Palliative Care for Patients with GI and Hepatic Disease

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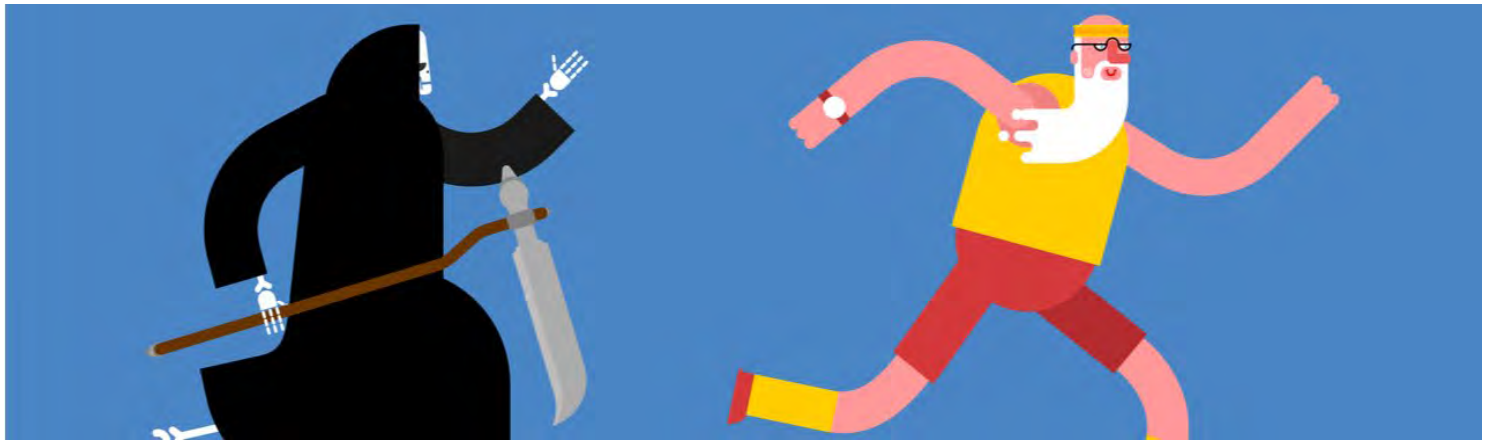
Agenda

Definitions
Prognostication
Symptom Management
Hospice



death, hopelessness, dependency and end-of-life

Palliative Care

Multidisciplinary, specialized medical care that addresses

- Physical
- Spiritual
- Psychosocial needs

Palliative Care

- Palliative care can be provided at any stage of a serious illness and concurrently with disease-directed and curative treatments (including organ transplants).

