Monthly Interesting case

29th May 2024

Presented by Fellow Natthanit S.

Karunruk center

Index

Patient Identification

A Thai Male 62 years old

ที่อยู่: จ.หนองคาย

อาชีพ: พยาบาลวิสัญญี, ผู้พิพากษา

สิทธิ์ : ข้าราชการฯ

Ward : 6ข

Status เดิม : ECOG1

PPS ปัจจุบัน : 50%

Past History:

SCC at Left Lateral tongue pT1N0 S/P: Left SND + WE of Tongue + nasolabial flap 8/10/64 >> > Recurrent CA tongue T4N2Mx
MRI neck 9/66 invasive carotid

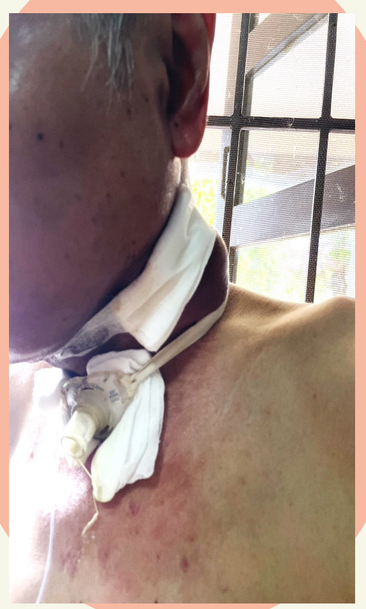
S/P CLN Tissue Bx 27/9/66 Scant atypical cells

S/P tracheostomy + PEG 9/10/66

S/P CCRT 21/12/66 (RT 35 fractions with CMT 4 cycles)

MRI neck 26/1/67: PD

Onco plan Cisplatin and FU and Pembrolizumab 200 mg q 3 week ต่อ start 27/03/67



Plan going on 2L CMT

ECOG 1

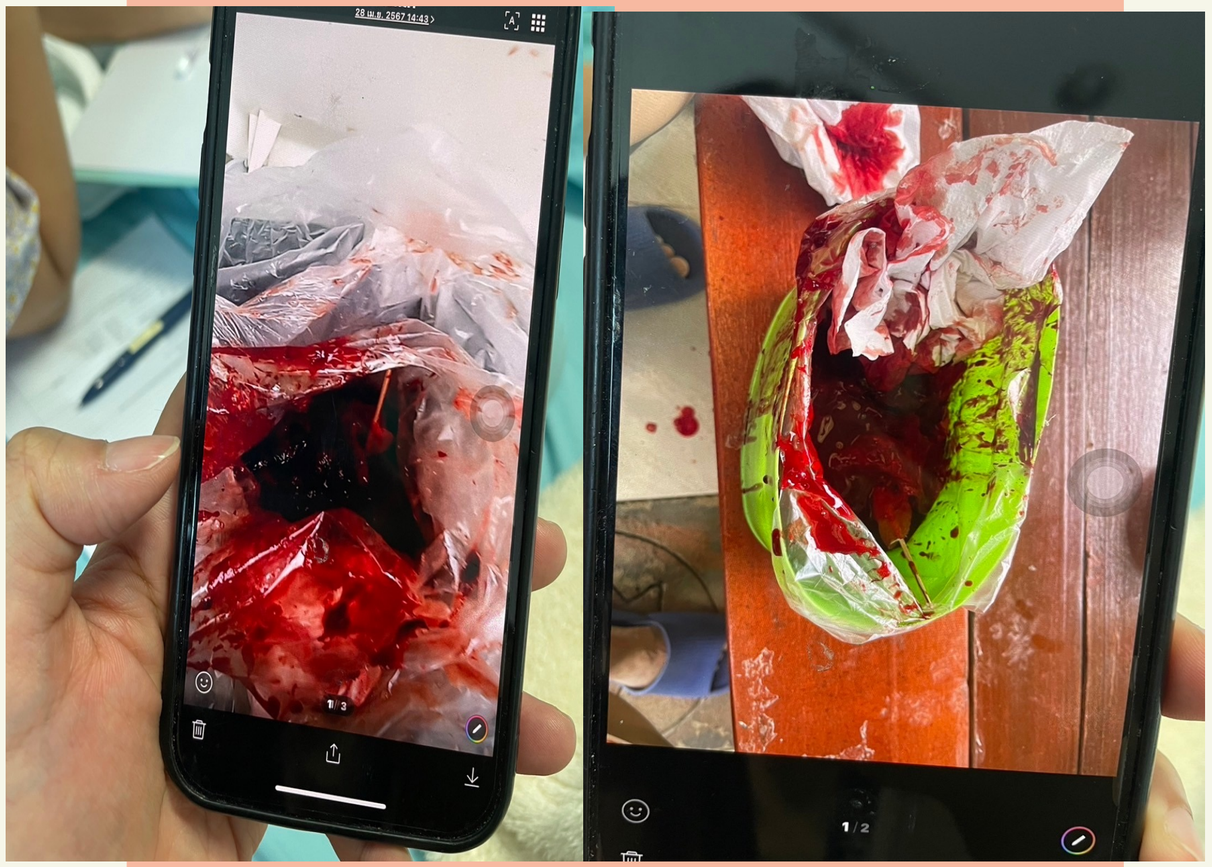
Admission date 18/4/67

CC: เลือดสีแดงสดออกจากปาก 1 ชม ก่อนมา รพ

PI: 1hr PTA เลือดสีแดงสดออกจากปากมาปริมาณประมาณ 2000ml ผู้ป่วยอมก้อนเลือดขนาดใหญ่ไว้ที่กระพุ้งแก้มซ้าย ไม่มีหน้ามืด ไม่วิงเวียน

at ER: adrenaline 1 mg + ก๊อซ pack ในช่องปาก , Transamine 1 g IV stat

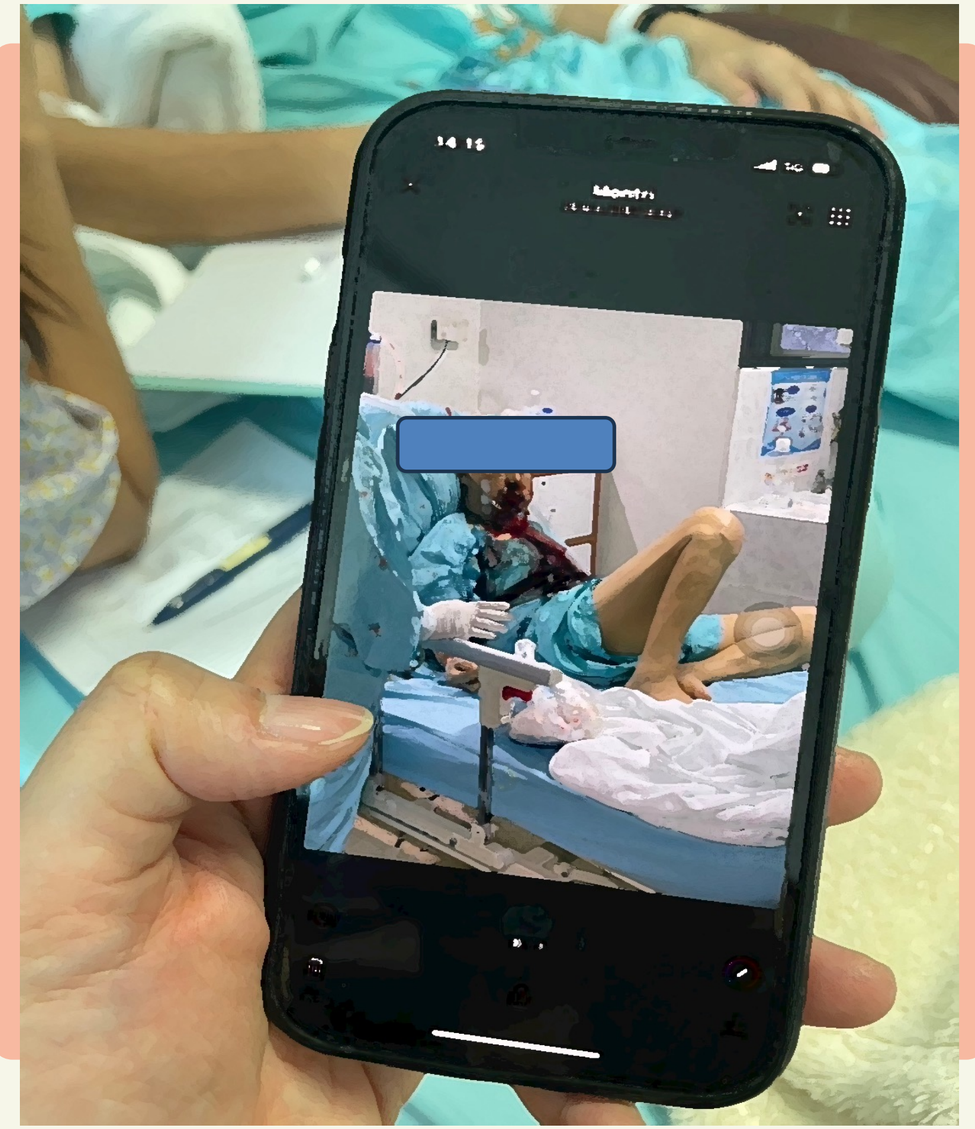
consult ENT evaluate bleeding : ENT evaluation



Physical examination:

