進的醫療設備，生活的質素必得以改善，繼而發展到自己的潛能，為自己在人生添上無限的色彩，亦可以繼續追求自己的目標，積極為我疾的學業、家庭、工作、理想等奮鬥，為社會作出貢獻，積極人生。相反地，若我在當初不理智的情況下作出一些無法挽救的行為並再無法去改變自己的命運了。

然而我們的痛苦及支援服務更應該得到社會人士的正視，而並非以死作為解決人世間痛苦的路徑。「安樂死」只會令到社會人士認為這是一個處理嚴重病患者的良策。社會及政府應思考未來應尋求多少支援或資源來鼓勵及支持這班病人及其家人，從而放棄安樂死的方法。積極尋找「安樂生」的道路反而能做得更有意義呢？當然我們需要尊重每位病友對於生命的看法，他們亦可以有權選擇以怎樣的觀點及角度看待自己的日子，但從訂立政策的立場看來，又是另一回事。必須衡量整體好處與壞處，以及是否有其他替代的方法。

李遠大
路向四肢傷殘人士協會

李遠大先生是路向四肢傷殘人士協會主席，他在廿二歲時，跟一班朋友在海邊騎腳踏車，發生了意外：當時他昏迷中醒過來，他已變成一個終生癱瘓的人。經過痛苦的心路歷程，他終於重新對生命有所領悟。李遠大先生經常參加公眾活動，以追求人的體會，傳達對生命正面的訊息，以及面對逆境時積極的態度。

李遠大獲於中國北京萬里長城及烏巢：看！障礙往往不在身外，而是在心內。

我們這群肢障人士鰣不算是擁有堅強的情義的偉大人物，可以影響世人，但我們的行為也可以潛移默化地影響著社會的下一代。遇到形形色色的困難需要我們面對及解決。「健全」與「傷殘」也需要面對，沒有這些困難，我們又何來與「優質生活」作比較呢？

相信世上沒有絕對的「仙境」與「困境」，很多事情需要我們持著漫遊態度來面對。我們可以選擇「積極」或「消極」，也可以選擇「面對」或「逃避」，但需要記起我們是生活在群體的社會中，我們的行為因自身的而作出甚至還用任何方法意詼諧自己的生命，那未來的世界將會變成怎樣？也是一個對於未來一代不負責任的行為？

The Death of Craig Ewert: Repercussions and Reflections
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Is Euthanasia the Answer?

Dr. TSE Chun Yan,
Honorary Advisor, Hong Kong Society of Palliative Medicine.

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According to the Professional Code of Practice of the Medical Council of Hong Kong, euthanasia is defined as “direct intentional killing of a person as part of the medical care being offered”. Euthanasia is illegal throughout the world with the exception of Netherlands and Belgium. Additionally, physician assisted suicide is legally permitted in Oregon of USA.

Recently, there are debates on whether euthanasia should be legalized or not in Hong Kong. The major argument supporting euthanasia is that one should respect the patient's personal choice to end his/her life to relieve his/her suffering. There are two major objections to this argument. Firstly, with modern palliative care, pain and suffering of the great majority of patients can be controlled. The pro-euthanasia camp would argue that there are always the exceptional cases with symptoms difficult to control. However, besides the consideration of palliative sedation as an alternative to euthanasia for refractory symptoms in the terminal stage, one should look into the second major objection to legalizing euthanasia, which is “euthanasia is not simply a matter of individual choice”. Legalizing euthanasia has multiple implications to society as a whole. Firstly, licensing killing in non-war situations has significant impact on societal values. Secondly, there would likely be implicit pressure on the chronically ill and the vulnerable groups to choose euthanasia, especially in a Chinese society like Hong Kong. Strict consent procedures would not help this because the patients are not coerced by others to choose euthanasia, but they are “enlightened” by the legal status of euthanasia and voluntarily choose euthanasia when they feel being a burden to their family. Thirdly, there may be negative effect on resource allocation to the chronically ill and terminally ill. Fourthly, there is the slippery slope where the barrier to euthanasia is broken, as one can see in Netherlands, where euthanasia has now been extended to teenagers and to disabled infants. From the utilitarian point of view, societal resources are better utilized if society gets rid of the chronically ill, disabled and debilitated. But is this what the medical profession wants to see?

While I do not agree to euthanasia, I agree that, in appropriate circumstances, one may withhold or withdraw futile life-sustaining treatment (LST) in order not to prolong the dying process. The public should be clear that forgoing futile LST implies the acceptance of the fact that human is mortal. This is ethically and legally distinct from euthanasia, and is legally acceptable in most parts of the world including Hong Kong. Many medically advanced countries in the world have issued guidelines on this, and the Hospital Authority of Hong Kong has issued the guidelines in 2002. To avoid any unnecessary confusing connotations, the term “passive euthanasia” is not used in the relevant guidelines and legislations in many western countries and Asian regions (including Hong Kong, Taiwan and Singapore). Forgoing LST is itself a complex ethical issue, and what constitutes futility is not easy to define. Some situations are non-controversial, like forgoing CPR in a terminally ill, which is being practiced everyday in Hong Kong, whereas some situations are controversial, like the withdrawal of ventilator support in a conscious quadriplegic patient. This is not reasonable to lump all these together under the label of “euthanasia”. Forgoing futile LST is a necessary sequel of advancement of medical technology. Otherwise, all dying patients have to go through various meaningless futile treatments that only add suffering before they are certified dead. The normal practice in medicine is to give treatment only when it is indicated. Contrary to some recently expressed views in Hong Kong, forgoing futile LST does not logically lead to the acceptance of euthanasia. Consideration of specific legislation to govern the practice of forgoing LST in Hong Kong needs not be tied with legalization of euthanasia.

The recent debate on euthanasia reflects the concern of the community to the plight of the chronically ill and terminally ill in Hong Kong. The Government and the community should consider more resources to help these patients. There should be more education to the public and to the medical community on how best to care for these patients. The medical profession should understand the background reasons for a euthanasia request. The story of Bun Tsai is paradoxical and illustrative. His earlier request for euthanasia was not acceded to. He then received belated support to improve his quality of life, and he now wants to continue living. To help the chronically ill and terminally ill, euthanasia is not the answer.

Footnote

1 He is an unfortunate tetraplegic patient in Hong Kong who openly requested euthanasia.
Palliative Care for Advanced Heart Failure: An Overview

Dr. Jeffrey Sheung-ching Ng,
Palliative and Pulmonary Care Unit, Haven of Hope Hospital.
Correspondence: ngscj@ha.org.hk

Background

As in many parts of the world, hospital admissions in Hong Kong due to heart failure is both common and on the rise\(^1\), and heart failure is a final common pathway of various cardiac conditions leading to death. In fact, advanced heart failure (AHF) was described as more 'malignant' than cancer because of its poor one-year survival rate and its prognosis worse than for most common forms of cancer\(^2\). However, patients with AHF are disadvantaged as compared with cancer patients, as they are less likely to have an understanding of their illness, to receive supportive care, and to have the opportunity to plan for care with regard to death and dying\(^3\). Quality of life assessment of patients with AHF revealed worse physical role function and higher pain scores than patients with end-stage renal failure or respiratory failure\(^4\).

Prognosis and disease trajectory in advanced heart failure

It has been reported that mortality of patients with heart failure at New York Heart Association (NYHA) functional class IV would be up to 40% to 50% in one year\(^5\). Other demographic and clinical powerful predictors associated with a poor prognosis in heart failure include advanced age, ischaemic aetiology, hypotension, prior heart failure hospitalization, hyponatraemia, wide QRS complex, low left ventricle ejection fraction (LVEF) and reduced work with low peak \( \dot{V}O_2 \)\(^6\). The list of poor prognostic conditions also includes renal dysfunction, diabetes, raised uric acid, anaemia, COPD, sleep-related breathing disorders and depression\(^7\). Yet, quite a number of these published model predictors are only important to ambulatory patients or specific target groups. Prognostigation to patients with AHF, who commonly suffer from multiple co-morbidities, remains difficult.

