

GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Palliative Care for the Patient with Incurable Cancer or Advanced Disease Part 1: Approach to Care

Effective Date: June 15, 2010

Scope

This guideline presents assessment and management strategies for primary care practitioners caring for adult patients (≥ 19 years) with incurable cancers and end stage chronic disease of many types and their families.

NOTE: Care gaps have been identified at important transitions for this group of patients:

- Upon receiving a diagnosis of incurable cancer
- When discharged from active treatment to the community
- While still ambulatory but needing pain and symptom management
- At the transition when end of life care may be needed

Diagnostic Code: 239 (neoplasm of unspecified nature)

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Assessment

A palliative approach is needed for patients living with active, progressive, life-limiting illnesses who need pain and symptom management and support around practical or psychosocial issues, have care needs that would benefit from a coordinated or collaborative care approach, and/or have frequent emergency room visits. Assess where patients are in their illness trajectory, functional status, and symptom burden. Clarify goals of care.

Estimating prognosis allows optimal use of limited time for patients and families. Rapid change in clinical condition is an understandable and helpful sign. Although prognoses can only be estimated, poor prognostic factors include:

- progressive weight loss (especially $> 10\%$ over 6 months)
- rapidly declining level on the Palliative Performance Scale (PPS) (refer Appendix A)
- dyspnea
- dysphagia
- cognitive impairment

Part 2 will deal with Pain and Symptom Management, Part 3 will deal with Bereavement.

Investigations (Refer Appendix B)

Before ordering investigations, ensure that the results will change management to improve quality of life and/or prognostication, consistent with a patient's goals of care. Investigations may be indicated in the following situations to:

- better understand and manage distressing clinical complications,
- assist in determining prognosis,
- clarify appropriate goals of care, and
- determine whether all options have been considered before admission to hospice.

Management

Evaluate performance status and then symptom burden in order to accurately assess a patient's needs for added supports and symptom management. A common use of assessment scales among providers (e.g. PPS, Edmonton Symptom Assessment System [ESAS]) facilitates communication and collaboration.

a. Monitor patient's functional capacity.

Use the PPS (refer Appendix A) to base care on a patient's functional capacity and prognosis. "The single most important predictive factor in cancer is performance status and functional ability – if patients are spending more than 50% of their time in bed/lying down, prognosis is likely to be about 3 months or less".¹

b. Co-ordinate care with allied health care providers.

To enhance co-ordination with allied health providers involved in the care of the patient, the following are recommended:

- Application of the PPS to determine a need for increased patient support:
 - For a drop from PPS 70% to 60%, refer to the hospice palliative care program (submit a Palliative Benefits Application for prognoses \leq 6 months and discuss and/or complete a home No CPR form (refer Resources)).
 - For a drop from PPS 40% to 30%, increase home support or hospice care.
 - For a PPS of 20% or 10%, use the End of Life (EOL) Care check list (found on page 4).
- A bereavement follow-up call and/or visit by a physician, a suitable allied health professional, or a trained hospice volunteer.

c. Evaluate symptom burden.

Use a scale like the ESAS (refer Appendix C) to assess symptom management. The ESAS may be provided to the patient to complete while in the reception area. Pain and other symptoms are assigned a numerical rating between 0 (none) and 10 (most severe imaginable). Record the level and range of symptom severity, aiming for \leq 3 and thoroughly assess for values \geq 4. For ESAS symptom scores, using pain as an example, a useful frame of reference is:²

- 0-1: no pain or minimal pain
- 3: able to watch TV or read newspaper without paying much attention to pain
- 5: pain is too distracting to find much pleasure in activities (e.g. TV, reading)
- $>$ 5: on the verge of being or already overwhelmed by pain
- 10: the worse pain that you could imagine

d. Establish goals of care with patients and families.