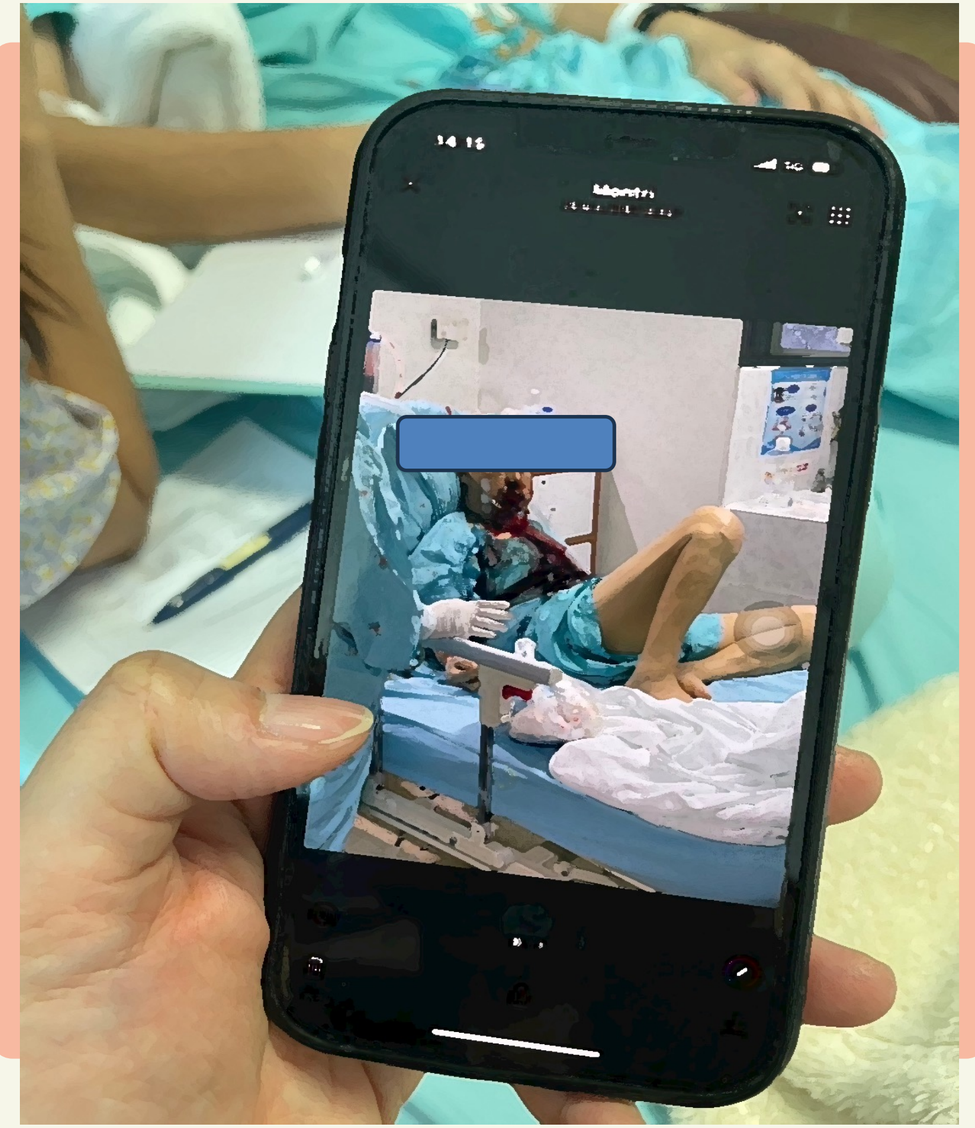
- GA: Good consciousness, alert and co-operative

  Vital sign: BT 36.7 HR 126 RR 24 BP 92/61
- Oral cavity : Trismus, not seen bleeding point, cannot see the source of bleeding point



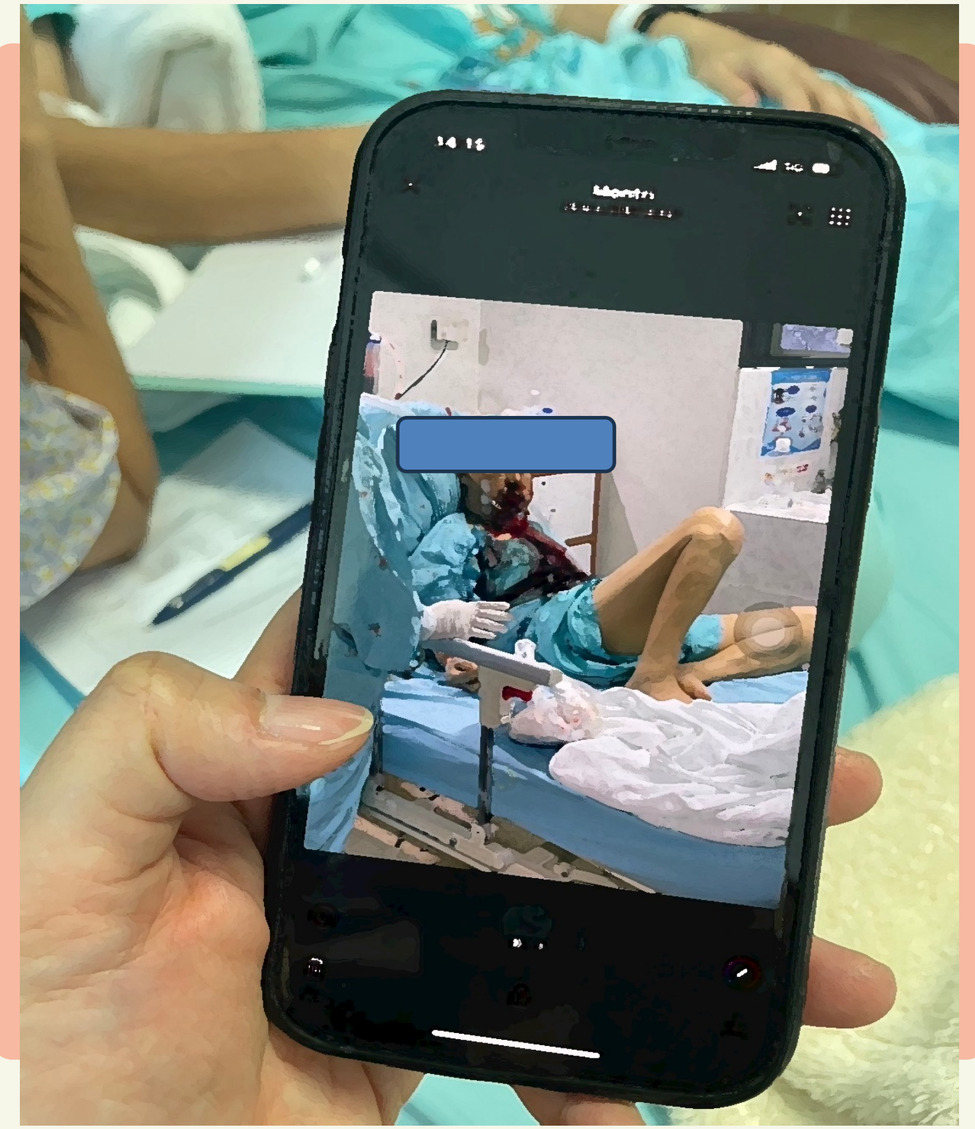
Physical examination(ต่อ):

- FOL via nostril: submucosal mass at Lt lateral pharyngeal wall, not seen bleeding point, marked swelling bilat FVC, arytenoid, decrease movement Lt TVC, normal movement Rt TVC
- FOL via trach: patent AW to carina, no bleeding
- Neck: fibrotic neck, palpable huge Lt CLN level II 5 cm, no active bleeding



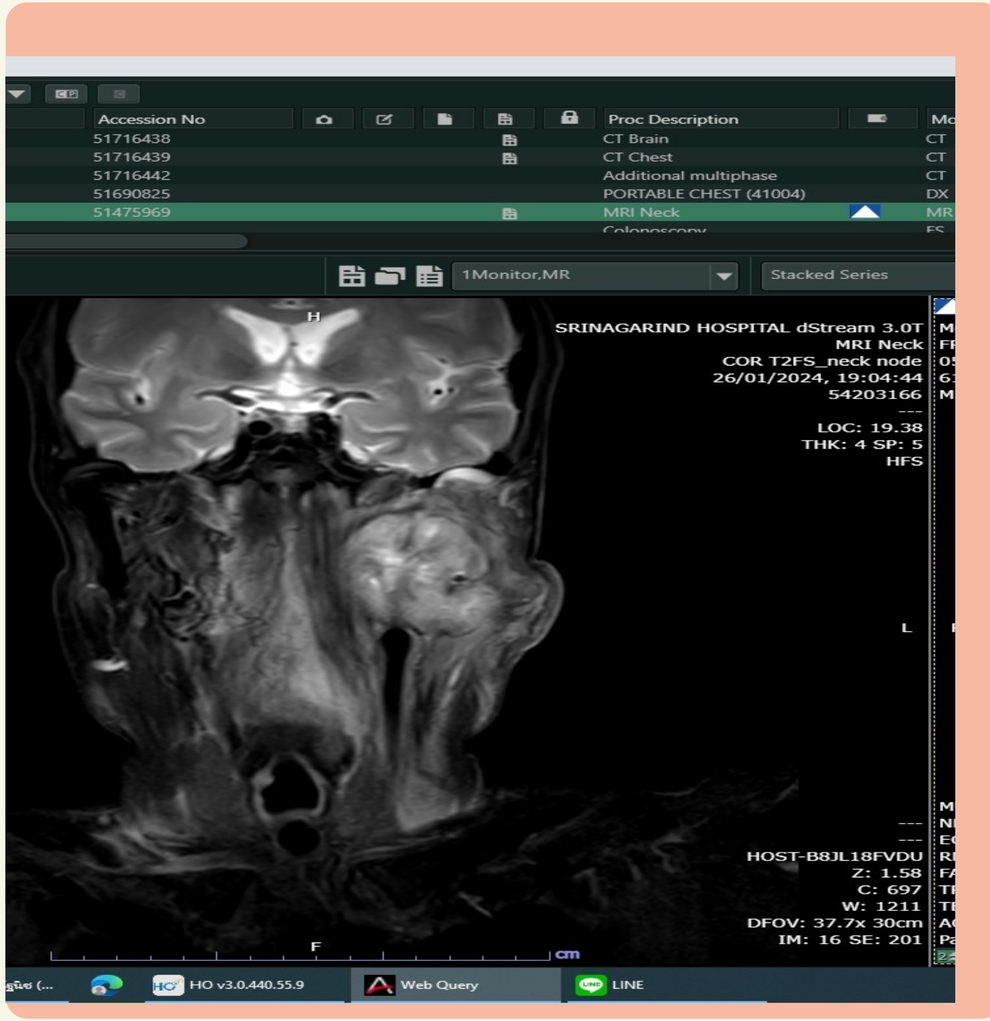
Investigation

- PTT 31.7 INR 0.98 PT 2.83 L
- Hb 8.2 L Hct 25.7 (33) L WBC 9.64 N 82.9 L8.9 Platelet 319,000
- Bun 18 Cr 1.0 GFR 80.3
- Na 134 K 4.8 HCO3 30 Cl 94
- Ca 8.6 PO4 3.5 PO4 2.2 Alb 3.1
- TB/DB 0.3/0.2 ALT/AST 21/16 ALP 133

