HOT SPOT

The Newsletter of the Rapid Response Radiotherapy Program
of the Odette Cancer Centre

Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Volume 10, Issue 3, August 2008

Editorial

By Edward Chow

We have expanded our readership by including the most recent referring physicians to the Odette Cancer Centre in our mailing list. Please email Ms. Stacy Lue at **stacy.lue@sunnybrook.ca** if you would like your colleagues on the mailing list.

In this issue, Dr. Monica Branigan discusses "Only talk about positive things!" Professor Susanna Edwards shares with us her research "Decision-making in a family dyad in the context of advanced cancer." Dr. Margaret Fitch suggests screening for emotional distress as the sixth vital sign. Dr. Carlo DeAngelis features a part one of four series "Opioid Dose Equivalency—Part 1—General Overview." Dr. Ewa Szumacher again has compiled the latest update in continuing medical education.

We have two inserts. The first one was written by Dr. Richard Jay on secondary prophylaxis of venous thromboembolism in cancer patients. The second one is about the prostate bone metastases clinic: A multidisciplinary approach by Dr. Urban Emmenegger. The fax-in referral form to this joint clinic is also attached for your convenience.

We hope you continue to find **Hot Spot** resourceful.

Only talk about positive things!

By Monica Branigan, MD

A recent palliative care consult challenged me on many levels. The family in question was very clear from the beginning that they only wanted to hear "positive news" and, specifically, no talk about death. They expressed a belief that spiritual healing required them to be very positive. This was difficult to work with as medical professionals involved with the family believed the patient had a prognosis of weeks.

The ethical dilemma was how to respect the patient's autonomy "I only want to talk about positive things", and how to prevent harm or nonmaleficence. The harm that may ensue by simply following the patient's request could be a very traumatic death for the patient and the family. The patient may reach a point in time where they "know" because of their bodily experience that they are dying, and may feel completely unprepared. Fear may be a large part of the dying experience if one is totally unprepared. In a similar way, the family may be unprepared emotionally, financially and in other ways. If the patient dies, family may feel guilty they were not "positive enough". Financial, funeral and legal arrangements may not be made. Most importantly, family, patient and friends may lose an opportunity for leave taking: saying goodbye, I love you and other important messages.

It was difficult to support a request to be only positive, but supporting patient autonomy includes supporting requests that we may consider unwise. In such a situation where we feel the patient's best interests are not being met, it may be tempting to fall into a more paternalistic role. We may want to strongly argue against the patient's wishes or use fear to coerce the patient into changing their mind. It may even be difficult not to feel angry towards the patient. Our medical culture values rationality in decision-making and views the scientific paradigm as paramount. Not all of our patients share these values. Some patients may find comfort in anecdotal accounts of success and find our detached statistics difficult to

continued on page 2…

In this issue of HOT SPOT:

Decision-making in a family dyad in the context of advanced cancer

By Susanna Edwards, RN, MSc, PhD(c), Assistant Professor, Ryerson University, Daphne Cockwell School of Nursing

With the future expectation of a burgeoning elderly population and a projected shortage of health care personnel, particularly nurses, palliative care is increasingly occurring in the home. Yet, funding for this important work amounts to only five per cent of Canada's health care budget. This will place increasing burdens upon informal caregivers to manage the palliative care of their family members.

While health care practitioners have devoted considerable time and research to issues regarding medical decision-making, informed consent, autonomy, and the ethical implications thereof in the health care setting, very little research has been conducted on these aspects in a home care setting in the context of the family.

The purpose of this research is to understand the "grey area" that occurs when an ill family member is no longer able to make decisions and the family caregiver has not yet been ceded legal decision-making authority. Anecdotal evidence suggests that this is a time of heightened stress for family caregivers, as they must wait for further deterioration of their ill family member before they are legally allowed to intervene. Understanding these issues in the context of Canadian society where individual autonomy and control are valued will allow health care personnel to guide families when they find themselves in these "grey areas", as time spent with one's family at the end of life can be very rewarding if the family can be appropriately supported.

The research question for this qualitative, grounded theory study is: What is the process by which individuals with advanced cancer and their family caregivers make decisions regarding care when cognitive and physical abilities begin to decline during the palliative phase of the individual's illness? I am particularly interested in:

1. How the family decision-making process changes in the context of lost cognitive and physical abilities when an individual is no longer able to participate the way they previously did before becoming ill.
2. How the family decision-making process is influenced by a broader social context that values autonomy and control.