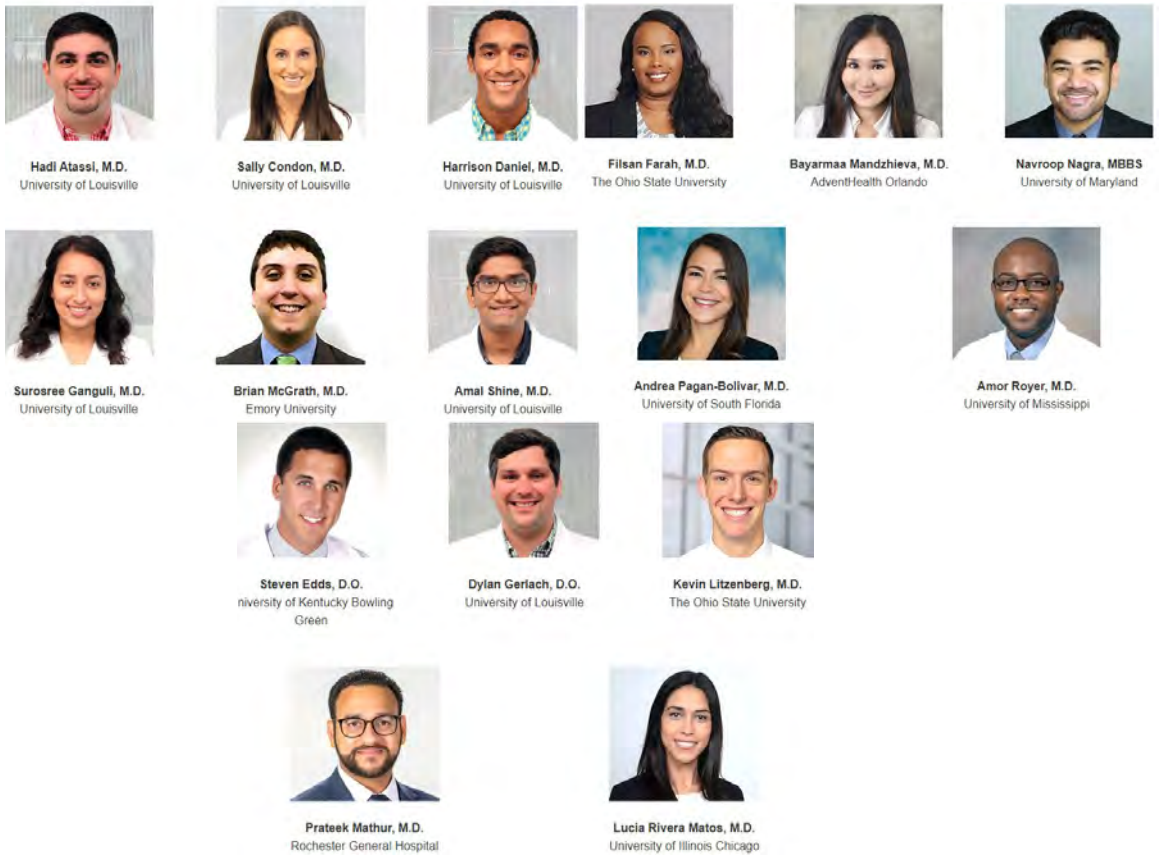
- person-centered
- about the aspects of care most important to patients and their families/ caregivers.

Palliative Care Definitions

- Primary Palliative Care
- Specialty Palliative Care
- Hospice
- Advance Care planning

Palliative Care Definitions

Primary palliative care



- Any treating team that care is aligned with the principles of palliative care (e.g., person-centered, communication focused symptom management).

Palliative Care Definitions

Specialty Palliative Care

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- Only 11% of patients with cirrhosis receive specialty palliative care or hospice care referrals, and consultation often occurs very late in the disease course.

Palliative Care Definitions

Hospice

- Hospice is different than palliative care in that it focuses exclusively on comfort, rather than disease-directed curative treatment, and includes only persons with a life expectancy measured in months.

BOX 132-3 Hospice Eligibility Criteria for End-Stage Liver Disease

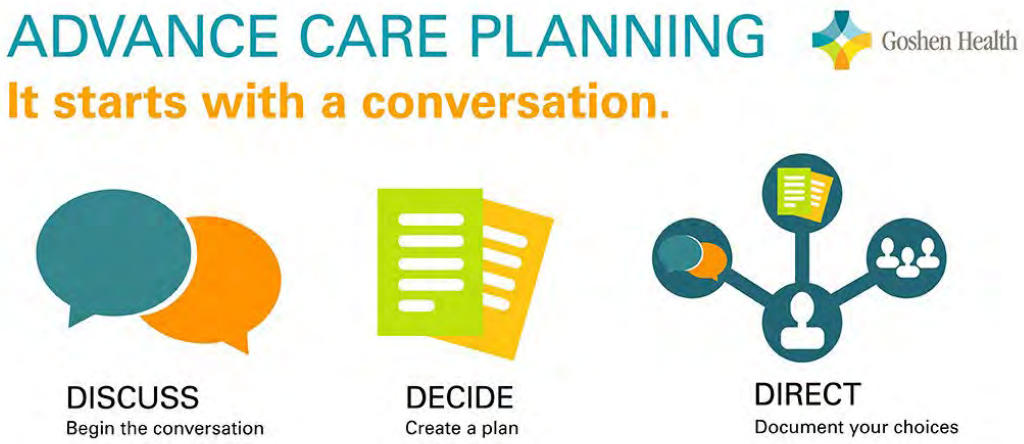
The patient is *not* a transplant candidate and opts for comfort care *and*
The patient has:
- Prothrombin time >5 sec over control or INR >1.5 *and*
- Serum albumin <2.5 g/dL *and* one or more of the following conditions:
  - Ascites refractory to treatment, or the patient is not compliant with treatment
  - SBP
  - Hepatorenal syndrome, elevated serum creatinine and BUN, oliguria (<400 mL/day), urine sodium concentration <10 mEq/L, cirrhosis, and ascites
  - Hepatic encephalopathy refractory to treatment, or the patient is not compliant with treatment
  - Recurrent variceal bleeding despite intensive therapy