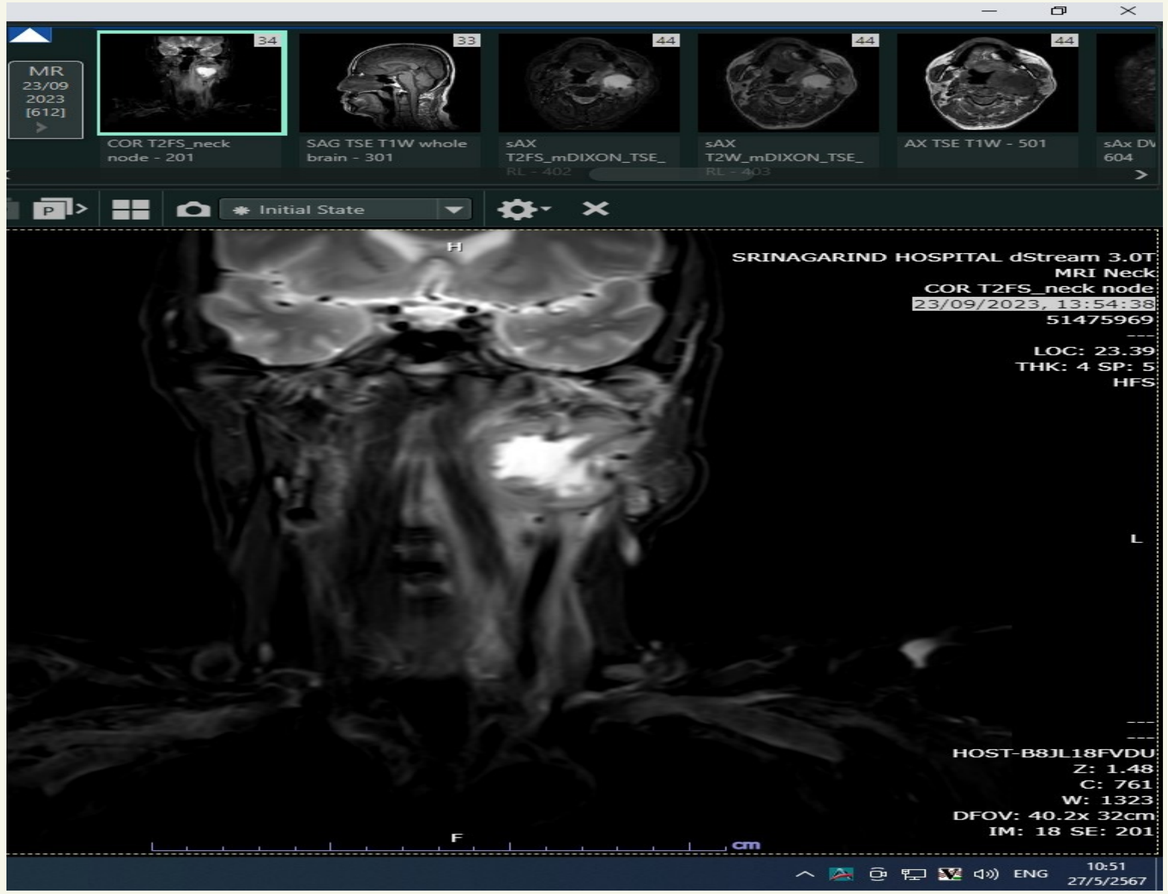


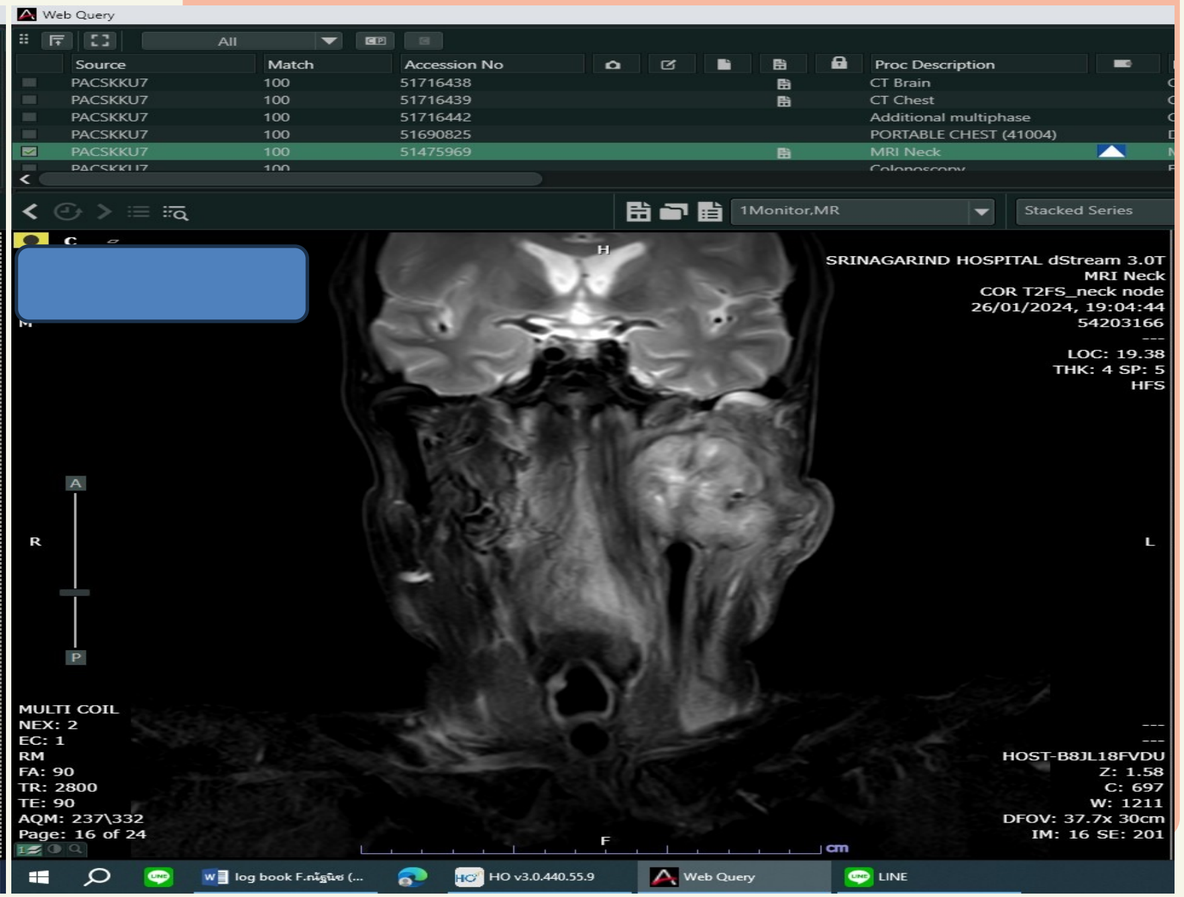
Imaging:

MRI neck 23/9/66
- Recurrent tumor at surgical bed of left base of tongue
- adjacent the large necrotic CLN level II
- Focal enhancing nodule in left side sphenoid sinus is 7.3 mm., metastasis mass is suggested.
- Decreased size and changing appearance (increase cystic/necrotic area) of the mass at left side of the oropharyngeal mucosa extending to left AE fold and left pyriform sinus
- No significant change in size of the cystic/necrotic node at left level IIa with invasion of left internal carotid artery and left internal jugular vein causing mild to moderate narrowing of the ICA.