- As the underlying condition progresses, a patient's goals of care often become less disease-specific and more palliative.
- Discuss a patient's wishes before clinical deterioration, possibly over several visits. Start by determining how much the patient desires to know about their disease and how much they desire to participate in decision making. When translation is required, a professional interpreter (rather than family member) is advisable.
 - Determine the patient's understanding of the disease and condition.
 - Discuss the anticipated course of illness, treatment choices, and options in relation to a patient's preferences, needs, and expectations.

- Document advance care planning discussions and the existence of any Advance Directive/ Representation Agreement. Document whether the No CPR +/- Planned Home Death forms are completed (refer Resources Section).
- Identify and appoint a legal substitute decision maker, ideally a person familiar with the patient's preferences and able to make informed choices.
- Establish plans for key decisions for acute episodes, crisis events, and declining function in relation to life-sustaining therapies and hospitalizations, considering all co-morbidities.
- Clarify the patient's preferred place of care.
- Establish caregiver's ability to provide care at home if that is the patient's preference.
- Review both regularly and when there is a change in clinical status.

e. Management strategies: non-pharmacologic.

- Lifestyle management
 - Exercise: Regular exercise and activity has been proven to improve quality of life and function in cancer survivors.³
 - Nutrition: Nutritional needs are different for patients with cancer, i.e. appetite is often reduced and forcing additional food may contribute to nausea or vomiting. When the goal is life prolongation, a consultation with a dietician may be helpful.
 - Rest: Fatigue is a common accompaniment of cancer or its treatment. Adequate rest and pacing of activities is important. Poor sleep will contribute to a lower quality of life for both patient and caregiver.
- Family support:
 - Caregivers who take time off work can apply for the Employment Insurance (EI) Compassionate Care Benefit (refer Resource Section).
 - Application can be made to the Palliative Benefits Program when a patient's life expectancy is estimated to be ≤ 6 months (refer Resource Section).
 - Completing the "Notification of Expected Death in the Home" form means families can avoid waiting for a physician to pronounce death.
- Patient self management (refer Patient Information and Resource Sheet)
 - Encourage patients to have an advance care planning discussion with family and/or caregivers (for an example see the "My Voice" booklet in the Resource Section).
 - Symptom reporting: Suggest that patients record symptoms using a numerical rating scale (0 = none to 10 = extreme) and report symptoms consistently ≥ 4 .
 - Medications: Suggest that patients keep up-to-date medication profiles to carry with them to appointments and ER visits, including flowsheets to record break-through medication. Ensure that treatment of incident pain is understood.
 - Bowel protocol: Constipation, an opioid side effect, does not improve over time. Provide written instructions for a bowel protocol that patients may self administer (refer Patient Information and Resource sheet).
 - Providing help 24/7: Includes contact numbers (and hours, where applicable) for the GP on call, home nursing, and HealthLinkBC (call 811).

f. Management strategies: pharmacotherapy.

See "Palliative Care Guideline Part 2: Pain and Symptom Management".

g. Referral to a specialist (refer Appendix D).

h. Indications for referral to a tertiary palliative care unit.

- Control of pain and other symptoms when these cannot be met in the community.
- Support for severe psychological, spiritual, or social distress.

i. Ongoing care.

- **Planned visits.**
 - A shared care plan, complete with planned follow-up visits, helps patients and family feel supported. Planned visits proactively anticipate care transitions and care crises.

- Recommended visit frequency depends on prognosis, e.g., if the illness is stable (PPS \geq 70%), quarterly visits are recommended; if the illness is changing monthly, then visit monthly. More frequent planned visits are warranted in the face of more rapid decline.
- **Monitoring and Documentation** (refer Appendix E - Cancer Management Flow Sheet).
 - Prognostic factors: Monitor for impending transition or crisis, e.g. new or accelerated weight loss, dyspnea, cognitive impairment, or change in PPS.
 - Signs and symptoms: Each visit, record pain scale for each pain type and location.
 - Medications: In addition to slow release opioid, record use of breakthrough meds, anti-nauseants, and bowel protocol. Also consider adjuvant analgesics (see “Palliative Care Guideline Part 2: Pain and Symptom Management”).
 - Care plan: Ensure that supports for patient and family are arranged through Home and Community Care and also document discussions regarding patient goals and advance directives.
- **Palliative care emergencies: recognize and respond.**