Supporting documentation (as applicable):
- Progressive malnutrition
- Muscle wasting with reduced strength and endurance
- Continued active alcoholism (>80 g ethanol/day)
- Hepatocellular carcinoma
- HBsAg positivity

Palliative Care Definitions

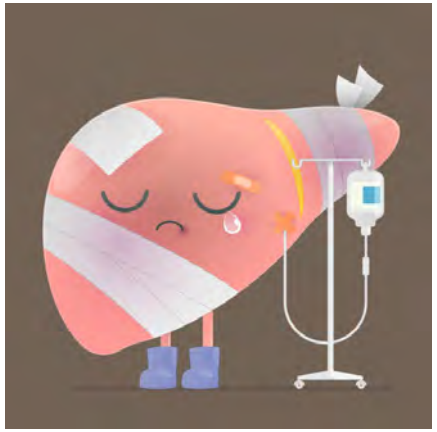
Advance Care Planning

- Longitudinal process of medical decision making for patients and their families over the course of their illness trajectory.
- ACP includes identifying surrogate decision makers, illness education and prognostic disclosure, and formal documentation of goals for medical and end-of-life care through advance directives that center on the goals, values, and preferences of patients and their families.



Numbers

- Chronic liver disease and cirrhosis is considered the 9th leading cause of death in the United States, accounting for 56,585 deaths in 2021.
- Annual cost is $22,752 in patients with compensated cirrhosis, and $59,995 annually for ESLD.
- 150,000 hospitalizations annually.
- 5-year mortality ranging from 20% to 80% across studies, the overall disease trajectory is progressive, with declining health and increasing symptom burden and frequent hospitalizations at the end of life.



Primary Palliative/Hepatology

Some elements of **primary palliative** care that could be provided as part of routine hepatology care include evaluating:

- managing symptoms
- identifying and documenting surrogate decision makers
- eliciting patient preferences about treatment and aligning care plans with these preferences
- providing counseling about what to expect in the future
- referring patients for social services to increase support in the community.

Barries to Palliative Care in Hepatology

- Shortage of specialty palliative care providers
- Absence of evidence-based referral criteria
- Lack of role clarity between specialists
- Stigma that palliative care is synonymous with “giving up” on curative treatments
- Lack of provider training
- Competing demands on providers’ time
- And prognostic uncertainty

Barries to Palliative Care in Hepatology

- Transplant evaluation and listing may also present a unique barrier to palliative care for patients with cirrhosis, related to the perceived incompatibility of transplantation and palliative care.

- One study found that patients with cirrhosis undergoing transplant evaluation received lower-quality of end-of life care.

- One study found that transplant teams avoided discussing nonaggressive treatment options with patients, leading caregivers to feel unprepared to support their loved ones at the end of life.

Barries to Palliative Care in Hepatology

Table 2. Topic and Example Questions From Interview Guides[a]