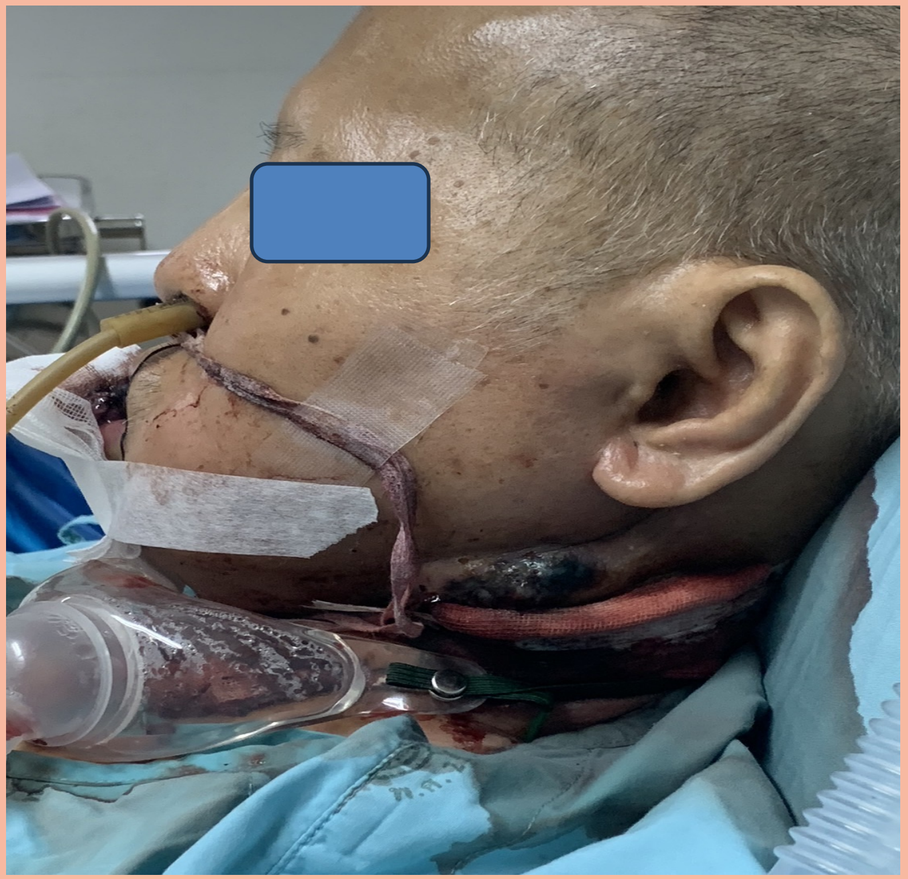
Imaging: MRI Neck; comparison





Management

- Anterior and posterior nasal packing



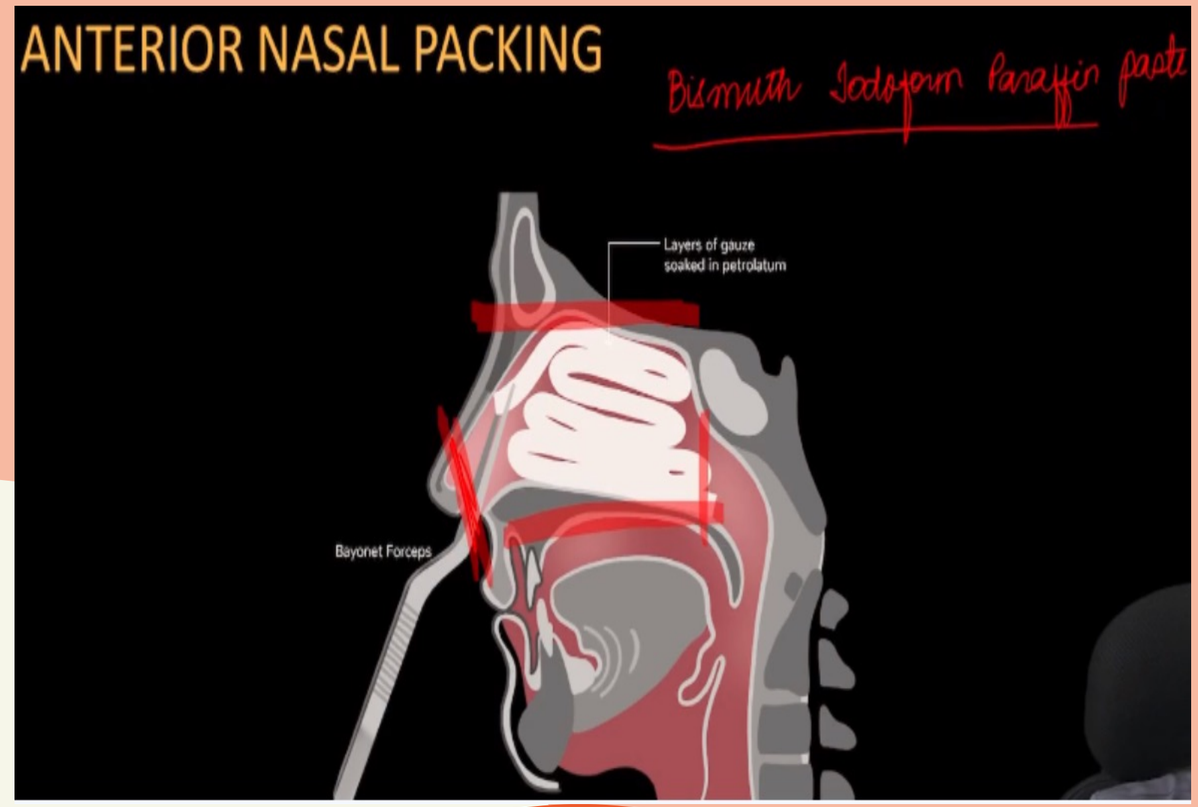
Active Problem:

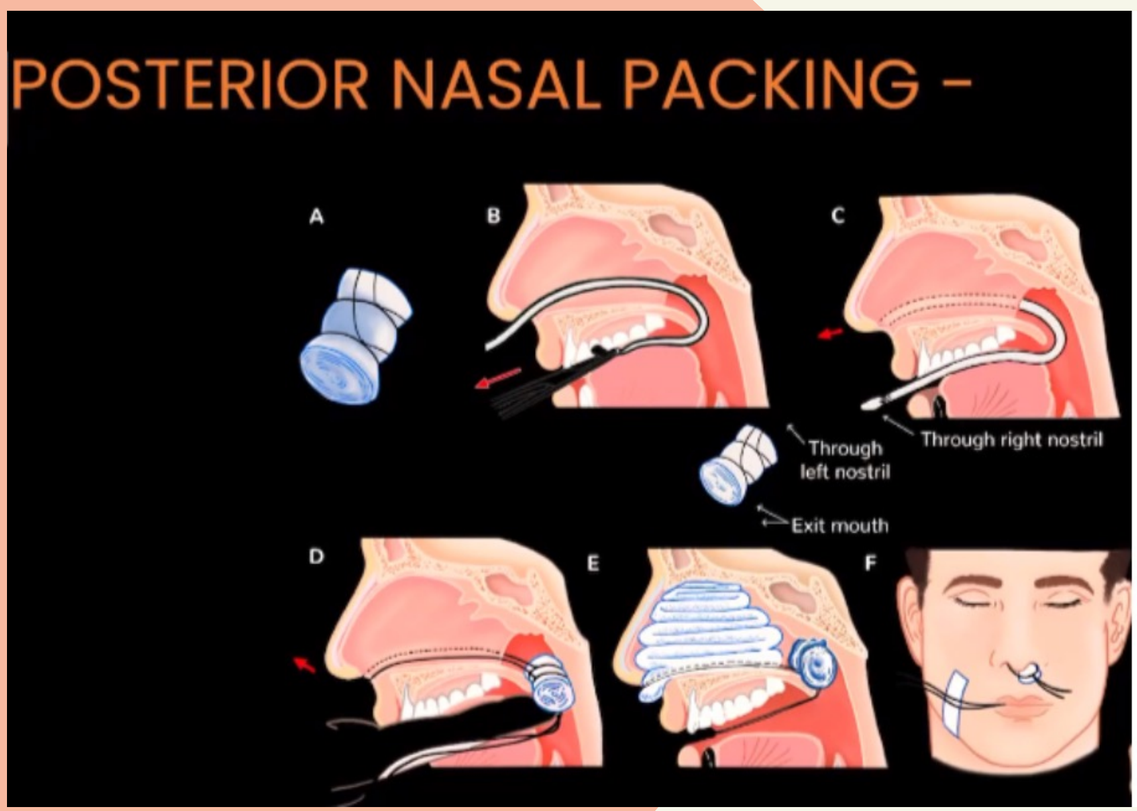
1. Recurrent CA tongue with suspected carotid blow out : sentinel bleed status post anterior and posterior nasal packing