Emergency	Investigation	Intervention
Spinal cord compression	Stat MRI (CT if MRI is not available)	Dexamethasone, surgical decompression and/or radiotherapy
Superior vena cava compression	CT chest	Dexamethasone, SVC stent or radiotherapy
Pathological fracture	X-ray, CT	Internal/external fixation, sufficient analgesia
Acute renal failure / obstructive nephropathy	Ultrasound	Ureteral stents or nephrostomies
Other: airway obstruction, hemorrhage, seizures	As required	Anticipate and provide crisis orders

MRI - magnetic resonance imaging; CT - computed tomography; SVC - superior vena cava

j. Allied health care and referral to the local hospice palliative care program.

- High quality palliative care is generally provided via a team approach and GPs are important team members as they often have good relationships with patients and families and the knowledge and expertise to co-ordinate and provide care for the whole patient. Team members may include medical specialists, advanced practice nurses, home care nurses, social workers, case managers, pharmacists, occupational therapists, physiotherapists, dieticians, spiritual care workers, hospice volunteers, and home support workers.
- Patients are often best educated by allied health providers when it comes to topics such as myths about opioids, proper use of breakthrough medications, managing side effects, accessing help after hours, how to plan a home death, etc.
- Refer to the local hospice palliative care program early in the illness trajectory so patients and their families can learn what home supports are available before they are required.

k. Actively dying: The End of Life (EOL) Care check list.

Points to consider when patients enter the dying phase:

- Review a patient’s goals of care, preferred place of care, what to do in an emergency.
- Refer to home nursing if not already arranged.
- Ensure that the required forms are completed (No CPR and/or Planned Home Death).
- Discontinue non-essential medications.
- Arrange for subcutaneous (SC) / transdermal medication administration or a drug kit to be placed in the home when a patient is no longer able to take medications by mouth (refer Appendix F).
- Arrange for a hospital bed +/- pressure relief mattress.
- Arrange for a Foley catheter as needed.
- Leave an order for a SC anti-secretion medication (e.g., atropine, glycopyrrolate).

I. Bereavement (see “Palliative Care Guideline Part 3: Grief and Bereavement”).

It is important to predict and be prepared to manage complex grief, of which 3 types have been determined:

Complexity	Comments
Non complex	Usual care would be follow-up after death and at 6 and 12 months.
Middle complexity	More time and support is required (e.g., children of a dying parent).
Very complicated	Characterized by bizarre grieving (includes people with mental illness).

Follow-up is important, but recognition of and preparation for complex grieving optimally takes place before death occurs.

Rationale

Patients diagnosed with incurable cancer may not identify themselves as requiring palliative care. A palliative approach addresses the needs for pain and symptom management, and psychosocial and spiritual support of patients and their families, even if they chose to undergo life-prolonging chemotherapy, radiotherapy, and/or surgery. A proactive chronic disease management approach will help prevent care gaps that may occur during transitions in the cancer journey and/or when the patient is not supported by a cancer agency or community hospice palliative care program.

References

(These references were chosen to be helpful and do not form an exhaustive list.)

1. Royal College of General Practitioners. The gold standards framework. Prognostic indicator guidance to aid identification of adult patients with advanced disease, in the last months/ year of life, who are in need of supportive and palliative care. Version 2.25 c2006. [cited 2010 March 22]. Available from <http://www.healthcareforlondon.nhs.uk/assets/End-of-life-care/Prognostic-Indicator-Guide-2008.pdf>
2. Lynn J, Schuster J, Wilkinson A, et al. Improving care for the end of life: a sourcebook for health care managers and clinicians. Oxford University Press. 2008.
3. Cramp F, Daniel J. Exercise for the management of cancer-related fatigue in adults. [Cochrane Review]. In: The Cochrane Library, Issue 2, 2008.