There are conceptual models of disease trajectories commonly quoted in literatures in geriatric and palliative medicine, describing typical patterns of decline of functional status over time\(^8\). These models are helpful in planning and delivery of palliative care as well as in communication with patients and their families. While cancer patients are more likely to sustain a relatively stable functional state until a short period of evident decline before death, patients with heart and lung failure are commonly depicted to share a slower decline with long-term limitations and intermittent serious (and usually sudden) episodes until a lethal one. However, the course of AHF in reality is likely to be even more unpredictable. A prospective study looking at the dying trajectories in heart failure delineates the functional state of twenty-seven patients for 24 months prior to death\(^8\). It turns out that no 'typical' dying trajectory could be identified, and only a minority of patients conformed to the theoretical trajectory of dying in heart failure\(^8\). Such unpredictable clinical trajectory often results in patients dying before they are deemed eligible for palliative care.

Palliative care for advanced heart failure

For the definition of advanced heart failure, besides the presence of severe symptoms, the position statement from the European Society of Cardiology (ESC) has recommended the inclusion of objective evidence of severe cardiac dysfunction, severe impairment of functional capacity, history of heart failure hospitalization and presence of these features despite optimized guideline-recommended therapies\(^8\). In order to provide due care to patients with heart failure, the first step is to confirm the diagnosis of heart failure and to understand its aetiology, such that appropriate, guideline-recommended and evidence-based therapies can be given. Guidelines on diagnosis of heart failure are available in detail\(^8,10\). Although current knowledge in specific symptoms management for AHF is still limited, the following discussion
the following discussion will address on a small number of studies on palliative interventions which can be beneficial. Issues related to implantable cardiac devices will also be discussed.

Active communication with patients with AHF and their families is essential, and liaison with palliative care specialists in a shared care approach is encouraged, to address and coordinate patient’s care need optimally. Education for patients and their care-givers on principles of self-care maintenance and heart failure management should be provided. Explanation on disease progression and change in treatment emphasis is a sensitive issue and must be approached with care and empathy. Advanced care planning should be initiated and reviewed regularly, with discussion on preferences on future treatment options. Decision on device management (including deactivation) and resuscitation orders must be clear for patient with end-stage heart failure. End-of-life care should include plans for crises, spiritual support and bereavement support. To maintain hope for patients with AHF, Davidson and colleagues suggested the following issues as important: 1. acknowledgement of the changing life circumstances, 2. restructuring of reality, 3. dealing with vulnerability, 4. achieving normalization and 5. resolving uncertainty.

Medical management of advanced heart failure

It is important that evidence-based guideline-recommended treatment of heart failure is optimized because this has major benefits not only on survival but also on symptom control and quality of life. Such treatment is made on basis of improving the symptoms of sodium and water retention, modifying on-going cardiovascular risk and targeting neurohormonal activation. Yet we have to be aware that the benefits from such evidence-based strategy are based on extrapolation of the study findings in heart failure as a whole. At present there is limited evidence specifically addressing AHF, and it is uncertain whether such benefits could be translated to these patients, who are typically elderly, complex, symptomatic and with multiple co-morbidities.

The most desirable approach is to use proven agents in the proven dosage regimens in accordance with contemporary clinical guidelines and not to assume a ‘class effect’. Lack of adherence to guidelines has been found to be an independent negative predictor of outcome in chronic heart failure. However patients with AHF may not tolerate the recommended regimens. Individualized therapy with realistic targets should be attempted, and some drug is better than none.

Angiotensin-converting enzyme inhibitors (ACEI) have a pivotal role across the entire spectrum of heart failure severity. The landmark Co-operative North Scandinavian Enalapril Survival (CONSENSUS) Study, which included only patients with NYHA Class IV, has shown the benefits from ACEI not only on reduction in mortality and hospital admissions, but also on improvement on symptoms and functional capacities. ACEI should be initiated at a low dose, and doubled slowly, with careful monitoring of renal function and blood pressure. Pre-existing renal dysfunction (with serum creatinine below 220 micromol/L) is not considered a contraindication by ESC, and rise of creatinine level is not considered clinically important if the increase in creatinine is less than 50% or its absolute value less than 265 micromol/L, whichever is lower. Complete intolerance to ACEI due to haemodynamic or renal cause is uncommon but a particularly poor prognostic indicator in patients with AHF.

Beta-blockers provide incremental benefits in addition to ACEI in terms of outcome and reversal of the detrimental remodeling process in heart failure. For patients without asthma and significant atrioventricular conduction defects, beta-blockers should be initiated as early as tolerated. The effective agents include a slow-release preparation of metoprolol, bisoprolol and carvedilol. The concern for negative impact of beta-blockers on quality of life especially on initial phase was not supported by a meta-analysis addressing this issue. The nine randomized controlled trials identified have included patients with NYHA Class III, and quality of life was found to improve more often in patients taking beta-blocker, although the standardized mean difference did not reach statistical significance.

Other therapeutic agents which have studies involving patients with NYHA Class III to IV include angiotensin receptor blockers.
(spironolactone\textsuperscript{23}) and hydralazine plus isosorbide dinitrate (in dosage of hydralazine 75mg/ isosorbide dinitrate 60mg three times daily\textsuperscript{24}). Digoxin has also been found to decrease hospitalization when being used on top of diuretic and ACEI therapy in patients with symptomatic heart failure and low LVEF\textsuperscript{25}.

**Symptom palliation in advanced heart failure**

The principles in symptom management are the same irrespective of diagnosis. A holistic assessment of aetiology of symptoms (including relevant investigations), intervention to reverse any reversible factors and palliation of irreversible situations would be a system applicable to both cancer and heart failure patients\textsuperscript{26}.

Dyspnoea is common and its severity is the criterion for NYHA classification. Besides pulmonary edema, dyspnoea in patients with AHF can be due to pleural effusion, pneumonia, pulmonary embolism, underlying obstructive airway disease or cachexia. There are a few randomized controlled trials\textsuperscript{27-29} with small sample size suggesting the effectiveness of opioids for palliation of dyspnoea in heart failure. A randomized placebo controlled crossover pilot study conducted in out-patient setting has shown that low dose oral morphine lowered breathlessness score by day two while sedation score increased until day three, with both reaching statistical significance\textsuperscript{27}. Another randomized controlled study has shown that low dose intravenous diamorphine significantly improves aerobic exercise capacity for patients with chronic heart failure performing cardiopulmonary exercise\textsuperscript{28}. For non-pharmacological measures, a low-level leg muscle strengthening exercise has been found to improve strength and endurance of lower limb muscles in patients with moderate to severe heart failure, along with improvement in both dyspnoea and functional state in \textsuperscript{30}.

Heart failure patients commonly experience pain, and it has been reported to affect up to 78% of patients dying of AHF\textsuperscript{31}. Besides angina, pain can be due to edema and claudication as well as from conditions not confining to cardiovascular system, like musculoskeletal pain, osteoarthritis, diabetic neuropathy, shingles and chest drains. If angina is refractory to optimal conventional antianginal treatment, opioids can be considered\textsuperscript{26}, and there is some evidence for the use of transcutaneous electrical nerve stimulation (TENS)\textsuperscript{32}, acupuncture and spinal cord stimulation\textsuperscript{33}. For arthritic pain, joint injection, joint-sparing exercise and local therapy (e.g. topical NSAIDs or lignocaine) are potential measures. Systemic non-steroidal anti-inflammatory drugs (NSAIDs) should be avoided as they precipitate decompensation by fluid retention.