2. AFI Ddx: infected tumor, pneumonia

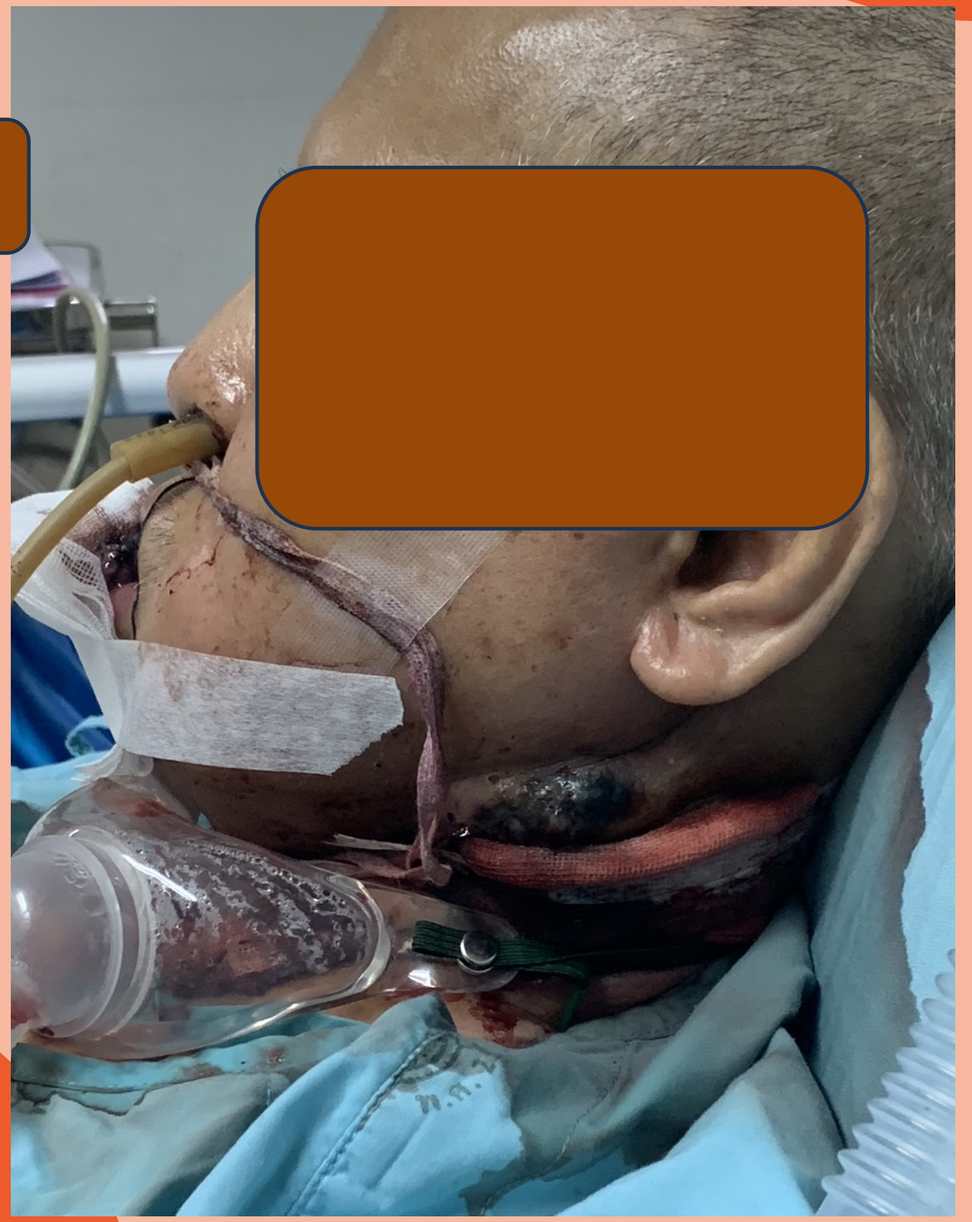
Consult Palliative for
Patient and family
request Palliative sedation

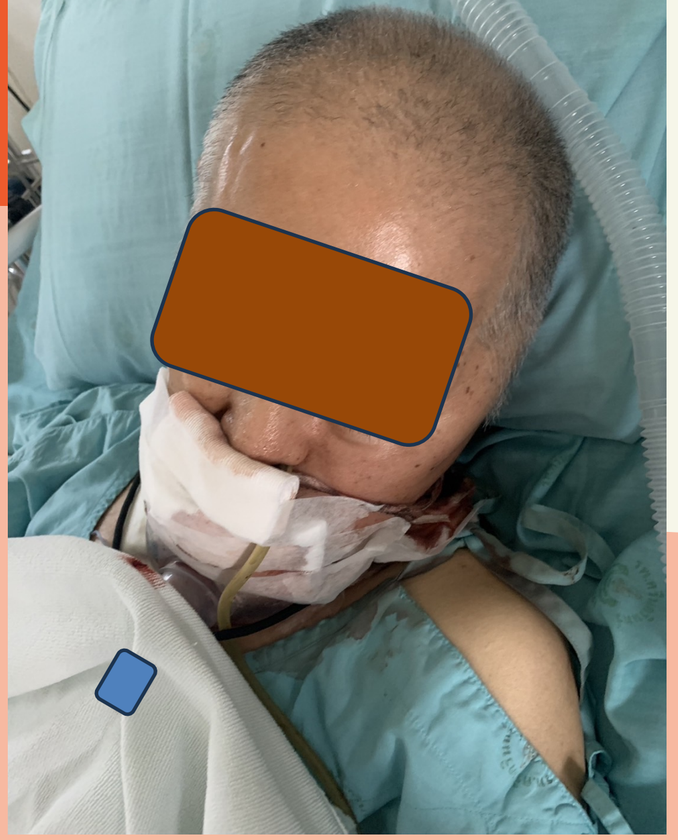
Do you feel awkward about this request?

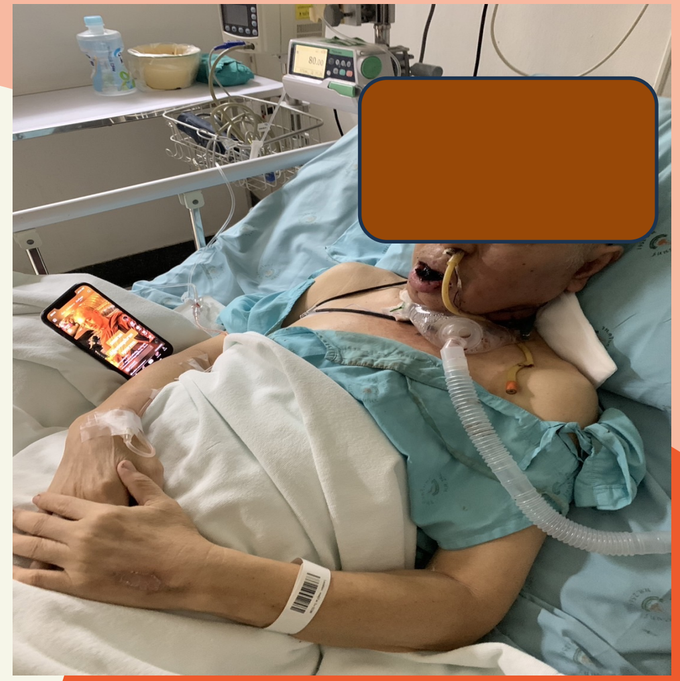




Ref.: EPISTAXIS: Causes and Management - NEET PG ENT [Internet]. prepladder. [cited 2024 May 18]. Available from: https://www.prepladder.com/neet-pg-study-material/ent/epistaxis-causes-and-management-neet-pg-ent

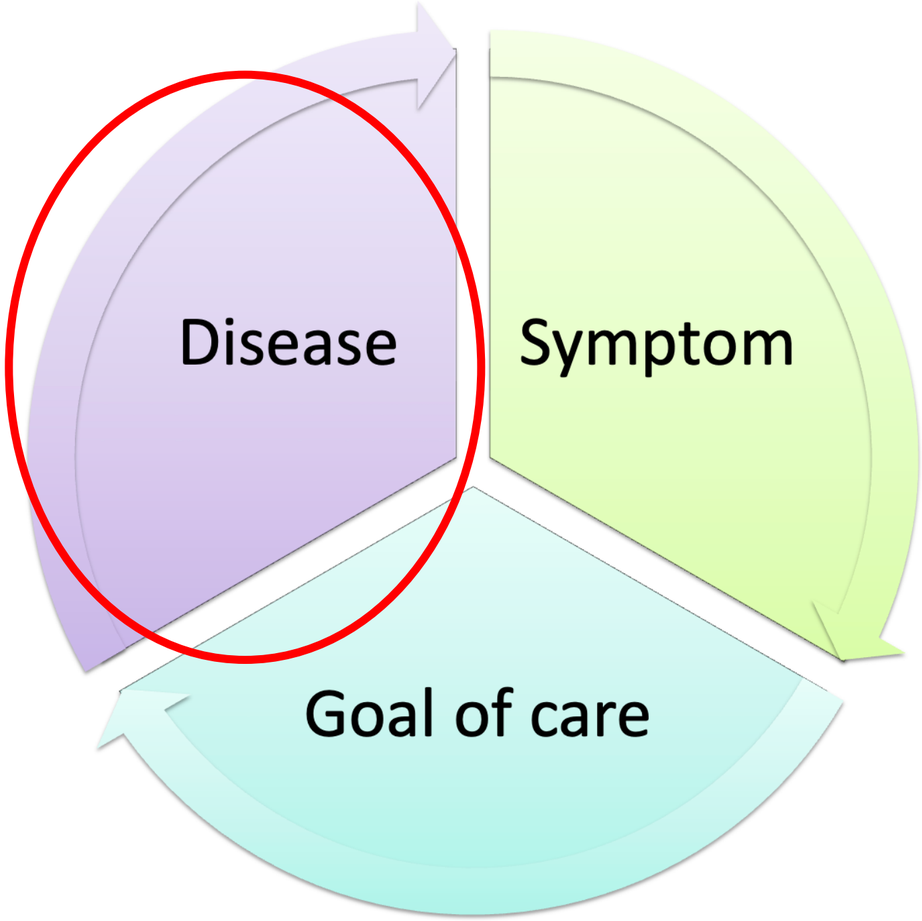






What is your decision?

Specific treatment
Trajectory
Complication
Prognostigation



Specific treatment
Trajectory/function
Complication

Best & Worse case synario
Patient preference
Psycho-social-spiritual

Carotid blow out

Carotid blow out

- ‘Carotid blowout’ occurs when the extracranial carotid arteries or their major branches rupture
- ‘bleeding from an artery which is likely to result in death within a period of time that may be as short as minutes’ (Harris and Noble, 2009).
- Risk factors for this event occurring include prior radiation therapy, extensive surgery, wound breakdown, local infection, local tumour recurrence, and the development of a pharyngocutaneous fistula.

Carotid blow out

- clinical diagnosis is suspected, angiography can both provide definitive confirmation and offer potential therapeutic interventions such as endovascular stenting or embolization (Cohen and Rad, 2004).
- Local control measures: 1:1000 adrenaline
- Pre-emptive prescribing: having immediate access to injectable midazolam
- Supportive measures: dark towels in the patient's place of care

Box 14.11.3 'Carotid blowout' definition

- Threatened: evidence on physical or radiological examination that haemorrhage will occur if no immediate action is taken (e.g. directly exposed artery)
- Impending: episode of bleeding, 'sentinel bleed' often caused by a pseudo-aneurysm that either resolves itself or with packing/pressure
- Acute: haemorrhage that cannot be stopped by packing or pressure.