The Temmy Latner Centre for Palliative Care and the palliative care team of the Toronto Central Community Care Access Centre are facilitating participant recruitment for the study. Through consultation with these organizations, the research findings will be integrated into practical recommendations for health care personnel and developed into a program of palliative care research in community settings.

Acknowledgement

This study is funded in part by the Golda Fine Memorial Academic Award through the Temmy Latner Centre for Palliative Care.

Only talk about positive things!

… continued from page 1

fathom and frankly overwhelming. The challenge then becomes how to support a patient with a "nonscientific" viewpoint.

One way through these challenges is to move away from trying to get the patient to see the situation through our eyes, and to truly see it from the patient's perspective. This struggle will likely be seen by the patient as a sign of our caring. This caring goes far in building trust in the doctor-patient relationship, which is built on so much more than our expertise. With trust, the patient may reconsider what we have to say. If the patient only feels that we are reacting to having our authority and viewpoint challenged, they may not be as sympathetic.

Things did not go well for this family or our team. The patient died with a lot of agitation. The family was filled with anger and guilt. Our team felt we were held back from doing a good job. The only way to make sense of this is to try to learn from it. After reflecting on this case, I would do things differently with future patients who refuse to talk about death by initiating a process of more explicit conversations:

1. "Hope for the best but prepare for the worst."

This phrase may be a helpful beginning. One could genuinely say, "I do hope things go well. If things do not work out as we hope, let's have a plan in place."

2. Indirect communication style

One can refer to the situation in general with comments such as, "I have had patients in similar situations. They also wanted to be very positive, but recognized that being positive may not always be sufficient." This gives some space by not implicating the patient in front of you.

3. Expressing partnership

"I would like to provide the best care I can for your family. Sometimes we may have a difference of opinion, but let's work together on finding the best way to resolve our differences." This is a kind of warning shot.

4. Ask permission

Ask of the patient and/or family. "What would you like me to do if I really believe that you will die soon and we need to actively prepare?"

5. Express your opinion

If I were honest, I might express my dilemma as: "I feel as if I am being asked to do my job in a way I know will lead to harm for you and your family. Can we find another way?" This situation felt to me analogous to being a cardiologist who was told they could treat blood pressure and lipids, but not discuss smoking and exercise. This intervention will only be received well if you have developed trust with the family through a process that respects difference.

Simply challenging the patient's request may cause more harm than it prevents. The "truth" will unfold and either the patient will live or die. Working with an ambiguous situation may be challenging for a physician who prefers clarity about goals of care and may feel almost dishonest, as if one is colluding with deception. In the end, one needs to be very clear about the reason and the manner in which to reveal the truth as you see it: is this for the benefit of the patient, or for your own benefit? The next time I encounter a family who doesn't want to discuss death, I hope I can find a way to compassionately engage in a more helpful manner.

Screening for emotional distress: The sixth vital sign

By Margaret Fitch, RN, PhD

Cancer and its treatment have more than a physical impact on individuals. There are social, psychological, informational, spiritual and practical consequences as well. For many individuals, life is irrevocably altered when they hear about their cancer diagnosis. A sense of transition and uncertainty characterize their experiences during the course of investigation and treatment.

As individuals undergo this cancer journey, they are challenged to deal with the many changes. Emotional distress is often associated with this struggle to confront and manage the transitions. This emotional distress emerges to a greater or lesser degree for all individuals who are dealing with cancer. It is an unpleasant experience that can interfere with the ability to cope effectively with situations. Distress exists along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis (NCCN Practice Guidelines, 2008).

Cancer patients have reported in various forums that access to understandable and meaningful information, effective management of symptoms and side effects, and effective compassion communication are critically important to their capacity to cope. With access to these types of supportive behaviours, some cancer patients will mobilize their own network and cope effectively. Others will experience ongoing and/or escalating distress and require from interventions by psychosocial and supportive care experts.

Overall, approximately 35% of cancer patients experience elevated distress at a level that they would benefit from referral to a psychosocial specialist. The challenge in busy clinical settings is one of easily identifying those at risk for high emotional distress and who would benefit from such a referral.

Across Canada, work is emerging to implement screening approaches or interventions to identify the level of emotional distress (Sixth Vital Sign) in cancer patients and survivors and then orchestrate the appropriate referrals. This type of approach includes application of a standardized instrument or tool to categorize the amount of emotional distress a person is experiencing. Several reliable and valid tools exist for this purpose, including the Hospital Anxiety and Depression Scale, Brief Symptom Inventory, Edmonton Symptom Assessment Scale, and the Distress Thermometer. Each of these scales measures a slightly different perspective about distress, but all are based on the notion that once a score has been calculated, that score determines the need or basis for referral (Figure One).