Sleep disturbances are frequently reported in heart failure. Sleep-disordered breathing is associated with sleep disturbance in over 50% of ambulatory patients with heart failure\textsuperscript{34}. Oxygen desaturation and apnoea result in marked elevation of noradrenaline, which is associated with general malaise, anxiety and depression. Screening with overnight-oximetry should be considered for patients with AHF. For sleep apnoea in left ventricular dysfunction, continuous positive airway pressure (CPAP) ventilation has been shown not only to reduce apnoea and improve oxygenation, but also to improve LVEF and functional status\textsuperscript{35}.

Depression has been reported in 20-30\% of patients with chronic heart failure\textsuperscript{36}. Serotonin-specific re-uptake inhibitors (SSRIs) are the first-line treatment for major depressive disorder and for dysthymia in patients with heart failure. SSRIs have relatively favorable cardiac profile, but there is potential risk of hyponatraemia and worsening of heart failure, likely due to increased antidiuretic hormone\textsuperscript{37}. Tricyclics should be avoided for their risks of arrhythmias and postural hypotension. For patients with end-stage heart failure and limited life expectancy, psychostimulants such as methylphenidate can be considered as it has few adverse effects and a quick onset of action\textsuperscript{38}.

**Management of implantable cardiac devices at the end of life**

Implantable devices that treat potentially lethal arrhythmias and support cardiac function have become standard therapies. These devices include implantable cardioverter defibrillators (ICDs) and bi-ventricular pacemakers for cardiac resynchronization therapy (CRT) and ventricular assist devices (VADs). According to ESC guidelines\textsuperscript{6}, ICD therapy is recommended for survivors of ventricular fibrillation (VF) and
symptomatic ventricular tachycardia (VT) as primary prevention, and for patients with LVEF <35% and NYHA class II or III as secondary prevention. CRT is recommended for patients with NYHA class III to IV with LVEF <35% to improve symptoms and to reduce hospitalization and mortality. Besides bridging to transplantation and managing patients with acute severe myocarditis, now VADs are also indicated for long-term use (as destination therapy) when no definitive procedure is planned for end-stage heart failure.

Issues related to deactivation of implantable cardiac devices should be discussed with patients with end-stage heart failure. At the end of life, there are severe electrolyte and homeostatic disturbances which will result in VT or VF refractory to ICD shocks. Patients with AHF may prefer arrhythmic death to their symptoms or to invasive therapy, and this AHF may prefer arrhythmic death to their symptoms or to invasive therapy, and this may be more appropriate. Delivery of ICD shocks can be avoided without affecting backup pacemaker function by computer reprogramming. The shock function can also be turned off by taping a doughnut-shaped magnet at the chest over the generator. In fact, on maintaining pacemaker function without defibrillation, ICDs can alleviate symptomatic arrhythmia; and they have shown to be not prolonging life for pacing dependent patients. On the other hand, if patients want to keep defibrillation function, options include use of amiodarone and sotalol to prevent ventricular arrhythmia, electrophysiological study to ablate arrhymogenic foci in selected patients, or reprogramming of devices to enhance anti-tachycardia pacing (ATP).

Different from ICDs, CRT devices improve quality of life by inducing favorable reverse remodeling of the left ventricle, leading to improvements in ejection fraction and reduction in amount of mitral regurgitation. CRT reduces mortality in a different fashion as do ICDs, and de-activation of CRT may worsen symptoms. On the other hand, instead of de-activation, function of the devices can be optimized using electrocardiographic and echocardiographic measures to direct the settings. These may not only reduce the number of CRT non-responders, but it may also help to alleviate refractory symptoms.

De-activation of VAD is technically and ethically distinct from that of ICD or CRT. De-activation of VAD should be regarded as a terminal event, as this will lead to back flow and thrombosis within the device or the heart, inducing worse cardiac dysfunction. Detailed discussion must be conducted with patients and families. Standard VAD management is complex, including handling of backup system, wound care, assessment of dysfunction and complications, and most patients with VADs probably die in the acute setting.

Conclusion

Because of its unpredictable clinical course, AHF poses specific challenges to providers of palliative care. To improve the quality of life of patients with AHF, knowledge on both evidenced-based medical treatment and symptom palliation is essential. Education and support for patients and caregivers as well as timely communication on advanced directives and end-of-life issues are important, and often need a multidisciplinary approach. Further research in this area is imminently needed, so is the awareness of the suffering and uncertainties faced by these patients.

References

Palliative Medicine Grand Round

The Withdrawal of Non-invasive Ventilation in a Patient with Chronic Obstructive Pulmonary Disease and Transitional Cell Carcinoma

Dr Mok, Ka Wai Alice, Palliative Care Unit, Shatin Hospital.
Correspondence: mkw474@ha.org.hk

Summary

Over the past decades, non-invasive ventilation (NIV) has gained increasing acceptance as a treatment modality for respiratory failure. Its application on those who have decided to forego intubation and those who are approaching their end of lives has aroused controversies. We shared our experience on a case of NIV withdrawal after its failure from a gentleman with end-stage respiratory disease suffering also from a recurrent solid cancer. Investigators have tried to identify parameters that might aid in the prediction of NIV success and failure. Some have advocated a more systematic approach to the use of NIV in acute respiratory failure, including those who opted not for intubation, and those who used NIV as a means of palliation. NIV may be ethically and morally withdrawn if it is not providing net benefits of care.

Case History

Mr Chow was a 72 year-old gentleman with a past history of pulmonary tuberculosis treated a few decades ago. He suffered from an episode of pneumothorax in 1996 for which he was managed with talc pleurodesis. He was diagnosed with chronic obstructive pulmonary disease (COPD) with a history of intubation in 2004 for type II respiratory failure. His exercise tolerance was up to 1-2 flights of stairs in 2005 but had decreased to only 5 minutes of walk on level ground in 2008. He did not show up for the lung function test, and he declined the offer to arrange home oxygen.

Mr Chow was father of 3 children, living with his wife and the youngest daughter who was in her 30s. He quitted after having smoked for many years. Despite the slow pace because of limited lung function, Mr Chow remained independent for his daily activities, and was mentally shrewd enough to manage his financial accounts.

In 2000 he was diagnosed with Grade I transitional cell carcinoma of the urinary bladder and had undergone a transurethral resection of the tumour. Unfortunately he developed a local recurrence in 2005 but in preparation for the operation, both medical and anaesthesia colleagues determined that Mr Chow’s was a high risk case for radical operation because of the underlying poor pulmonary reserve. Instead of surgery, he received a course of whole pelvis radiotherapy, giving rise to subsequent complications of radiation proctitis and bulbous urethral stricture.

Since 2005, Mr Chow had made multiple visits to the emergency department which resulted in multiple hospital admissions because of either COPD exacerbations or urological complications and problems.

In early June 2008, Mr Chow was admitted again for COPD infective exacerbation, requiring up to 6L of oxygen support at the time of admission. Treatment with antibiotics, bronchodilators, steroids and chest physiotherapy was given. Despite his initial apparent response, Mr Chow gradually went into a worsening type II respiratory failure with the arterial blood gas measured pH 7.26, pCO2 12.5 kPa, pO2 7.5 kPa and a base excess of 11 taken a week after his admission. He was in respiratory distress and oxygen saturation was suboptimal even with maximal oxygen flow. His chest radiograph showed a whitened-out left lung and his fever respiked. Antibiotics regime was escalated to piperacillin/tazobactem, and BiPAP was started.