Resources

BC EOL Care: <http://www.health.gov.bc.ca/hcc/endoflife.html>

BC Palliative Care Benefits Program Application form: <https://www.health.gov.bc.ca/exforms/pharmacare/349.pdf>

BC Palliative Care Benefits Program Physician Guide: <http://www.health.gov.bc.ca/pharmacare/outgoing/palliative-physguide.pdf>

BC Pharmacare Special Authorites Branch: 1-877-657-1188, fax: 1-250-405-3587

BC Provincial Palliative Care Consult Line (available 24/7): 1-877-711-5757

BCCA Pain and Symptom Management Clinics at each of 5 regional cancer centres: <http://www.bccancer.bc.ca/PPI/InfoforNewPatients/CancerCentres.htm>

Fraser Health Hospice Palliative Care Symptom Guidelines: http://www.fraserhealth.ca/professionals/resources/hospice_palliative_care/hospice_palliative_care_symptom_guidelines

Gold Standards Framework: <http://www.goldstandardsframework.nhs.uk/>

My Voice Advance Care Plan booklet: http://www.fraserhealth.ca/your_care/planning_for_your_care/workbook

No CPR Form: <https://www.health.gov.bc.ca/exforms/bcas/302.1fil.pdf>

Notification of Expected Death in the Home form: http://www.health.gov.bc.ca/hcc/pdf/expected_death.pdf

Palliative Care Integration Project: http://meds.queensu.ca/palliativecare/assets/ccp_lite.pdf

Abbreviations

CPR	cardiopulmonary resuscitation
CT	computed tomography
EI	Employment Insurance
ESAS	Edmonton Symptom Assessment System
MRI	magnetic resonance imaging
PPS	Palliative Performance Scale
SC	subcutaneous
SVC	superior vena cava

Appendices

Appendix A: Palliative Performance Scale (PPS) Including Instructions for Use

Appendix B: Possible Investigations and Interventions

Appendix C: Edmonton Symptom Assessment System (ESAS)

Appendix D: Indications for Referral to a Specialist

Appendix E: Cancer Management Flow Sheet

Appendix F: Contents of typical home drug kit & medications that may be given by SC route

This guideline is based on scientific evidence current as of the Effective Date.

The guideline was developed by the Family Practice Oncology Network and the Guidelines and Protocols Advisory Committee. The guideline was approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

The principles of the Guidelines and Protocols Advisory Committee are to:

- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances

Contact Information

Guidelines and Protocols Advisory Committee
PO Box 9642 STN PROV GOVT
Victoria BC V8W 9P1
Phone: 250 952-1347
Fax: 250 952-1417
E-mail: hlth.guidelines@gov.bc.ca
Web site: www.BCGuidelines.ca

DISCLAIMER

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problems.

Appendix A: Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Occasional assistance required	Normal or reduced	Full or confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or coma +/- confusion
0%	Death	-	-	-	-

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- PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
- Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.
 Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.
 Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.
 Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'
- PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
- PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall 'best fit' using all five columns.

1. Ambulation

The items **'mainly sit/lie,' 'mainly in bed,'** and **'totally bed bound'** are clearly similar. The subtle differences are related to items in the self-care column. For example, 'totally bed bound' at PPS 30% is due to either profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between 'sit/lie' and 'bed' is proportionate to the amount of time the patient is able to sit up vs need to lie down.

'Reduced ambulation' is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. Activity & Extent of Disease

'Some,' 'significant,' and **'extensive'** disease refer to physical and investigative evidence which shows degrees of progression. For example in breast cancer, a local recurrence would imply 'some' disease, one or two metastases in the lung or bone would imply 'significant' disease, whereas multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be 'extensive' disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, 'some' may mean the shift from HIV to AIDS, 'significant' implies progression in physical decline, new or difficult symptoms and laboratory findings with low counts. 'Extensive' refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (e.g. trying to walk the halls).

3. Self-Care

'Occasional assistance' means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

'Considerable assistance' means that regularly every day the patient needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes but the patient is then able to eat of his or her own accord.