Source data from Kozin, E. *et al.* (2012). Carotid blowout management #251. *J Palliat Med.* 15(3): 360–1. https://doi.org/10.1089/jpm.2012.9604.

“Palliative sedation”

Original Article

PALLIATIVE MEDICINE

Palliative Medicine
23(7) 581–593

DOI: 10.1177/0269216309107024
pmj.sagepub.com
SAGE

European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

Sedation is used in palliative care in several settings:

(1) transient sedation for noxious procedures

(2) sedation as part of burn care

(3) sedation used in end of life weaning from ventilator support

(4) sedation in the management of refractory symptoms at the end of life;

(5) emergency sedation

(6) respite sedation

(7) sedation for psychological or existential suffering.

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European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

- Abuse of palliative sedation:
  - called ‘slow euthanasia’. Indeed, some physicians administer doses of medication, ostensibly to relieve symptoms, but with a covert intention to hasten death. This may occur by the deliberate use of deep sedation in patients who have no refractory symptoms, or in the deliberate use of doses that far exceed that which is necessary to provide adequate comfort.
  - Excess doses can compromise physiological functions such as spontaneous respiration and haemodynamic stability.

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European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

Injudicious use of palliative sedation:

(1) Instances of inadequate patient assessment in which potentially reversible causes of distress are overlooked

(2) Situations in which before resorting to sedation, there is a failure to engage with clinicians who are experts in the relief of symptoms despite their availability.

(3) The case of an overwhelmed physician resorting to sedation because he is fatigued and frustrated by the care of a complex symptomatic patient.

(4) Situations in which the demand for sedation is generated by the patient's family and not the patient him/herself.

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Injudicious withholding of palliative sedation:

- clinicians defer the use of sedation excessively whilst persisting with other therapeutic options that do not provide adequate relied

- Clinicians should be aware of the potential for a ‘counter phobic determination to treat’ whereby anxiety about having to deal with all of the difficult discussions about sedation and end-of- life care leads to avoidant behaviors and futile therapeutic trials ultimately resulting in increased patient distress or reservations based on exaggerated concerns about hastening death.

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A framework for procedural guidelines : 10-item framework

1. Recommend pre-emptive discussion of the potential role of sedation in end-of-life care and contingency planning
2. Describe the indications in which sedation may or should be considered
3. Describe the necessary evaluation and consultation procedures
4. Specify consent requirements
5. Indicate the need to discuss the decision-making process with the patient's family
6. Present direction for selection of the sedation method
7. Present direction for dose titration, patient monitoring and care
8. Guidance for decisions regarding hydration and nutrition and concomitant medications
9. The care and informational needs of the patient's family
10. Care for the medical professionals

1. Recommend pre-emptive discussion of the potential role of sedation in end-of-life care and contingency planning

address specific issues such as CPR, ventilator support, pressor support, comfort care, antibiotics and artificial hydration and nutrition.

catastrophic events such as bleeding or extreme distress is foreseen, contingency plans for the management of these events should be discussed

documented and the documentation stored in a readily accessible format.

Patient and family goals and concerns should be revisited periodically, with attention paid to ongoing documentation of these discussions, even if there is no change in the plan of care.

2. Describe the indications in which sedation may or should be considered

The most common symptoms include agitated delirium, dyspnoea, pain and convulsions. Emergency situations may include massive haemorrhage, asphyxiation, severe terminal dyspnoea or overwhelming pain crisis.

Continuous deep: the very terminal stages of their ill- ness with an expected prognosis of hours or days at most.

Transient or respite sedation: earlier in the patient's trajectory to provide temporary relief whilst waiting for treatment benefit from other therapeutic approaches.

be considered for severe non-physical symptoms such as refractory depression, anxiety, demoralization or existential distress.7

3. Describe the necessary evaluation and consultation procedures

- The patient must be evaluated by a clinician with sufficient experience and expertise in palliative care.

+ interdisciplinary.

The evaluation should include:

(1) the patient's medical history;
(2) all relevant investigations; and
(3) a physical examination of the patient.

3. Describe the necessary evaluation and consultation procedures (2)

- exclude acute deterioration caused by a treatable complication of illness such as
  - sepsis,
  - a reversible metabolic event,
  - medication toxicity
  - common events such as pleural effusion, pericardial tamponade, ureteric obstruction, upper airway obstruction, gastrointestinal obstruction, active bleeding, urinary retention or elevated intracranial pressure.

3. Describe the necessary evaluation and consultation procedures (3)

evaluate any psycho-social and environmental factors, including sources of spiritual or existential distress, which may be adversely affecting the level of distress.

interdisciplinary: psycho-social health-care providers, nursing staff, family and any other relevant sources.

patient's primary physician in the assessment process and in any recommendations.

assessment estimates death: within minutes to hours, hours to days, days to weeks, or longer.

3. Describe the necessary evaluation and consultation procedures (4)

- Prognostic assessment should be based on the extent of disease, validated prognostic instruments, rate of decline in functional status, presence or absence of vital organ failure, and the presence or absence of adverse prognostic factors such as very poor performance status, dyspnoea, anorexia, degree of oral intake, delirium and oedema.

- If decisional capacity is in doubt, then the expert evaluation by a psychiatrist may be required.

4. Specify consent requirements

If the patient lacks decisional capacity and there is no advanced directive, permission needs to be obtained from a legally recognized proxy.

no advanced directive and no health-care proxy and who are in severe distress whilst actively dying, provision of comfort measures (including, if necessary, the use of sedation) is the ‘standard of care’ and should be the default strategy for clinician treatment decisions.

5. Indicate the need to discuss the decision-making process with the patient's family

- Family members do not assent to the treatment plan, the care team should:

(1) provide sufficient information to help families better understand the patient's conditions and suffering

(2) support the patient and their family by talking with each party and finding a solution that is acceptable to both; and

(3) provide psychological support to families to relieve them of factors that contribute to conflicts, such as grief and guilt.

6. Present direction for selection of the sedation method

In general, the level of sedation should be the lowest necessary to provide adequate relief of suffering.

intermittent or mild sedation should generally be attempted first.

a state of ‘conscious sedation’, in which the ability to respond to verbal stimuli is retained, may provide adequate relief without total loss of interactive function.

Doses can be titrated down to re-establish lucidity

Continuous deep sedation could be selected first if:

- (1) the suffering is intense;
- (2) the suffering is definitely refractory;
- (3) death is anticipated within hours or a few days;
- (4) the patient’s wish is explicit; and
- (5) in the setting of an end-of-life catastrophic event such as massive haemorrhage or asphyxia.

7.Present direction for dose titration, patient monitoring and care

- Initially, the patient should be assessed at least once every 20 minutes until adequate sedation is achieved

- at least three times per day after adequate sedation has been achieved.

- The severity of suffering

- level of consciousness

- adverse effects related to sedation (such as delirium, agitation or aspiration) should be evaluated regularly.

- The doses of the medications should be increased or reduced gradually to a level at which suffering

- documentation of the reason for changes and response to such manoeuvres.

7.Present direction for dose titration, patient monitoring and care (2)

- Consciousness is assessed by the patient's response to stimuli, agitation or motor activity, and facial expression.
- The level of sedation and routine physiological parameters such as
  - heart rate, blood pressure and oxygen saturation should be monitored regularly
- If the patient experiences heavy snoring and abrupt onset of apnoea, the dose of sedative should be decreased.
- If obtundation with respiratory depression occurs in a patient undergoing respite sedation, and the situation is life threatening, careful administration of a benzodiazepine antagonist (flumazenil) may occasionally be indicated and appropriate to re-establish patient stability.

8.Guidance for decisions regarding hydration and nutrition and concomitant medications

the patient's wishes and the estimated benefits/harms in light of the treatment aim (palliation of suffering).

If adverse effects of artificial hydration and or nutrition therapy exacerbate patient suffering, then reduction or withdrawal of artificial hydration/nutrition should be considered.

In most cases opioids should be continued, possibly with dose modification, unless adverse effects or signs of overdose (e.g. respiratory depression or myoclonus) are observed.

If symptoms are well palliated and over- dose signs are observed, opioids doses should be reduced, but should not be withdrawn rapidly, owing to the risk of precipitating withdrawal.

9.The care and informational needs of the patient's family

Families should be allowed and encouraged to be with the patient and, in many situations, an opportunity to say goodbye

availability of basic supports for the family such as tissues, chairs, water, access to a telephone, and opportunity to sleep in the room or nearby.

talking to and touching the patient, providing mouth care, and managing the atmosphere of the patient's care (e.g. providing the patient's favourite music, scents, singing favourite songs, saying prayers or reading to the patient).

The care team should provide regular information updates to the family including the patient's condition, degree of suffering, anticipated changes or, when appropriate, notification that death is approaching and what can be expected in the dying process.

10. Care for the medical professionals

The care team should recognize the potential for staff distress. All participating staff members need to understand the rationale for sedation and goals of care.

Possible this should be addressed at team meetings or case conferences, both before and after the event, to discuss the professional and emotional issues related to such decisions and to improve local procedures when necessary.

Benzodiazepines

Midazolam

General: Midazolam is the most commonly used agent.

Pharmacology: Water soluble, short-acting benzodiazepine. Metabolised to a lipophilic compound that rapidly penetrates the central nervous system. Brief duration of action because of rapid redistribution, therefore administration by continuous infusion is generally required to maintain a sustained effect.

Starting dose: 0.5–1 mg/hr, 1–5 mg as needed.