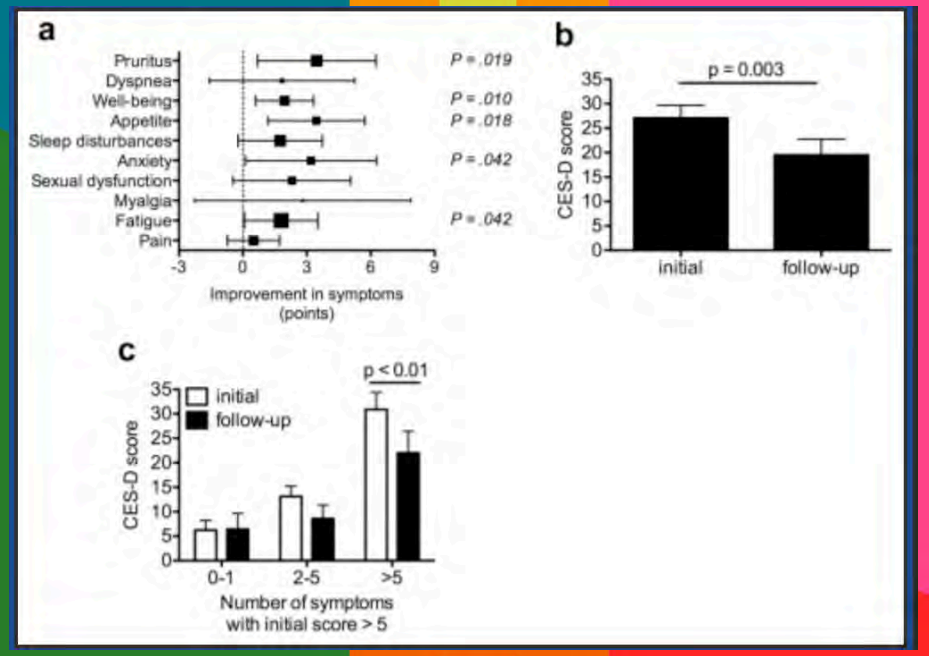
Broad topic	Specific topics	Example questions
Patient		
Lead-in questions	1. Diagnosis of cirrhosis, past experiences 2. Present illness	1. Can you tell me about how you became diagnosed with cirrhosis and what that experience was like? 2. If you had to pick 2-3 concerns you have about your experience with cirrhosis, what would they be?
ACP: main questions	1. Prognosis 2. Surrogate decision-making 3. Health care preferences 4. Values and goals 5. Documentation	1. Have you thought about what may happen to you if you were not a candidate for a liver transplant? Has this ever been brought up? 2. As you know, there are instances regarding your cirrhosis where you can get so sick that you may be unable to make medical decisions for yourself. Have you had discussions with your loved ones or medical team about who can specifically make medical decisions for you if that were to happen? What were those discussions like?
Probes	1. Barriers 2. Facilitators 3. Preferences	1. What are some reasons why you do not think that happens? 2. What made it easier for you to do? 3. How would you feel if someone from the medical team talked to you about that?
Clinician		
Lead-in questions	1. Job description and context	1. Given that clinician roles can vary across institutions, can you start by telling me a little bit about how you spend your professional time at the liver transplant center and the role you play in treating patients with cirrhosis?
ACP: main questions	1. Prognosis 2. Surrogate decision-making 3. Health care preferences 4. Values and goals 5. Documentation	1. Can you describe a typical conversation you will have with patients with decompensated cirrhosis about certain medical emergencies or events that can happen in the future? Can you explain any conversations you may have regarding a patient's chance of dying? 2. In what way do discussions about assigning a health care decision maker come up in the care of these patients? 3. Do discussions with patients about advance directives or POLST forms regarding their medical care ever come up?
Probes	1. Barriers 2. Facilitators 3. Preferences	1. What are some reasons why you think it may not happen? 2. What makes the conversation easier? 3. What are some ways you believe we can improve this?

"No, I don't touch [those conversations]. Unless [the patients] are in the hospital or at the last moment, but not before. I think some [of them] have advance directives." (Hepatologist)

"It's probably a terrible answer. I assume that [finding the decision maker] is somebody else's job. When they go into the hospital, I'm sure someone asks them on admission or something. I don't know." (Hepatology nurse practitioner)

- Finally, hepatology training does not routinely include palliative care training, and palliative care competencies for hepatologists have not been developed.