Request to support of Mr Chow in the intensive care unit was rejected because of his underlying poor premorbid condition. A do-not-intubate decision was agreed by his children and a DNR order was signed. In the next few days, all attempts to tail down the
BiPAP setting had failed, and his type II respiratory failure worsened. Ten days after the use of BiPAP, his arterial blood gas measured pH 7.27, pCO2 16.5, pO2 7.1. His progress had been reviewed by Respiratory team colleagues, who suggested that there was not much room for further optimizing the BiPAP setting and medication use.

Since the start of BiPAP, Mr Chow was physically restrained because of his excessive struggling against the machine. Five days into the use of BiPAP, a nasogastric tube was inserted for feeding purpose and it was further complicated by episodes of coffee ground aspirates. While Mr Chow was still alert and able to make simple gestures, he made a clear indication that he would like the BiPAP discontinued.

The issue of withdrawing BiPAP was raised. A series of interviews was arranged with his relatives discussing the clinical situation. The family showed understanding and agreed that the machine was adding discomfort to Mr Chow. They expressed no objection to respect patient’s wish yet they showed hesitance when it came to the actual process of withdrawal thinking that the action would lead to the immediate death of Mr Chow. Their concern was addressed with explanations on the anticipated course after discontinuing the BiPAP, reassuring them the action would not be the direct cause of the ultimate death. After a period of consideration, it was agreed that the BiPAP would be switched off in the presence of his closest relatives after the last ones had arrived from Mainland. Mr Chow finally passed away twelve hours after BiPAP was withdrawn.

The Role of Non-invasive Ventilation in Palliative Care

Non-invasive ventilation (NIV) has been shown to improve mortality and shorten hospital stay. The use of NIV provides time to assess and correct reversible factors in a clinical condition, hence potentially reduces the rate of endotracheal intubation. Respiratory distress is one of the most commonly reported symptoms in terminal patients and the physical sufferings associated with it can be substantial. Different pharmacological and non-pharmacological means of alleviating dyspnea in this group of patients have been actively studied. The application of NIV in those who opted not for intubation, however, has raised controversies. Reported success rates of NIV use in patients opted not for intubation varied across a wide distribution in different studies. One may argue that NIV will prolong the dying process or escalate the patient’s sufferings, and it may induce false expectations on the aim of care. Where medical resources are limited, the appropriateness of allocating utilities and manpower for the use of NIV in palliative care is also a legitimate concern. On the other hand, others may argue also that NIV can palliate symptoms, and provide time for terminal patients to complete their last wishes.

Whether to start NIV for patients under palliative care is partly subject to clinicians’ discretion, and it is expected to vary among different centres depending on the staff and equipment availabilities. Sinuff et al.1 did a survey study on clinicians at 18 Canadian and 2 US hospitals, analyzing factors associated with stated use of NIV for do-not-resuscitate and comfort-measures-only patients. They found that >80% clinicians used NIV for do-not-resuscitate patients with chronic obstructive pulmonary disease and cardiogenic pulmonary oedema, while fewer reported using NIV for patients with underlying malignancies (59% physicians and 69% respiratory therapists), or patients who choose comfort measures only (40% physicians and 51% respiratory therapists).

In response to the controversial issue of using NIV in patients who decided to forego endotracheal intubation, the Society of Critical Care Medicine formed a task force and developed a framework for considering the use of NIV in these patients2. They proposed an approach to the application of NIV, categorizing the clinical conditions with evaluations on 1) the goals of care; 2) the main goals to communicate with patient and family; 3) the determinants of success and failure; 4) the likely location of using NIV; and 5) the alternatives if NIV fails.

Based on the above, the task force reviewed the clinical evidence and proposed a 3-category approach regarding the use of NIV for acute respiratory failure. The first belongs to those without preset limits of life-sustaining treatments. If NIV fails, one would be expected to proceed to endotracheal intubation and mechanical ventilation. The second category applies to patients who decline endotracheal
intubation and invasive ventilation. In this category, NIV is considered successful if it improves symptoms while the underlying cause of respiratory failure is treated. If it fails to do so, NIV is discontinued in favor of other comfort measures to alleviate symptoms. In the last category, NIV is regarded as a form of palliation to relieve dyspnea and maintain cognition. It is successful only if NIV improves symptoms without causing additional burden or discomfort to the patients. In particular, they stated that this category of NIV application could potentially be supported in hospice provided that the staffs had been appropriately trained. The authors stressed the importance of communication with patients and families on the goals of care under each category, and to take into consideration the patients’ own preferences. Further evaluations of the outcomes, and the perspectives of patients and relatives in each of these categories of NIV application would be an informative objective to pursue in future studies.

**Predictors of NIV Success and Failures**

One of the most frequently encountered uncertainties by physicians is whether the start of NIV would yield a net clinical benefit, and if so, how we should communicate with the relatives regarding the likelihood of success and failure. The latter is important because should the patient fails NIV, subsequent actions will have to be planned in advance. Several studies have investigated or reviewed the possible predictors of NIV success and failure.

Levy et al.\(^3\) tried to determine whether diagnosis and bedside observations could predict the outcomes of patients who had decided not for intubation. In this prospective cohort trial, they recruited 114 patients with do-not-intubate order who were begun on NIV. They found that those with diagnosis of congestive heart failure had significantly higher survival rates than those with chronic obstructive pulmonary disease, cancer, pneumonia, or other diagnoses. Those with better cough effort and who remained awake also had a more favourable odds for survival.

Cuomo et al.\(^4\) reported a prospective study of NIV use in 23 patients with solid malignancies receiving palliative care, 13 of these 23 patients were successfully ventilated and discharged alive. Of these 23 patients, only 4 were treated in palliative care units, while the rest were taken care of under respiratory intensive care units or the intensive care units. In this study, causes of failure of NIV included intolerance to NIV, a progressive worsening of arterial blood gas, irreversible vomiting, sudden death, and the need for palliative sedation. Two of the ten who failed accepted intubation. In the end, all but one died within a short time. The authors reported that the types of tumours, the causes and types of acute respiratory failure were not significantly different between the success group and the failure group.

Nava and Ceriana\(^5\) reviewed the parameters studied in the prediction of NIV failure: the arterial blood gas, the severity of disease, patient’s cooperation, mixed indexes, training and equipment, and the environment.\(^6\) While pH changes 1 hour after start of NIV was shown to be a strong predictor in hypercapnic patients, it was not significant in the group of hypoxic patients. Integrity of patients’ sensorium and severity of disease were also predictors of NIV success though they were less reliable as compared to blood gas. With hypoxic failure, besides disease severity, patients’ age, degree of oxygenation, and the presence of community-acquired pneumonia or ARDS all contributed to poor prognosis on NIV failure. These studies, however, were conducted in the acute settings where most of the patients were not under palliative care.

**Ethical Aspects of NIV in Palliative Patients**

Few people will doubt the value of NIV in the management of exacerbations in chronic lung diseases. The application of NIV in end-stage non-COPD diseases, however, is still short of the substantiation from randomized controlled trials. The decision to start NIV in a palliative patient should be individually contemplated, and so should the action to take when NIV fails. It is important that patients understand that there exist alternatives to NIV, and the goal of care with the start of NIV should be discussed.

The American College of Chest Physicians published a position statement in 2005\(^11\) supporting palliative and end-of-life care for patients with cardiopulmonary diseases. They recognized the transition to palliative care as patients enter the terminal phase of their illnesses. With this, they stated that ‘as part of this process, it may be necessary to withhold or withdraw treatment measures that can no longer
achieve the patient’s goals for care’. While the decision on withdrawal should be individualized, the principle behind the action should follow ethical guidelines.