One of the most popular tools is the Distress Thermometer (Figure Two). It is easy to use for patients and quickly offers a visual depiction of the level of distress. In most instances, the thermometer is accompanied by a Problem Checklist.

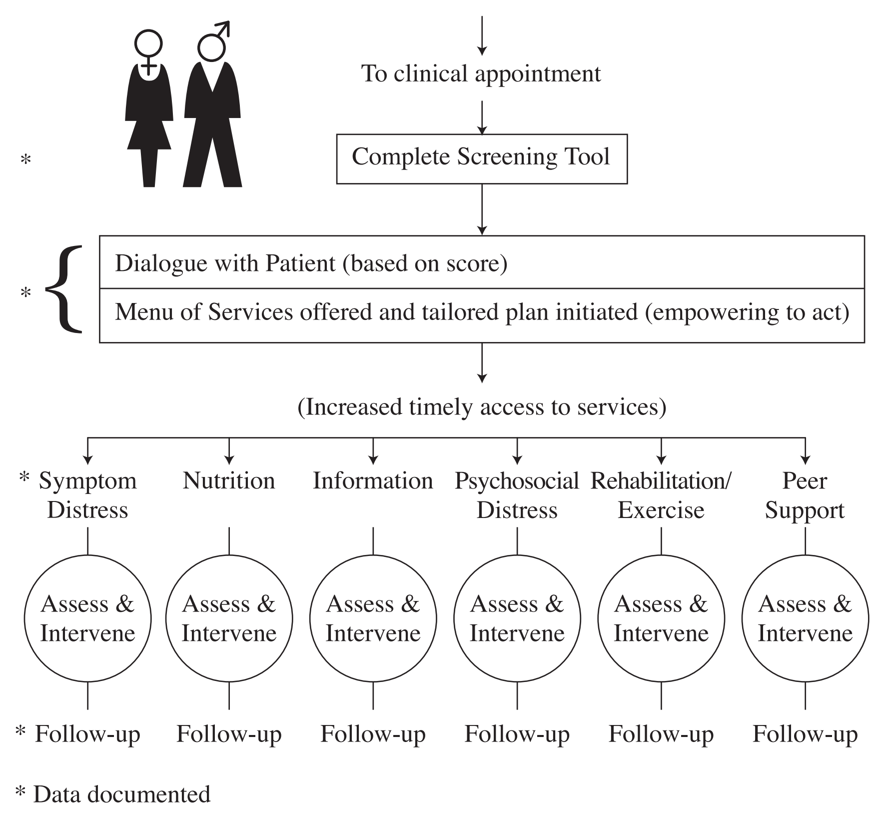
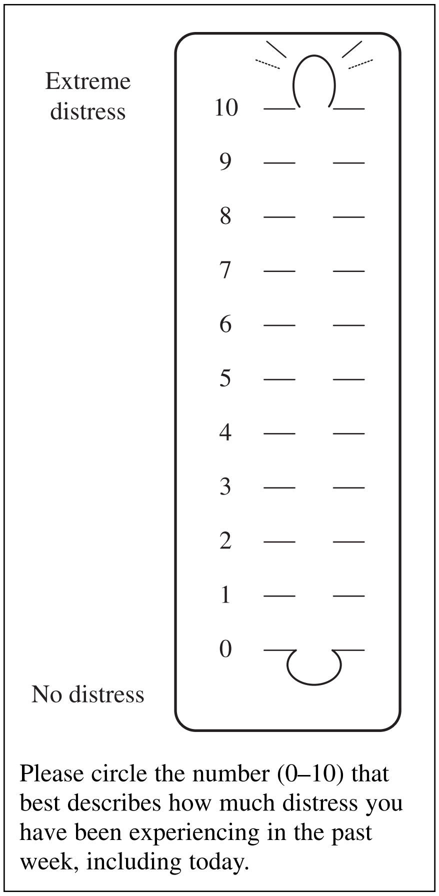


Figure 1. Screening and referral to supportive care services



Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Figure 2: Example of the Distress Thermometer. It is often accompanied by a listing of the problems commonly experienced by cancer patients so that they can indicate the source of their distress.