'Mainly assistance' is a further extension of 'considerable.' Using the above example, the patient now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.

'Total care' means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him or her.

4. Intake

Changes in intake are quite obvious with 'normal intake' referring to the person's usual eating habits while healthy. 'Reduced' means any reduction from that and is highly variable according to the unique individual circumstances. 'Minimal' refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. Conscious Level

'Full consciousness' implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. **'Confusion'** is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. **'Drowsiness'** implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor. **'Coma'** in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.



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The Palliative Performance Scale version 2 (PPSv2) tool is copyright to Victoria Hospice Society and replaces the first PPS published in 1996 [J Pal Care. 9(4):26-32]. It cannot be altered or used in any way other than as intended and described here. Programs may use PPSv2 with appropriate recognition.

Appendix B: Possible Investigations and Interventions

Reason for Investigation	Investigation	Possible Interventions
Reversible causes of bone pain	Bone scan (for metastases)	Radiotherapy, bisphosphonates
	X-ray/CT spine (for compression fracture)	Cementoplasty
Reversible causes of dyspnea	Chest x-ray (for pleural effusion)	Thoracentesis, pleurodesis
	CT pulmonary angiogram or V/Q scan (for pulmonary embolism)	Anticoagulation
	Pulmonary function testing	Bronchodilators
	Pulse oximetry, Arterial blood gases	Supplemental O ₂ if hypoxic
	CBC & diff, BNP	Treat infection, anemia, CHF if present
Reversible causes of confusion	Calcium (ionized) (for hypercalcemia)	Hydration, bisphosphonates, calcitonin
	Electrolytes (for hyponatremia)	--
	eGFR (for renal failure)	Hydration, ureteric stents
	CBC & diff/cultures (for sepsis)	Treatment of sepsis or infection
	CT head (for cerebral metastases)	Dexamethasone, radiotherapy
	KUB x-ray (for fecal loading)	Aggressive bowel protocol
	Bladder scan or in/out catheterization	Urinary catheterization
Reversible causes of fatigue	Hemoglobin (for anemia)	RBC transfusion
	Potassium (for hypokalemia)	Potassium supplementation
	eGFR, liver function tests (for renal or hepatic dysfunction)	
Reversible causes of jaundice	CT abdomen (for common bile duct obstruction)	Common bile duct stent
Reversible causes of nausea & vomiting	eGFR (for pre-renal failure)	Hydration
	3 views of abdomen (bowel obstruction)	Stent, venting gastrostomy, medical treatment of small bowel obstruction, bowel protocol
Obvious or suspected malignant ascites	Ultrasound	Diagnostic/therapeutic paracentesis
	Albumin, eGFR, liver function tests	Spirolactone/furosemide

Appendix C: Edmonton Symptom Assessment System (ESAS)

			
Edmonton Symptom Assessment System Numerical Scale Regional Palliative Care Program			
Please circle the number that best describes			
No pain	0 1 2 3 4 5 6 7 8 9 10		Worst possible pain
Not tired	0 1 2 3 4 5 6 7 8 9 10		Worst possible tiredness
Not nauseated	0 1 2 3 4 5 6 7 8 9 10		Worst possible nausea
Not depressed	0 1 2 3 4 5 6 7 8 9 10		Worst possible depression
Not anxious	0 1 2 3 4 5 6 7 8 9 10		Worst possible anxiety
Not drowsy	0 1 2 3 4 5 6 7 8 9 10		Worst possible drowsiness
Best appetite	0 1 2 3 4 5 6 7 8 9 10		Worst possible appetite
Best feeling of well-being	0 1 2 3 4 5 6 7 8 9 10		Worst possible feeling of well-being
No shortness of breath	0 1 2 3 4 5 6 7 8 9 10		Worst possible shortness of breath
Other problem	0 1 2 3 4 5 6 7 8 9 10		
Patient's Name _____ Date _____ Time _____		Complete by (check one) <input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Caregiver assisted	

Bruera E, Kuehn N, Miller MJ, et al. The Edmonton Symptom Assessment System (ESAS): a simple method of the assessment of palliative care patients. *J Palliat Care*. 1991;7:6-9.