Continuing NIV in a failing clinical condition poses a burden on the patients and stress on the relatives. While being kept behind the machine, patients are unable to communicate with their families, and it is not uncommon to find them feeling depressed and isolated with the fear of dying and being abandoned. The process of NIV removal follows the same principle as withholding or withdrawing life-sustaining treatment in that treatment which does not provide net benefit may be ethically and morally withheld or withdrawn. There are no specific guidelines on when to withdraw ventilation, but it is important to gain the understandings of the relatives, while taking into account patients’ wish and perception on quality of life. It is good practice to provide information to the patients and families regarding the potential outcomes of withdrawing NIV, and the process of withdrawal should be explained.

Conclusions

Respiratory failure is among the most common symptoms seen in palliative patients, either those suffering from end-stage cardiopulmonary diseases or other terminal illnesses, both cancer and non-cancer. While we have an armoury of pharmacological and non-pharmacological options for the treatment of dyspnea, studies have been going on to investigate the value of adding non-invasive ventilation in the treatment protocol. Evidence has shown that NIV for palliative patients is acceptable among clinicians but the reported success rate varied in different studies. Investigators have been trying to identify the various parameters that may help predict the likelihood of success in an NIV application. As for all treatments, the goal of care should be communicated with the patients and family and patient’s own preference should be sought. With proper use, NIV can add valuable time to palliative patients, but when this goal of care cannot be met without compromising patient’s quality of life, withdrawal of NIV is ethically justified with subsequent enhancement of other means of comfort measures for symptoms control.

References

Introduction

Pancreatic cancer is a disease with poor prognosis. Majority of these tumours are unresectable at presentation. Palliative care represents an important aspect of care in patients with pancreatic cancer. Pain occurs in 80% of patients with advanced pancreatic cancer. Around 10 to 15% of patients have difficult pain control and required other analgesic techniques.

Review of pain management in pancreatic cancer

A review was performed by the Palliative Care Unit of Caritas Medical Centre to review the pain control of advanced pancreatic cancer patient in a period of 36 months from 1st July 2004 to 30th June 2007. A total of 80 patients with advanced pancreatic cancer were identified and they were under the care of the Surgical unit, Medical unit or Palliative Care unit in this hospital. The median survival, the prevalence of pain, the use of analgesics, and the use of interventions in pain control were analyzed. The mean age of the sample was 72.5 years and their median survival was 5 months. Majority of these patients (71%) were under the care of the Palliative Care Unit. (Table 1).

Pain was highly prevalent in this group of patients and present in 97.5% of them. Among the analgesics prescribed, strong opioids were prescribed in 59% of patients. (Table 2).

Patients who were under the care of Palliative Care Unit were more likely to be given strong opioid (66%), compared with other unit (38%) (Table 3).

Adjuvant analgesics such as anti-epileptic and anti-depressant were used in a few cases (one patient was on anti-epileptic agent, two other patients were on anti-depressant). Four patients had intractable pain, 2 of them required the use of Ketamine infusion and the other 2 patients received palliative sedation. These 7 patients were under the care of the Palliative Care Unit.

Ten patients (13%) underwent interventional methods for pain control. Two patients had intra-operative celiac plexus block and 8 patients had endoscopic ultrasound (EUS) guided celiac nerve block performed. The intra-operative celiac nerve blocks were given for prophylactic intent. One patient had the analgesic stepped down from strong opioid to combination of weak opioid and Naproxen. The other patient had improvement in pain severity without stepping up of analgesic (Table 4).
A total of 8 patients received EUS guided celiac nerve block for pain control (Table 5). Five of them had the procedure done for poor pain control, and the other 3 patients for intolerable side effect of opioid. All patients had pain improvement as documented by a reduction of pain scores. The pain score was measured by numeric rating scale (NRS), or verbal descriptor rating scale (VRS) if the patient could not rate the pain by NRS. Three patients had reduction of the dosage of analgesic after the procedure, and 2 patients had a step down of analgesic from strong opioid to weak opioid. The effect of the pain relief following the procedure lasted from 1 to 3 months. Only 2 patients reported transient hypotension and one had diarrhea after the procedure. There were no major complications reported.

Pain Pathway in Pancreatic Cancer

Celiac plexus is a sympathetic nervous system structure that transmits both visceral afferent and efferent information for the majority of the upper abdominal viscera including that from the pancreas. The splanchnic nerves are composed of sympathetic nerve fibers that synapse at the celiac plexus and pass through the diaphragmatic crus to reach the spinal cord.

Pain Mechanisms in Pancreatic Cancer

The nociceptive information was then transmitted to the thalamus and cortex of the brain, and thus perceived as pain.

1. Neuropathic pain state:
   Tumour may directly infiltrate the pancreatic nerves causing neuropathic pain. This mechanism is common in ductal pancreatic cancer which secretes neurolytic enzymes that allow tumour to infiltrate and spread along the nerve sheaths. Enlarged lymph nodes due to metastases may infiltrate or stretch the surrounding neural tissue at celiac axis and neural ganglia.

2. Localized “pancreatitis”:
   A form of localized “pancreatitis” may be caused by pancreatic cancer. This ongoing inflammatory process may sensitize the intrapancreatic nerves to chemical and mechanical stimuli. Localized inflammation may also cause loss of the perineural sheath which in turn make the nerves being hypersensitive to stimuli.

3. Increased ductal and interstitial pancreatic pressures can cause pain by mechanical stimuli to nerves, by inducing pancreatic ischaemia or pancreatic “compartment syndrome”.

4. “Centrally sensitized” pain:
   Due to repeated visceral afferent stimulation from the above described mechanisms, a “centrally sensitized” pain state can be resulted. The peripheral nerve endings may have increased sensitivity, decreased threshold to stimulation, and prolonged and enhanced response to stimulation after these repeated stimulation. Release of neurotransmitters will be increased at spinal cord and the spinal neurons become more easily excitable. This “centrally sensitized” state may result in the amplification of pain.

Table 5: Efficacy and complications of EUS guided celiac nerve block

<table>
<thead>
<tr>
<th>Patient</th>
<th>Indications</th>
<th>Analgesic (mg/day)</th>
<th>Pain outcome</th>
<th>Duration of relief</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Poor pain control</td>
<td>Morphine 45 → 25</td>
<td>Mod → No</td>
<td>1M (died)</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>Drowsiness</td>
<td>Methadone 5 → 2.5</td>
<td>Mod → No</td>
<td>2M (died)</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Poor pain control</td>
<td>Morphine 90 → 60</td>
<td>VRS 6 → 3</td>
<td>2M (died)</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Sweating</td>
<td>Methadone 10 → Dologesic 4 tab</td>
<td>VRS 7 → 2</td>
<td>3M</td>
<td>Transient ↓BP</td>
</tr>
<tr>
<td>5</td>
<td>Poor pain control</td>
<td>Morphine 90 → Dextropropoxyphene 128</td>
<td>VRS 8 → 2</td>
<td>2M</td>
<td>Transient ↓BP</td>
</tr>
<tr>
<td>6</td>
<td>Poor pain control</td>
<td>Morphine 40 → 90</td>
<td>VRS 8 → 2</td>
<td>-</td>
<td>Transient ↓BP</td>
</tr>
<tr>
<td>7</td>
<td>Poor pain control</td>
<td>Morphine 30 → 37.5</td>
<td>Mild → No</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>Nausea</td>
<td>Dextropropoxyphene 256 → Tramadol 200</td>
<td>Mod → Mild</td>
<td>-</td>
<td>Diarrhoea</td>
</tr>
</tbody>
</table>
Pain management in pancreatic cancer

Analgesic is the mainstay of pain control. Weak opioids and strong opioids are often required for moderate or severe pain. Anti-convulsants and antidepressants may be used as adjuvants.