This listing of commonly experienced problems for cancer patients allows the individual to indicate the nature of their emotional distress. After all, the source of the distress may be quite different from one patient to another. One may be worried about return to work and finances while another may be struggling with communication in the family and sexual issues. Knowing about the course of the emotional distress will help in making the appropriate referral (Table One).

Table One

Patients are at increased risk for distress	Periods of increased vulnerability
History of psychiatric disorder/substance abuse	Finding a suspicious symptom
History of depression/suicide attempt	During work-up investigation
Cognitive impairment	Finding out the diagnosis
Communication barriers	Awaiting treatment
Severe co-morbid disease	Change in treatment modality
Social problems	End of treatment
Family/caregiver problems	Discharge from hospital following treatment
Inadequate social support	Stresses of survivorship
Living alone	Medical follow-up and surveillance
Financial problems	Treatment failure
Limited access to medical care	Recurrence/progression of disease
Young or dependent children	Advanced cancer
Younger age: women	End of life
Other life stressors	
Spiritual/religious concerns	

No longer is it appropriate to provide care that is only bio-medically focused. Cancer care needs to address the comprehensive nature of the illness experience. According to a recently released Institute of Medicine report, all patients and their families should expect and receive cancer care that ensures the provision of appropriate psychosocial health services. We are not providing good quality of cancer care if we are not addressing the psychosocial health needs. Using standardized short scales to screen for emotional distress on a regular basis throughout the cancer journey will help to identify those patients at increased risk of difficulties and who would benefit from additional intervention.

Opioid Dose Equivalency : Part 1—General Overview

By Carlo DeAngelis, PharmD

Opioid analgesics are the mainstay of any strategy to control cancer pain. Despite the central importance of opioid dose equivalency in optimizing pain control, it continues to be poorly understood. Optimizing the analgesic strategy for a patient involves establishing a balance between the pain relief desired, side effects experienced by the patient and the convenience of taking the medication. Incorrect dose conversion can lead to worsening pain, increased side effects or poor adherence. There are several strategies used to establish an optimal opioid analgesic regimen including: dose titration, change in mode of drug delivery (e.g. regular release tablet formulation changed to a sustained release form), change in route of administration and switching of opioid. Whatever the strategy used, an understanding of opioid dose equivalency is fundamental to attaining optimal pain relief.

Opioid dose equivalency is the concept where one opioid or the same opioid given by a different route of administration can provide equal pain relief when given at the appropriate (or "equivalent") dose. This presupposes there is good evidence to support the concept and guide dose conversion. But, in reality, there is poor evidence to support the equianalgesic dose ratios used to determine an equivalent analgesic dose when switching opioid or changing route of administration. Many of the equivalent opioid dose ratios currently used are based on single dose or short-term acute opioid administration studies, studies using diverse patient populations and small sample sizes where, often, the opioid dose equivalency reported is an "incidental" finding or secondary endpoint; calling into question the veracity of these ratios when applied to the chronic cancer pain situation. The weight of clinical experience and practice lend support to the need for dose adjustments when changing route of administration or opioid. However, opioid pharmacokinetic and pharmacodynamic data demonstrate large interpatient variability in the metabolism and response to opioids suggesting it is unreasonable to expect a single equianalgesic opioid dose ratio would suffice for every patient.

The purpose of calculating an equianalgesic dose, therefore, is to avoid using too high or low a dose (increasing the risk of side effects or worsening pain control respectively) of the new opioid or for the new mode or route of administration. The mathematical calculations involved in determining the new opioid dose provide a false sense of accuracy to the exercise. Given the poor supporting evidence for opioid dose equivalency ratios and limitations associated with available opioid dosage forms and strengths, we must always remember that the calculated new opioid dose is not exact. Thus, it seems more reasonable, indeed practical, to consider equianalgesic dose ratios as a "starting point".

This is Part 1 of 4 in a series with the goal of reviewing the basic concepts of opioid dose equivalency and providing some guidance to clinicians trying to determine equianalgesic doses of opioids. Practical examples, with calculations will be provided in subsequent articles.

2008 Pain and Symptom Management Conference
Saturday, November 22, 2008

Bahen Centre for
Information Technology
40 St. George Street
Adel Sedra Auditiorium, Room 1160
University of Toronto

Objectives

This conference is intended to provide participants with current information regarding pain and symptom management in patients living with life threatening illnesses. In attending this conference, participants will: be updated on the latest advances in the management of pain and symptoms in advanced cancer; discuss the current concepts in psychosocial care and quality of life issues in palliative care; be able to identify and discuss the controversial issues in the care of patients with terminal cancer; and be able to integrate research into practice setting.