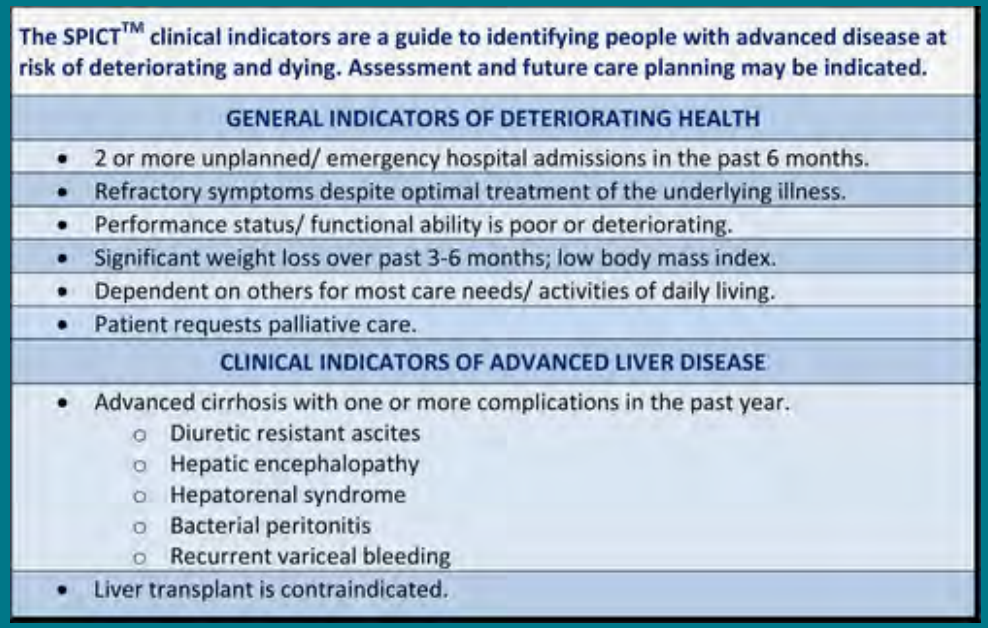
Palliative Care and Liver Transplantation: Can they Exist Together?



- One study showed that outpatient specialty palliative care referral for all patients undergoing liver transplant evaluation resulted in improved physical and psychological symptom scores.
- Early intervention with the palliative care team was associated with earlier consensus around goals of care, reduced length of stay, and earlier provision of comfort-focused care without any change in mortality. Caregivers also reported having more time to say goodbye.

Prognostication

- Stable Cirrhosis:
  - – Prognosis determined by **MELD-Na score**
  - – Provides 90 day mortality.
- Acute on Chronic Liver Failure (ACLF)
  - – Mortality Provided by CLIF-C ACLF Calculator
  - – Provides mortality at 1, 3, 6 and 12 months.
- Acute Decompensation (without ACLF):
  - – Mortality Provided by CLIF-C Acute decompensation Calculator
  - – Provides mortality at 1, 3, 6 and 12 months.
- Survival of Ambulatory Patients with HCC (MESIAH)
  - – Provides survival at 1, 3, 6, 12, 24 and 36 months



The SPICT™ clinical indicators are a guide to identifying people with advanced disease at risk of deteriorating and dying. Assessment and future care planning may be indicated.

GENERAL INDICATORS OF DETERIORATING HEALTH

- 2 or more unplanned/ emergency hospital admissions in the past 6 months.
- Refractory symptoms despite optimal treatment of the underlying illness.
- Performance status/ functional ability is poor or deteriorating.
- Significant weight loss over past 3-6 months; low body mass index.
- Dependent on others for most care needs/ activities of daily living.
- Patient requests palliative care.

CLINICAL INDICATORS OF ADVANCED LIVER DISEASE

- Advanced cirrhosis with one or more complications in the past year.
  - Diuretic resistant ascites
  - Hepatic encephalopathy
  - Hepatorenal syndrome
  - Bacterial peritonitis
  - Recurrent variceal bleeding
- Liver transplant is contraindicated.

Symptom Management

Most frequently reported symptoms are

- pain (prevalence range, 30%–79%)
- breathlessness (20%–88%)
- muscle cramps (56%–68%)
- sleep disturbance (insomnia, 26%–77%; daytime sleepiness, 29.5%–71.0%)
- psychological symptoms (depression, 4.5%–64.0%; anxiety, 14%–45%)
- sexual dysfunction (53%–93%

Pain

- Somatic- stretching from ascites, splenomegaly, hepatic capsular stretch
- Visceral- peritonitis
- Neuropathic- Neuropathy
- Musculoskeletal

- Tx: treat reversible cause, nonpharmacological options, local pharmacotherapy, pharmacological options.