Interventional techniques for pain control

Neurolytic celiac plexus block (NCPB)

NCPB is also called celiac plexus neurolysis (CPN). It is performed by injection of neurolytic agent into the celiac plexus to ablate the ganglion so as to interrupt pain transmission. Alcohol and phenol are the commonly used neurolytic agents. NCPB is indicated for upper abdominal pain associated with cancer of the distal esophagus, pancreas, stomach or liver.

There are three approaches to perform NCPB. Transcutaneous approach, as guided by fluoroscopic, CAT scan or ultrasound, is the traditional method. It has been associated with potential serious complications including paraplegia, bowel perforation, anterior spinal artery syndrome, aortic dissection, and pneumothorax. Minor complications are local pain, diarrhea, and transient hypotension. Endoscopic ultrasound (EUS)-guided NCPB is first described in 1996 by Wiersema4. EUS incorporates both endoscopy and ultrasonography (Figure 1). Patient is placed in a left lateral decubitus position. The celiac ganglion is identified by its relative position to celiac artery. Complications are similar to the minor complications of the transcutaneous approach. The advantages of EUS-guided NCPB include a real-time direct visualization of the injection, allowing accurate location of celiac ganglia even with distorted anatomy by tumour, and fewer major complications as mentioned above. NCPB may also be performed by surgeon intraoperatively or laparoscopically.

Fig. 1: The probe of EUS. The arrow indicates the direction of protrusion of needle for injection of neurolytic agents.

Efficacy and Safety of NCPB

From the systematic review and meta-analysis involving 302 unresectable pancreatic cancer patients in 5 RCTs, NCPB was associated with a minimal improvement in pain control, and significant reduction in opioid dosage and constipation compared with standard treatment5. Most studies suggest that NCPB is effective for only 2 to 3 months, probably due to nerve regeneration.

For the EUS-guided technique, a prospective study of 58 operable pancreatic cancer patients, 78% of patients had reduction of pain score 2 weeks after the procedure, lasting for 24 weeks6. There was no major complication, and transient increase in pain occurred in 0.8% and transient hypotension in 20%.

Another prospective study compared the efficacy of fluoroscopic NCPB in 50 patients with pancreatic cancer, divided into 2 groups, one involving head of pancreas and the other involving body and tail7. NCPB was effective in 74% of patients, and more so in cases with tumour involving the head of pancreas.

Besides the location of tumour, the volume of neurolytic agent, presence of metastases to region outside the innervations of celiac plexus and nerve regeneration are other potential factors affecting the efficacy of NCPB.

Conclusion

Pancreatic cancer is associated with a poor prognosis. Our survey found that pain was highly prevalent and present in 97.5% of patients. Opioid was the mainstay of pain control and 59% of patients required strong opioids. NCPB was useful in our patients.

References

Palliative Medicine Grand Round

Palliative Sedation

Dr. Bryan CW Li, Palliative Medical Unit, Grantham Hospital.
Correspondence: lcw167@hotmail.com

Case History

A 74-year-old lady with lung cancer was admitted for shortness of breath and stridor. Her tumour, which was beyond surgical or oncological intervention, had caused main bronchus obstruction. Her symptoms were refractory to conventional palliative treatments including high dose dexamethasone, oxygen therapy and morphine. However, she remained calm and cheerful during her hospital stay though she reported breathlessness every time she was prompted. She was subsequently discharged with long term home oxygen therapy.

A month later she was readmitted with worsening breathlessness. We tried to step up her morphine but the effect was not satisfactory. Although she was in distress, she could still communicate with her family members verbally and appeared peaceful especially in the presence of her family. Our palliative care team and her family members were well aware of the possible further deterioration in dyspnoea.

We discussed the issue of palliative sedation with her family members and they agreed with the care plan of sedation in case patient was in unbearable respiratory distress. We explained that it was not a form of euthanasia. We also came to the consensus that intravenous fluid administration would be avoided if possible to minimize burden to the patient.

A week after the discussion, patient developed severe dyspnoea. She was in obvious distress with cold sweating, grimacing of face and noisy breathing. She was unable to take oral medications although she was still conscious. She was commenced on continuous subcutaneous infusion of midazolam 5mg daily together with her equivalent subcutaneous dose of her usual morphine. A day after starting palliative sedation, patient was sleeping peacefully with shallow breathing but not in sweating. The same dose of midazolam was continued and the patient died two days after the palliative sedation.

Discussion

Palliative care provides symptom relief for patients with advanced life-threatening diseases. Despite advances in technology, there remain circumstances in which patients experience distressing symptoms and unbearable suffering that cannot be adequately relieved. In the face of refractory symptoms, palliative sedation may seem to be valuable as a last resort. However, ethical dilemma and practical challenges remain inevitable. Decision regarding palliative sedation is definitely an area that requires high level of knowledge in symptom management, good communication and counseling skills, and appropriate attitude of respecting the dignity of patients all the time.

Palliative sedation is the use of sedating medications with the primary intention to reduce the consciousness of the patient in order to reduce the experience of unbearable sufferings from symptoms that are refractory to conventional palliative treatments. The intention is not to relieve sufferings by hastening death.

In a survey in the Netherlands over the years after the legalization of euthanasia, a secular trend of increase in palliative sedation and a decline in euthanasia was noted. Although no definite association could be concluded, it was noted that nearly 10% of the cases of palliative sedation was preceded by request for euthanasia that was not granted. Most cases of palliative sedation were initiated without specialist palliative care consultation. In the survey, nearly half of the patients died within one day and nearly all die within one week. Benzodiazepine was used most commonly because of its predictable effect and ease in titration. The commonest indication for palliative sedation was terminal restlessness, which might be difficult to define.

Theoretically palliative sedation is distinct from euthanasia in various ways. However, there are views that palliative sedation may just be a form of ‘slow euthanasia’ or ‘euthanasia in disguise’.

Palliative Sedation

HKSPM Newsletter 2009 Mar Issue 1 P27
It is the different intention that distinguishes the two, palliative sedation is intended to relieve symptoms whereas euthanasia is intended to end life. Ethical arguments supporting the use of palliative sedation include the 'principle of double effect', which draws a moral distinction between the intention of an act (to relieve sufferings) and its foreseen but unintended consequence (death).

<table>
<thead>
<tr>
<th>Euthanasia</th>
<th>versus</th>
<th>Palliative sedation</th>
</tr>
</thead>
<tbody>
<tr>
<td>To hasten death</td>
<td></td>
<td>Intend to relieve refractory symptoms</td>
</tr>
<tr>
<td>Aim at immediate death</td>
<td></td>
<td>Not to hasten death</td>
</tr>
<tr>
<td>Prolonged dying process viewed as complication or failure</td>
<td></td>
<td>As the patient's disease cause death, duration may be prolonged up to weeks</td>
</tr>
</tbody>
</table>

We as physicians are often faced with the dilemma of under-treating refractory distressing symptoms of the patients and sacrificing valuable conscious time to spend with family towards the end of life. It has been reported that palliative sedation does not shorten life expectancy as the survival time of palliative care patients after admission with and without palliative sedation was similar ³.

In reality it may not be easy to convey these messages to patients and their relatives without ambiguity, especially for the difference between palliative sedation and euthanasia. Euphemisms for death in Chinese language also pose challenge in communication. For example, ‘going to sleep’ is sometimes used by layman to indicate ‘dying’.

The discussion itself is already a burden to all the parties involved ⁴. The decision-making process is stressful to patients and their relatives. Decision on artificial hydration and nutrition as palliative sedation is initiated is yet another challenge. Finally, like all other treatments, palliative sedation can have complications. Morita reported serious complications including respiratory suppression without cardiac arrest, aspiration, and paradoxical reaction in patients receiving palliative sedation ⁵.