Usual effective dose: 1–20 mg/hr.

Lorazepam

General: Intermediate-acting benzodiazepine that has a peak effect approximately 30 min after intravenous administration. It is less amenable to rapid titration up or down than midazolam, because of its slower pharmacokinetics.

Pharmacology: Elimination is not altered by renal or hepatic dysfunction.

Advantages: Rapid onset. Can be administered IV or SC.

Starting dose: 0.05 mg/kg every 2–4 hr when administered by intermittent bolus.

Neuroleptics/antipsychotics

Chlorpromazine

General: Widely available antipsychotic can be administered orally, parenterally (IV or IM) and rectally.

Advantages: Antipsychotic effect for delirious patients.

Starting dose: IV or IM 12.5 mg q 4–12 hours, or 3–5 mg/hour IV or 25–100 mg q 4–12 hours PR.

Usual effective dose: Parenteral 37.5–150 mg/day, PR 75–300 mg/day.

Adverse effects: orthostatic hypotension, paradoxical agitation, extrapyramidal symptoms, anticholinergic effects.

Barbiturates

Barbiturates reliably and rapidly cause unconsciousness and, since their mechanism of action differs from the opioids and benzodiazepines, they may be useful in patients who have developed extreme levels of tolerance to these other medications. They do not have an analgesic effect, so opioids will probably be necessary for patients with pain.

Pentobarbital

General: Barbiturate.

Advantages: Rapid onset, anticonvulsant.

Dose: Loading dose: 2–3 mg/kg slow intravenous push (no faster than 50 mg/min); at time of loading dose, start infusion at 1–2 mg/kg/hr; titrate to desired level of sedation.

General anaesthetics

Propofol[79,80]

General: Short acting general anaesthetic.

Advantages: Quick onset of sedation, ability to rapidly titrate, rapid washout.

Adverse effects: Hypotension and respiratory depression, pain on infusion into small peripheral veins.

Precautions: Use strict aseptic technique when administering propofol. Change infusion tubing every 12 hours. Discard vial and any unused drug if not fully infused after 12 hours.

Non-sedative benefits: antiemetic, antipruritic and bronchodilatation.

Starting dose: 0.5 mg/kg/hr.

Usual dose: 1–4 mg/kg/hr.

Appendix 3: Scales to help assess distress in patients with lowered consciousness

Critical-Care Pain Observation Tool (CCPOT)

Indicator	Description	Score	
Facial expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening and levator contraction	Tense	1
	All of the above facial movements plus eyelid tightly closed	Grimacing	2
Body movements	Does not move at all (does not mean the absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs, thrashing about, not following commands, striking at staff, trying to climb out of bed	Restlessness	2
Muscle tension (evaluate by passive flexion and extension of upper extremities)	No resistance to passive movements	Relaxed	0
	Resistance to passive movements	Tense, rigid	1
	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
Compliance with the ventilator (for intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
Or			
Vocalization (for non-ventilated patients)	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2
Total possible score (range)			0–8

Note that the higher the total score, the greater the pain level.
Adapted from: Gelinas C, Fillion L, Puntillo KA, Viens C, Fortier M. Validation of the critical-care pain observation tool in adult patients. Am J Crit Care 2006; 15: 420–427 with permission from the American Association of Critical-Care Nurses.[81]

Richmond agitation sedation scale (RASS)*

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
−1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* (≥10 seconds)	Verbal stimulation
−2	Light sedation	Briefly awakens with eye contact to *voice* (<10 seconds)	Verbal stimulation
−3	Moderate sedation	Movement or eye opening to *voice* (but no eye contact)	Verbal stimulation
−4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical stimulation
−5	Unarousable	No response to *voice or physical* stimulation	Physical stimulation

Procedure for RASS assessment

1. Observe patient
   a. Patient is alert, restless, or agitated. (score 0 to +4)
2. If not alert, state patient's name and *say* to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. (score −1)
   c. Patient awakens with eye opening and eye contact, but not sustained. (score −2)
   d. Patient has any movement in response to voice but no eye contact. (score −3)
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing stemum.
   e. Patient has any movement to physical stimulation. (score −4)
   f. Patient has no response to any stimulation. (score −5)

Reproduced from Sessler CN, Gosnell MS, Grap MJ, et al. The Richmond Agitation–Sedation Scale: validity and reliability in adult intensive care unit patients. Am J Respir Crit Care Med 2002; 166: 1338–1344 with permission from the American Thoracic Society.[82]

Original Article

PALLIATIVE MEDICINE

Revised European Association for Palliative Care (EAPC) recommended framework on palliative sedation: An international Delphi study

Palliative Medicine
2024, Vol. 38(2) 213–228

DOI: 10.1177/02692163231220225
journals.sagepub.com/home/pmj

Sage

What is already known about the topic?

- The European Association for Palliative Care (EAPC) developed a framework on palliative sedation in 2009, acknowledging it as an important and ethically acceptable last resort intervention for terminally ill patients experiencing refractory symptoms.
- Over the last two decades, a number of guidelines on palliative sedation have been developed in Europe and beyond.
- The general weakness of their methodological development has been criticised and their lack of consensus on terminology and concepts make their applicability difficult.
- Some issues, such as the complexity of assessing refractory symptoms or the differentiation between somatic, psychological and existential suffering, remain under debate.

What this paper adds?

- This paper provides the first consensus-based guidance on palliative sedation structured in 42 statements and explanatory texts, for which a high or very high level of consensus has been reached among experts from 28 different countries with a broad range of professions, and a European patient organisation.
- The importance of patient autonomy is emphasised in all phases of the process (timely discussion of patient preferences, shared decision-making process, informed consent by patient/legal representative).
- The term *suffering* defined as to encompass distressing physical and psychological symptoms as well as existential suffering is used to reflect the shift towards a broader recognition of existential suffering as indication for palliative sedation.
- No specific period of remaining life expectancy has been defined for the use of palliative sedation based on the three key principles of (1) refractoriness of suffering, (2) proportionality, which has been explicitly introduced in the definition of palliative sedation and (3) independent decision-making for hydration.
- A step-by-step pharmacological approach with a detailed description of the recommended medications as well as a more detailed guidance on decision-making regarding hydration based on recent literature are provided.

Implications for practice, theory or policy

- This paper provides evidence- and consensus-based guidance for healthcare professionals involved in the care of adult patients with life-limiting disease in all settings, as well as for medical associations and health policy decision-makers.

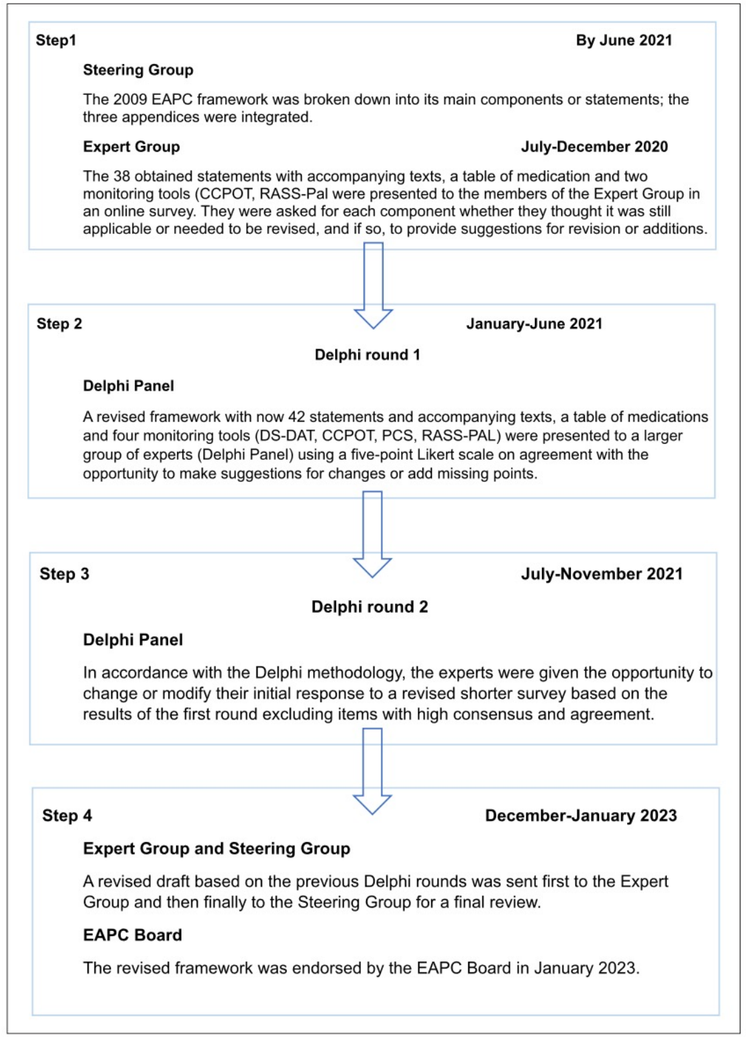


Figure 1. Steps of the Delphi procedure.