Sponsored by the Division of Palliative Care, University of Toronto

A conjoint effort of:The Rapid Response Radiotherapy Program at the Odette Cancer Centre, Sunnybrook Health Sciences Centre and the Department of Radiation Oncology, University of Toronto; and the Division of Palliative Care of the Department of Family and Community Medicine, University of Toronto.

For registration, please visit
www.cme.utoronto.ca

Course Directors:

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Dr. Russell Goldman, CCFP
Lecturer of Family and
Community Medicine

Dr. Jeff Myers, CCFP, MSEd
Assistant Professor Family and
Community Medicine

Visiting Guest Faculty:

Dr. Mellar P. Davis
Cleveland Clinic
Cleveland, Ohio

Program

Plenary I
Opioid Induced Hyperalgesia
Dr. Mellar Davis

Plenary II
Management of the febrile chemo patient. Is it ever okay to treat them at home?
Dr. David Warr

Plenary III
Psychosocial Dimensions of Palliative Care: Are We Meeting the Needs of our Patients and Families?
Susan Blacker, MSW

Plenary IV
“Is there nothing more you can do for my pain?” An interventional approach to cancer pain management
Dr. Jeff Myers, Dr. Mike Gofeld

Workshops

Management of Nausea and Vomiting
Speaker: *Dr. Mellar Davis*

Constipation
Speaker: *Dr. Larry Librach*

Cancer Treatment Related Pain
Speaker: *Dr. David Warr*

Wounds in Advanced Illness: The Hidden Epidemic
Speaker: *Dr. Vincent Maida*

Conflict? Thanks But No Thanks
Speaker: *Susan Blacker, MSW*

a. Communication between referring community physicians and radiation oncologists regarding palliative radiotherapy delivery
Speaker: *Dr. Elizabeth Barnes*

b. Technologies for spine mets: Does more pain mean more dose?
Speaker: *Dr. Arjun Sahgal*

Cancer Related Fatigue
Speaker: *Dr. Mellar Davis*

From the Case Files of the Temmy Latner Centre for Palliative Care
Speaker: *Dr. Russell Goldman*

Continuing Medical Education 2008

By Ewa Szumacher, MD, MEd, FRCP(C)

Continuing Medical Education (CME) can update health care professionals on the latest advances for modifications to their clinical practice. At the request of the CME organizers, Hot Spot will list the national and international CME activities in palliative medicine that are of interest to our readers. Please kindly forward details of the CME activities to: **Ewa.Szumacher@sunnybrook.ca**

- August 17–22, 2008—**12th World Congress on Pain, The International Association for the Study of Pain,** Glasgow, United Kingdom, **www.iasp-pain.org/ 2008Congress.html**
- October 26–29, 2008—**2008 Canadian Hospice Palliative Care Conference**, Charlottetown, Prince Edward Island, **www.chpca.net**
- November 22, 2008—**14th Science & Art of Pain and Symptom Management**, Toronto, Ontario, **http://events.cmetoronto.ca/website/ index/ONC0802**

Continuing Medical Education Activities

- University of Western Ontario Certificate in Palliative Care and Death Studies (on-line) Service Provision in Hospice/Palliative Care, **www.advancedprofessional education.com**
- Hospice Palliative Care Multidiscipline Certificate—Humber College, **pamela.mckintuck@humber.ca**
- Temmy Latner Centre for Palliative Care—Mount Sinai Hospital, **www.tlcpc.org**
- RTS Perinatal Bereavement Support Training, **www.pbso.ca**
- Comprehensive Bereavement Skills Training—COPING Centre—Cambridge, **www.griefsupport.cc**
- Humber College Annual Conference on Palliative Care—Toronto, **www.palliativecare.humber.on.ca**
- Ian Anderson Continuing Education in End of Life Care—Toronto, **www.cme.utoronto.ca/endoflife/**
- Bereavement Ontario Network Conference (each September), **www.bereavementnetwork.ca**
- National Conference of Hospice Palliative Care—Canada, **www.chpca.net**
- Palliative Care Certificate Program, Distance Program—Grant MacEwan College, Edmonton, **www.macewan.ca/palliative**
- Compassionate care for the Terminally Ill (4 non-credit distance program)—Grant MacEwan College, Edmonton, **www.macewan.ca/palliative**

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