While there is room for controversies, palliative sedation is frequently practiced across different countries. A recent systematic review⁶ found that the prevalence of palliative sedation is variable, ranging from 3% to 50%. The wide variance in the use of palliative sedation may be due to the variation in definition of palliative sedation, the retrospective nature of many studies, and the lack of consensus on the definition of a refractory symptom (particularly refractory existential suffering) and even the act of palliative sedation itself ⁷.

**Summary**

Palliative sedation is generally regarded as ethically acceptable treatment for refractory symptoms at the end of life, with the intention to relieve symptoms.

Sedation should be titrated against the clinical effect of symptom relief. However, palliative sedation has its own emotional, ethical and practical challenges. It should be used judiciously and careful communication between family, patients, doctors, and the multidisciplinary team members is of utmost importance. Potential benefit and burdens should be weighted in patient-centered way. Whether to go for palliative sedation or stay with the acceptance of unrelied sufferings should be tailored with patient’s wish. Palliative sedation is not a one-size-fits-all option to every refractory symptom, and it cannot replace holistic palliative care of each individual patient.

**References**

Palliative Medicine Grand Round

Delirium in Palliative Care Setting

Dr. Raymond Woo Kam Wing,
Palliative Care Unit, Our Lady of Maryknoll Hospital.
Correspondence: wookamwing@yahoo.com

Introduction

Delirium is not a new disease entity. Hippocrates in 500 BC used the term “phrenitis” to describe acute mental abnormalities caused by fever, poisoning or head trauma.¹ Celsus in the 1st century was the first one to use “delirium” to describe such mental disorders. In a case of suppurative disease with fever, the delirious patient became more talkative and audacious than before. He might have experienced auditory hallucination and sleep-wake cycle disturbance in contemporary medical terms. Celsus also pointed out that delirium occurred when disease progressed or when death was imminent.²

2500 years later, not all about delirium has been unravelled. Classically delirium is described as acute onset, transient and reversible mental disturbance secondary to other medical illness. DSM-IV diagnostic criteria remains the gold standard for diagnosing delirium (Table1).³ This concept is also subjected to challenge, as we find more and more irreversible delirium episodes, and superimposed delirium may account for the psychotic symptoms in dementia.⁴

Table 1: DSM-IV Diagnostic Criteria for Delirium

| A. Disturbance of consciousness (e.g. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention. |
| B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia. |
| C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. |
| D. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiologic consequences of a general medical condition. |

Delirium is common

Delirium is prevalent in palliative care setting. Morita et al. found that delirium were present in 68% of hospice patients during their final 2 weeks of life.⁵ It was the second commonest psychiatric diagnosis and accounted for 17.4% of psychiatric referral in a Japanese study, while the commonest diagnosis is adjustment disorder.⁶ It was also the second commonest reason for specialist telephone consultation from general practitioners in the Netherlands.⁷

How about the situation in Chinese population? In a Taiwan study involving 228 terminal cancer patients who were screened by the Chinese Version of Delirium Rating Score, 109 patients were above the cut off score of 10 and regarded positive for delirium. Two patients were later excluded from the diagnosis after psychiatric assessment. The overall prevalence of delirium was 46.9%. Only 9 out of 38 patients with brain metastasis developed delirium. They also observed that mortality was higher in the delirium group (77.6% vs. 50.9%, p < 0.001). The detection rate of delirium by palliative care team was around 44.9%.⁸

In one local study, Lam et al. reported an incidence of 40.2% of delirium in patients with advanced cancer, and 30 out of 51 deaths suffered from delirium. The mean number of causes of delirium was 2.1, similar to other overseas studies. The 30-day mortality was reported to be 80%, and significant association was found between delirium and mortality.⁹

Delirium as Distress

Delirium is a distressing experience, not only to patients, but also to caregivers, health care workers as well as physicians. A study performed by Breitbart et al. found that 53.5% delirious hospice patients could recall their delirium experience. In a Numerical Rating Scale (NRS) of 0-4, 80% of patients described the delirium as “severe distressing”, and the overall mean NRS score was 3.2.¹⁰ The
variables associated with patient distress included presence of perceptual disturbance, delusion, steroid as delirium etiology and the Karnofsky Performance Status (KPS).

Delirium is distressing to patient’s formal and informal caregivers. The same study also showed that among patients, spouses and nurses, spouses experienced highest distress with a mean NRS of 3.75. Morita et al. interviewed the bereaved families, 54% reported that they felt “very distressed” or “distressed” about the experience of terminal delirium. Buss showed that caregivers of patients with caregivers-perceived delirium were 12 times more likely to have generalized anxiety.

Delirium episodes can be the source of conflicts between family members and health care workers. Presence of delirium was shown to be predictive of fall during hospitalization in palliative care unit.

There are little evidence on the degree of distress experienced by palliative care physicians when facing delirious patients. Palliative care physicians are responsible for diagnosing the condition, ordering investigations and providing treatment for the patients. As a palliative care physician, I do have the following questions in my mind: Have I misdiagnosed an agitated patient as delirium? Or have I missed something important, like brain metastasis? Do I understand a delirious patient’s symptoms burden and suffering? How far should I correct those contributing factors, even empirically? How far should I investigate in a dying patient? Have I provide the correct treatment? Is my “treatment” targeting the etiology of the patient’s delirium? Should I restrain the patient?

Different tools are available for screening, diagnosing and assessing severity of delirium. The Confusion Assessment Method is gaining popularity.

**Confusion Assessment Method**

Confusion Assessment Method (CAM) was developed by Dr. SK Inouye from Yale Medical School. The original aim is to allow non-psychiatric clinicians to diagnose delirium quickly and accurately after a brief formal cognitive testing. Four cardinal features of delirium will be assessed, including (1) acute onset and fluctuating course, (2) inattention, (3) disorganized thinking, (4) altered level of consciousness. The presence of criteria (1) and (2) plus either (3) or (4) pointed to the diagnosis of delirium. Using CAM to diagnose delirium, the sensitivity was 94-100% and the specificity was 90-95%; with a positive predictive value of 91-94% and a negative predictive accuracy around 90-100%.

Confusion Assessment Method has been validated in different settings, including nursing home, geriatric ward, ventilated patients in intensive care unit, acute and emergency department and in patients with dementia of Lewy Body. It is now accepted as a screening tool by British Geriatric Society, Society of Critical Care of Medicine as well as Australian Health Ministers’ Advisory Council.

A Chinese version of CAM is available for intensive care setting. In Hong Kong, Leung JLM et al. investigated the application of CAM among the Chinese geriatrics inpatients. English version was used as assessment was performed by clinicians in this study. The sensitivity of CAM was 0.76 and specificity was 1.00 in this study. They concluded that CAM is an accurate diagnostic instrument for detection of delirium in geriatric in-patient setting.

**CAM in palliative care setting**

CAM has been used in palliative care setting. In Caraceni’s study, 109 out of 393 consecutive palliative care patients gave positive results when screened by CAM. They found that delirium as detected by CAM was an independent factor associated with worse prognosis; the median survival of delirious patient was 21 days, while that of non-delirious patient was 39 days.