- Pharmacotherapy: "start low, go slow”
  - Although opioids are associated with increased pain-related disability, encephalopathy, ascites, post- transplant mortality, and readmission in patients with cirrhosis, patients at the end of life may accept these risks and prioritize short-term analgesia over cognition.
  - Prophylactic medications should be considered proactively to prevent constipation and encephalopathy.

The management of pain is complex and requires treatment of other contributing symptoms (e.g., sleep disorders, depression). Multidisciplinary approaches are often beneficial

Nonpharmacological options

- Hot/cold
- Physical therapy
- Mindfulness/meditation
- Other behavioral pain self-management strategies (e.g., cognitive behavioral therapy)
- Acupuncture (caution if platelets <50,000)
- Other complementary options based on preferences (e.g., transcutaneous nerve stimulation)

Pharmacological options

Topical/injection treatments

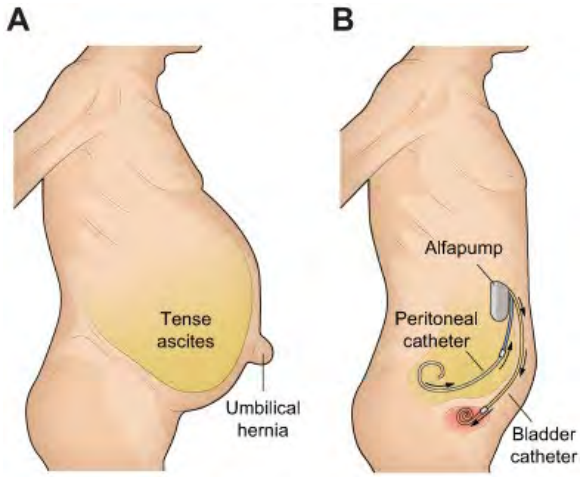
- Lidocaine patches
- Capsaicin cream or patch
- Topical nonsteroidal anti-inflammatory medications (e.g., diclofenac sodium 1% gel)
- Injections by pain specialists (e.g., osteoarthritis of knee)

Systemic therapies

- APAP 500 mg q6h for a maximum of 2 g/d is safe in most patients with.
- Gabapentin 300 mg daily (starting dose) or pregabalin 50 mg b.i.d. (starting dose)[a] (for neuropathic pain)
- Fentanyl patch 12-µg starting dose (typically not recommended as the initial agent; avoid in patients with sarcopenia/cachexia or fever)
- Hydromorphone 1-mg q6h prn starting dose
- Oxycodone 2.5-mg p.o q6-8h prn starting dose

Ascites

- Diet: Na restriction below Na excretion (usually 1-2 gm Na per day); 1.2-1.5 gm protein/kg,3 meals + 4 snacks
- Diuretics to increase Na excretion.
- Repeated large volume paracentesis.
- TIPS (if MELD </= 20)
- "Abdominal drains may be an alternative to serial large volumen paracentesis for patients with refractory ascites who are transplant and TIPS ineligible and whose goals are comfort focused. However, more comparative effectiveness research is needed before recommending this approach."
    - Study 1: Spontaneous bacterial peritonitis (SBP) occurred 17%.
    - Study 2: Patients with drains had spontaneous SBP 11% vs LVP 6%
- Automated low-flow ascites pumps (alfapumps)



Dyspnea

Experienced by 47%–88% of persons with cirrhosis
Causes: ascites, volume overload, hepatopulmonary syndrome, hydrothorax, portopulmonary syndrome, and infections.
Tx: Disease-directed therapies may be used as appropriate, including diuresis, bronchodilators, phosphodiesterase inhibitors, TIPS, and steroids.