Appendix D: Indications for Referral to a Specialist

Indication	Procedure	Physician Specialty
OBSTRUCTED LUMEN		
Stenting		
Common bile duct (CBD)	CBD stent	Gastroenterologist
Esophagus	Esophageal stent	Thoracic/GI surgeon
	Brachytherapy	Radiation oncologist
Duodenum	Duodenal stent	Gastroenterologist, GI surgeon
Colon	Colonic stent	
Ureter	Ureteric stent	Urologist
Superior vena cava (SVC)	SVC stent	Interventional radiologist
Bronchus	Radiotherapy, brachytherapy	Radiation oncologist
Venting		
High small bowel obstruction	Venting gastrostomy	GI surgeon
Lower bowel obstruction	De-functioning colostomy	
Ureter	Nephrostomy	Urologist
HEMORRHAGE		
Hemoptysis	Radiotherapy	Radiation oncologist
	Laser therapy	Respirologist
Hematemesis	Upper GI endoscopy	Gastroenterologist
	Radiotherapy	Radiation oncologist
Vaginal/uterine	Radiotherapy	Radiation oncologist
Rectal	Laser coagulation	Gastroenterologist
Hematuria	Radiotherapy	Radiation oncologist
Skin surface of tumour	Radiotherapy	Radiation oncologist
EFFUSION		
Pleural effusion	Thoracentesis	GP, radiologist
	Pleurodesis	Respirologist
	Pleural catheter	Thoracic surgeon
	Chemotherapy, radiotherapy	Medical oncologist
Malignant ascites	Paracentesis	GP, radiologist
	Peritoneal catheter	Interventional radiologist
PAIN		
Bone pain/pathological fractures	Radiotherapy	Radiation oncologist
Cancer of the pancreas	Coeliac plexus block	Anesthetist, gastroenterologist (U/S)
Severe opioid resistant pain	Ketamine by continuous subcutaneous infusion (CSCI) or Lidocaine CSCI	Palliative care physician
	Neuroaxial block	Anesthetist
Vertebral compression fractures	Vertebroplasty	Interventional radiologist, neurosurgeon
> 50% of the cortex of femur or humerus involved	Intramedullary nailing	Orthopedic surgeon

Appendix E: Cancer Management Flow Sheet

Patient Encounters, Diagnostic/Clinical Data/Prognostic Data, by Date

Review:		Enter Review Date: dd-mm-yyyy	Baseline:	Date:	Date:	Date:	Date:
Prognostic	WEIGHT		lbs	lbs	lbs	lbs	lbs
			kg	kg	kg	kg	kg
	Performance Status - PPS (0-100%)		%	%	%	%	%
	Dyspnea (0-10)						
	Cognitive Impairment/Confusion						
Symptoms (VAS 0-10)	Pain 1: location: type: (0-10)						
	Pain 2: location: type: (0-10)						
	Pain 3: location: type: (0-10)						
	Nausea (0-10)						
	Constipation						
	Other 1 (ie: fatigue)						
	Other 2 (ie: disease specific Sx - dysphagia)						
Signs	Lungs / BP (query Hypotension)						
	Liver/Spleen/Abdomen						
	Spine/Bone						
	CNS (query Cord compression)						
	Nodes						
	Skin /Edema						
Lab	(use for tumour marker, Hb, INR, Ca++, albumin etc.)						
Medications	Anticancer Rx	Systemic:					
		Biological:					
		Hormonal:					
		Radiation					
		Other: (bisphosphonate, paracentesis, RBC transfusion, etc.)					
	Symptom Control	Opioid SR:					
		Opioid IR:					
		Antiemetic: (eg: metoclopramide)					
		Bowel Protocol:					
		Adjuvant 1: (query neuropathic pain)					
Adjuvant 2: (query dexamethasone)							
Care Plan	DNR <input type="checkbox"/> Home DNR form <input type="checkbox"/> Expected home death form						
	Palliative Care Program Referral <input type="checkbox"/> Benefits Form <input type="checkbox"/> Home care <input type="checkbox"/> Discussion:						
	Advance Directive Preferred place of care: <input type="checkbox"/> Discussion						
	Proxy:	Phone:					