Confusion Assessment Method has been validated in palliative care setting recently. Ryan et al. reported the implementation of CAM by non-consultant hospital doctors (NCHD) in a palliative care unit in Ireland. Patients were assessed by NCHDs for delirium within 24 hours of admission using CAM, while subsequent blinded and independent evaluations were performed by a psychiatrist. The study consisted of the pilot phase and the post-training phase. Results showed that with post-pilot phase reinforcement training to NCHDs, the sensitivity of detecting delirium by CAM was 88% and the specificity was 100% as compared with the gold standard of DSM-IV criteria. The quality of observations during clinical interview would directly affect the accuracy of CAM. The initial
The enhanced training program was provided as two 1-hour sessions, which included case-based learning and multiple-choice questions. The junior colleagues might have difficulty in recognizing the cardinal features of delirium as they often attributed the symptoms as a "normal" phenomenon of disease progression, such as fatigue, emotional stress or drowsiness. The training program was regarded as the most important parameter by the authors in enhancing the correct use of the screening tool.

**Treatment of Delirium**

Half of the delirium episodes in palliative care setting can be reversed. The framework provided by Pan-Glasgow Palliative Care Algorithms 2005 may serve as a useful guide in management of delirium patients in palliative care setting. As the threshold for discomfort and disorientation is lowered in cachectic and anxious patients, the environment should be one that is stable, safe, quiet and comfortable. Soft lighting, attention by familiar faces, and frequent explanation to patients on what is happening help to reduce anxiety. The underlying causes of delirium should be elucidated. Potential contributing factors such as drugs, metabolic disturbance, anxiety/distress, uncontrolled pain, infection and immobility should be identified and rectified if possible.

A similar approach to delirium is adopted by the British Society of Geriatrics. The guidelines suggest measures including withdrawal of incremental drugs, or adoption of opioid rotation in selected cases. Electrolyte disturbance should be corrected, and underlying infection should be treated appropriately. A quiet environment with appropriate lighting are also emphasized. Patient should be engaged in activities, with mobilization encouraged with aids.

Joceyln White has devised an acronym of CHIMBOP26, including seven reversible causes of delirium in hospice setting to assist the attending nursing staff and the resident in assessment of the modifiable factors and in provision of appropriate management. (Table 2)

**Pharmacological Treatment**

Haloperidol remains the drug of choice in treating delirium as stated in various guidelines and recommendations, including that from American College of Critical Care Medicine and British Society of Geriatrics. In the Cochrane Systematic Review of drug treatment for delirium in terminally ill patients, the authors concluded that haloperidol was the most suitable drug therapy, while chlorpromazine might be an acceptable alternative if the small risk of cognitive impairment was not a concern. Haloperidol can be administered in various routes, including oral, intravenous, intramuscular and subcutaneous.

<table>
<thead>
<tr>
<th>C</th>
<th>Constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>hypovolemia, hypoglycaemia</td>
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<tr>
<td>I</td>
<td>Infection</td>
</tr>
<tr>
<td>M</td>
<td>Medications</td>
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<tr>
<td>B</td>
<td>Bladder catheter or outlet obstruction</td>
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<tr>
<td>O</td>
<td>Oxygen deficiency</td>
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<tr>
<td>P</td>
<td>Pain</td>
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</table>

**Typical or atypical antipsychotics?**

The typical antipsychotics have side effects including extrapyramidal signs and symptoms, arrhythmia and sedation, they are still favoured because of the wider availability, accumulated experience and clinical evidence. Atypical antipsychotics have a more favourable side effect profile, but they are generally more expensive. In the Cochrane Systematic Review in 2007, the efficacy and incidence of adverse effects of haloperidol were compared with risperidone, olanzapine and quetiapine. The authors concluded that there was no evidence that haloperidol in low dosage (<3.0mg/day) had a lower efficacy or a higher incidence of adverse effects when compared with the atypical antipsychotics, namely olanazapine and respiderone. However, a higher dosage of haloperidol was associated with greater incidence of parkinsonism than the atypical antipsychotics.28

The role of benzodiazepines in treating delirium is still unsettled, awaiting more studies and systematic review. Methylphenidate has been suggested to be useful in palliation of hypoactive delirium. However, the drug itself can be a cause of delirium. A randomized trial studying the effect of methylphenidate, rivastigmine and haloperidol in hypoactive delirium in intensive care patient was unfortunately terminated in 2008.
Conclusion: Mental State as 6th Vital Sign

Half of the patients in palliative care unit suffer from delirium, and half of the delirious palliative patients remain undiagnosed. Delirium is distressing to patient, caregivers and health care workers. CAM may be a useful tool in helping non-psychiatric clinicians to diagnose delirium efficiently. Management should be targeted at the underlying cause. Both non-pharmacological interventions and drug treatment have their roles in calming the patient. While pain is being promoted as the fifth vital sign, Flaherty et al. suggested that mental status should be the sixth vital sign and delirium should be recognized. Further studies are warranted to elucidate the best treatment of delirium in palliative care setting.

References
20. Leung JM, Leung VW, Leung CM, Pan PC. Clinical utility and validation of two instruments (the Confusion Assessment Method Algorithm and the Chinese version of Nursing Delirium Screening Scale) to detect delirium in geriatric inpatients. General Hospital Psychiatry 2008;30;171-6.
Global Year Against Cancer Pain 2008-09

The International Association for the Study of Pain (IASP) is launching the 2008 - 2009 Global Year Against Cancer Pain to focus attention on pain and suffering of cancer patients.

In echo to this important subject, a series of events have been jointly organized by the Hong Kong Society of Palliative Medicine, Hong Kong Pain Society, Hong Kong Hospice Nurses’ Association and Society for the Promotion of Hospice Care. The events include a press conference to kick off our campaign, interviews by RTHK, public talks on cancer pain control, and a problem based learning seminar on cancer pain management for health care workers.

A Press Conference

to introduce the Global Year Against Cancer Pain 2008-09 was held on 3rd Oct 2008 at Jessie and Thomas Tam Centre. In the press conference, Dr. Rico Liu, representing Hong Kong Society of Palliative Medicine, shared with the participants the efficacy of various modalities of cancer pain management.

There was also a sharing of the video of two advanced cancer patients, Ms Wong and Mr. Yu, cared by the Palliative Care Unit of Our Lady of Maryknoll Hospital. Ms Wong, suffered from pancreatic cancer, expressed her pain experienced and her worries about the side effects of analgesics, especially that of nausea and dizziness. She reported that how titration of analgesics and other medications had helped in her pain control with subsidence of side effects. Mr. Yu, who had prostatic cancer with bone secondary, expressed that his chest wall pain had been so severe that he could not even smile or raise his hand. Like Ms Wong, the pain of Mr. Yu was well controlled after admission to Palliative Care Unit, and he demonstrated how he could laugh and move his hands freely in the video shown.

Public Education Forums

“癌痛可受控”

The two public talks had attracted hundreds of participants with overwhelmingly good response and participation. Dr. Wong Kam Hung was the moderator of the forum, and the three speakers were Dr. Annie Kwok, Ms Ellen Yeung and Ms Damaris Hung. With a “multidisciplinary” team of Palliative Care Physician, Nurse Specialist and Clinical Psychologist respectively, it reflected and exemplified the importance of the multidisciplinary approach in cancer pain control.

**Interviewed by RTHK**

“精靈一點”,

broadcasted on 16th & 23rd Oct 2008

Dr. Lam Kwok Kwong of Hong Kong Society of Palliative Medicine and Ms Ellen Yeung of Hong Kong Hospice Nurses’ Association introduced the palliative care service in the public health care system in Hong Kong; while Dr. Wong Kam Hung of Hong Kong Society of Palliative Medicine and Dr. Theresa Li of Hong Kong Pain Society shared their rewarding experience in cancer pain control.

**And coming up...**

The Problem Based Learning Seminar on Cancer Pain Management

to be held on 28th March 2009 at Diamond Ball Room, Eaton Hotel. This will be a half day seminar for health care workers, with presentations and discussions on different aspects and modalities of cancer pain management.