Symptom	Nonpharmacotherapies	Pharmacotherapies
Dyspnea	• Manage reversible causes (e.g., volume overload, asthma, sleep apnea) • Bedside fans • Supplemental oxygen therapy • Mindfulness, meditation, guided imagery • Paracentesis • Thoracentesis • Placement of drains (usually in the setting of hospice care)	• Opioids can be used cautiously in select cases, typically at the end of life (example: starting dose i.v. hydromorphone 0.2 mg every 3 h as needed, titrated to symptom relief) • Anxiolytics can be considered for dyspnea-associated anxiety (typically at the end of life when focus of care is comfort)

Hepatic Encephalopathy

- Hepatic encephalopathy is associated with poor prognosis: cumulative survival in these patients was very short: approximately 20% to 40% at 1 year and 15% at 3 years of follow-up.
- Evaluating reversible causes and addressing HE.
- Tx: Lactulose and rifaximin
- surrogate decision maker is identified and documented before the onset of encephalopathy, as discussed under ACP.
- As persons approach the end of life, patient preferences and acceptability of treatment side effects may change.
- Rifaximin may not be available in some hospice settings because of its high cost, off-label neomycin or metronidazole may be considered as an alternative to
- zinc repletion, branched-chain amino acids, probiotic and carnitine

Muscle cramps

- The precise etiology of muscle cramps is unclear, alterations in nerve function, energy metabolism, plasma volume, and electrolytes may contribute.

Muscle cramps	• Correct electrolytes	• Taurine (2–3 g daily) • Vitamin E (300 mg three times a day) • Baclofen (5–10 mg three times a day)

Pruritus

- Bile acids accumulation with mu-receptor stimulation.
- Tx: nonpharmacological options, including using moisturizing creams, avoiding hot baths and harsh soaps, and using loose-fitting clothes and cool humidified air.
- Pharma: Cholestyramine(4g/dwithtitrationto16g/d)is first-line treatment for pruritus. Alternative agents include low-dose naltrexone, RIF (in anicteric patients), and sertraline, but these agents require careful titration in the context of DC.

Pruritis	• Moisturizing creams • Avoid hot baths and harsh soaps and detergents • Use loose-fitting clothing • Cool humidified air	• Cholestyramine (4 g/d, titrated to 16 g/d if needed) • Sertraline (25 mg/d, titrated to 75–100 mg if needed) • RIF and naltrexone may improve pruritus, but their use is limited in palliative treatment of patients with DC. • Antihistamines (e.g., diphenhydramine and hydroxyzine) may help with pruritis-associated sleep disturbance given their sedating properties

Sexual dysfunction

- Approximately two thirds of men and and 80% of women with cirrhosis suffer from sexual dysfunction.
- First, medications (e.g., beta-blockers) and substances (e.g.,alcohol, tobacco) that can cause sexual dysfunction underlying conditions that contribute to sexual dysfunction should be removed
- There are sparse data about management of erectile dysfunction treatment in this population, though tadalafil may be a safe short-term option in select patients and is undergoing further evaluation.
- There is a notable lack of research regarding the assessment or management of sexual dysfunction in women with cirrhosis.

Conclusion

- Palliative care is a person-centered approach to care, focusing on the aspects of care most important to patients and their families/informal caregivers.
- Palliative care should be offered earlier and to more patients with cirrhosis.
- Although palliative care can be provided by specialists, we encourage all members of the hepatology care team to consider providing palliative care to address the symptomatic, spiritual, and psychosocial needs of their patients and their caregivers.

Resources

- Rogal, SS, Hansen, L, Patel, A, Ufere, NN, Verma, M, Woodrell, CD, et al. AASLD Practice Guidance: Palliative care and symptom-based management in decompensated cirrhosis. *Hepatology*. 2022; 76: 819–853. https://doi.org/10.1002/hep.32378
- Benefit of Early Palliative Care Intervention in End-Stage Liver Disease Patients Awaiting Liver Transplantation. Baumann, Alexandra J. et al.Journal of Pain and Symptom Management, Volume 50, Issue 6, 882 - 886.e2
- Patel AA, Ryan GW, Tisnado D, et al. Deficits in Advance Care Planning for Patients With Decompensated Cirrhosis at Liver Transplant Centers. *JAMA Intern Med*. 2021;181(5):652–660. doi:10.1001/jamainternmed.2021.0152

Questions & answers

Overview Of The Approach To Symptom Assessment, Triage, And Management