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Ministry of Health Services

Guidelines & Protocols Advisory Committee



Appendix F: Contents of typical home drug kit & medications that may be given by SC route

Contents of a typical home drug kit ¹	
Atropine 0.6 mg/mL – 10 amps	Hydromorphone 50 mg/mL – 2 amps
Atropine 1% gtt – 5 mL bottle	Lorazepam 1 mg sublingual – 20 tablets
Dexamethasone 20 mg/5 mL – 2 vials	Methotrimeprazine 25 mg/mL – 10 amps
Diclofenac 100 mg supp – 10 supps	Metoclopramide 10 mg/2 mL – 4 amps
Dimenhydrinate 50 mg/mL – 10 amps	Midazolam 10 mg/2mL – 5 vials
Fentanyl 25 mcg/hr patch – 2 patches	Morphine 10 mg/mL – 20 amps
Fentanyl 50 mcg/hr patch – 2 patches	Morphine 50 mg/mL – 10 amps
Glycopyrrolate 0.4 mg/2 mL – 5 vials	Phenobarbital 120 mg/mL – 10 amps
Haloperidol 5 mg/mL – 5 amps	Prochlorperazine 10 mg supps -10 supps
Hydromorphone 2 mg/mL – 10 amps	Sufentanil 50 mcg/mL – 10 amps (for SL use)
Hydromorphone 10 mg/mL – 10 amps	

Availability, usage procedures, and contents of emergency drug kits vary throughout the province; contact your local Home Health Care Office or Palliative Care Team for information.

Medications that may be given by the SC route in the primary care setting ² (maximum volume per SC injection site = 2 ml)	
Atropine (0.6 mg/mL)	Ketorolac (30 mg/mL)
Calcitonin	Lidocaine
Chlorpromazine (25 mg/mL)	Lorazepam (4 mg/mL)
Clodronate (30, 60 mg/mL)	Low molecular weight heparin
Codeine (15, 30 mg/mL)	Loxapine (50 mg/mL)
Dexamethasone (4 mg/mL)	Methadone (Special Access)
Dimenhydrinate (Gravol® 50 mg/mL)*	Methylnaltrexone (Relistor®) (20 mg/mL)
Diphenhydramine (Benadryl® 50 mg/mL)	Midazolam (5 mg/mL)
Droperidol (2.5 mg/mL)	Methotrimeprazine (Nozinan®) (25 mg/mL)
Epinephrine	Metoclopramide (5 mg/mL)
Fentanyl (50 mcg/mL)	Morphine (10, 50 mg/mL)**
Furosemide (10 mg/mL – note max. 20 mg. SC/site)	Naloxone (0.4 mg/mL)
Glycopyrrolate (0.2 mg/mL)	Octreotide
Haloperidol (5 mg/mL)	Ondansetron (2 mg/mL)
Heparin	Potassium Chloride (2 mEq/mL)
Hydromorphone (2, 10, 50 mg/mL)	Phenobarbital (120 mg/mL)
Hydroxyzine (50 mg/mL)	Ranitidine (25 mg/mL)
Hyoscine butylbromide (20 mg/mL)	Scopolamine (0.4, 0.6 mg/mL)
Ketamine (10 mg/mL)	Sufentanil (50 mcg/mL)

* caution – sterile SC abscesses and skin necrosis

** caution – SC nodules if concentration > 50 mg/ml

References

1. Fraser Health Hospice Palliative Care. Palliative Care Kit Package. Fraser Health, B.C. July 14, 2006. [Information on file].
2. Derek Doyle, Geoffrey Hanks, Nathan Cherny, Kenneth Calman. Oxford Textbook of Palliative Medicine: 3rd ed. New York: Oxford University Press; 2005. p 218.