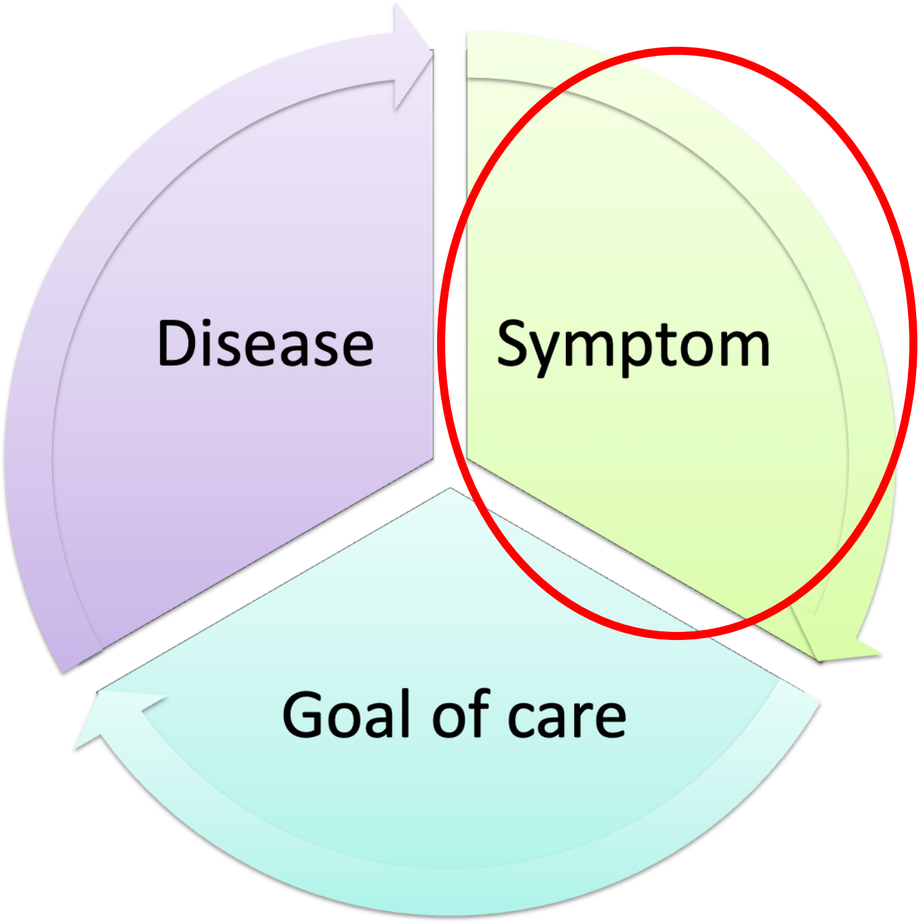
Table 2. Sociodemographic data of the Delphi panelists.

Delphi round	1 (*n* = 66)	2 (*n* = 59)
Gender		
Female	26	22
Male	40	37
Age range (years)		
31–40	6	5
41–50	12	8
51–60	25	22
61–70	21	22
>71	2	1
No answer	0	1
Profession		
Ethicist	6	6
Health caregiver	9	6
Legal expert	1	1
Physician	41	38
Psychologist/psychotherapist	2	1
Researcher	4	4
Social worker	1	1
Other	2	2
Faith		
Christian		
Greece Orthodox	3	3
Protestant	19	16
Roman Catholic	21	19
Jewish	2	1
Muslim	0	0
Not belonging to a religion	18	18
No answer	3	2
Countries		
Northern Europe: Denmark, Finland, Iceland, Norway and Sweden	9	9
Western Europe: Belgium, France, Ireland, Netherlands and United Kingdom	18	17
Central Europe: Austria, Czech Republic, Germany, Hungary, Poland and Switzerland	22	20
Eastern Europe: Romania and Ukraine	2	1
Southern Europe: Albania, Cyprus, Greece, Italy and Spain	10	10
Outside Europe: Japan, Canada and Israel	4	2
No answer	1	0

Table 5. Table of medications.

	Medication	Initial bolus	Maintenance dose
Step 1	Midazolam	Light palliative sedation 2.5 mg SC 1.25 mg IV Deep palliative sedation 5–10 mg SC 2.5–5 mg IV Bolus with half of the starting bolus dosage may be repeated after 20 min SC or 5 min IV if necessary. It is not uncommon to give two to three additional boli during the first hrs of palliative sedation.	Use 1 mg/h (SC and IV) and then adjust as needed. Dosage has to be titrated according to effect. It can be adjusted every 1–2 h as required in conjunction with another bolus. If risk factors are present (age >60 years, weight <60 kg, severe kidney or liver function disorder, very low serum albumin and/or co-medication that could exacerbate the effect of sedation): Half the initial dose, and Longer interval (6–8 h) before increasing maintenance dose. In the case of doses higher than 10 mg/h, consider adding or changing medication.
Alternative to midazolam	Lorazepam	1–3 mg SC or IV	When administered by intermittent bolus: 1–3 mg SC or IV every 2–4 h Or 1–5 mg/h SC or IV by continuous infusion
Step 2 in combination with midazolam	Levomepromazine	12.5–25 mg SC or IV	When administered by intermittent bolus: 12.5–25 mg SC or IV every 6–8 h Or 0.5–8 mg/h SC/IV by continuous infusion. After 3 days, reduce the dose of levomepromazine by half to avoid accumulation of the sedative medication. If the desired effect is not obtained, the administration of midazolam and levomepromazine should be changed to an alternative medication.
Alternative to levomepromazine	Chlorpromazine	12.5 mg in slow IV infusion over 0.5–1 h or 12.5 mg IM every 4–12 h or 3–5 mg/h IV or 25–100 mg PR every 4–12 h	Usual effective dose: Parenteral 37.5–150 mg/day, PR 75–300 mg/day.
Step 3	Propofol		Starting dose: 1 mg/kg/h IV, increase by 0.5 mg/kg/h every 30 min. Administration under the supervision of an anaesthesiologist is advisable.
Intermittent sedation	Benzodiazepines are appropriate for intermittent sedation. Midazolam should be stopped 30 min (if IV) or 2 h (if SC) before the expected awakening of the patient. To restart palliative sedation, the starting bolus and maintenance dose are those that were optimal last time.		

Specific treatment
Trajectory
Complication
Prognostigation



Specific treatment
Trajectory/function
Complication

Best & Worse case synario
Patient preference
Psycho-social-spiritual

Symptom management

- **Pain:** มีอาการปวดบริเวณก้อน 7/10 อาการปวดแสบๆจี๊ดๆตึงๆ ได้ fentanyl patch 12.5 mcg/hr ขอยาแก้ปวด mo syr (2mg/1hr) 5 ml * 4 dose ปวดมากเวลาขยับตัว กินยาน้ำเสริมอาการปวดดีขึ้น
- **Constipation:** ถ่ายอุจจาระทุกวัน แต่เป็นลักษณะขี้กระต่าย
- **Dyspnea:** ไม่มีหายใจเหนื่อย นอนหลับได้ PC management
- **No N/V/anorexia**
- ขณะนอน รพ. ผู้ป่วยได้ fentanyl patch 12.5 mcg/hr 1 patch แต่ยังมีอาการปวด ขอยาแก้ปวด mo syr (2mg/1hr) 5 ml * 4 dose >>> คำนวณขนาดยาใหม่ ได้ fentanyl 12.5+16.667 >29 mcg/hr
  - —fentanyl 25 mcg/hr 1 patch at chest wall เปลี่ยนทุก 72 hr
  - —morphine syr (2mg/1hr) 5 ml po prn q 2 hr for pain/dyspnea
  - —amitypthyline (25) 1 tab po hs (ผู้ป่วยมีอาการปวด neuropatic pain)
  - —senokot 2*2 popc (เนื่องจากผู้ป่วยทาน senokot 2 tab ยังมีอาการท้องผูก)
  - — actulosse 30 ml po prn hs for constipation

Pain management

Date	Pain score (Norciceptive,Neuropathic pain)/10	Management
18/5/67	7,7 prn 3 time/day	Off fentanyl patch 12.5 mcg/hr 1 patch >>> 25 mcg/hr 1 patch
19/4/67	7,7 prn 3 time/day	Off fentanyl patch switch to - Mo 1:1 iv rate 0.4 m//hr >>> 0.8 >>> 1.2 ml/hr - Amitriptyline 25 1x1 hs
24/4/67	7,7 prn 3 time/day	- Mo 1:1 iv rate 3ml/hr - off Amitriptyline 25 1x1 hs - Add gabapentin 300 1x1 hs
26/4/67	7,7 prn 3 time/day	- Mo 1:1 iv rate 3ml/hr - gabapentin 300 1x1 hs

Why he decided to palliative sedation?

We need to known him...

- อุปนิสัย: เป็นระเบียบรอบครอบ ใส่ใจรายละเอียด มีความหวังดีกับทุกคนรอบตัว
- จบพยาบาลทหารเรือ
- จบนิติศาสตร์ >>> เนติบัณฑิต >>> ผู้พิพากษา
- แต่งงาน กับภรรยาเป็นพยาบาล ตอนอายุ 27 ปี และช่วยภรรยาให้สามารถสอบเป็นผู้พิพากษาได้
- บุตร 2 คน บุตรชายคนโต เป็นแพทย์ใช้ทุนปี 3, บุตรสาวคนที่ 2 เป็นนักศึกษาแพทย์ชั้นปีที่ 2

Dignity life review

By ทีมดูแลใจ

Dignity life review

สิ่งที่หวัง หรือฝันว่าจะได้ทำร่วมกับคนที่ฉันรัก

- ไปเที่ยวต่างประเทศด้วยกัน

ครั้งหนึ่งในชีวิต ความภาคภูมิใจที่สำคัญ และความสำเร็จที่ฉันอยากแบ่งบัน คือ

- ขยัน มานะ อดทน เพื่อเป้าหมายสูงสุดในชีวิต คือ การสอบเป็นผู้พิพากษาได้

ฉันอยากแบ่งบันว่า ฉันสามารถผ่านสถานการณ์ที่ยากลำบากนั้นมาได้อย่างไร

- พุทธคุณเป็นเครื่องยึดเหนี่ยวจิตใจ และทุกคนในครอบครัว

Dignity life review

ช่วงวิกฤตของของชีวิตที่เกิดขึ้น ฉันอยากบอกกับครอบครัวให้รู้ว่า

- ฉันไม่อยากมีชีวิตอยู่อย่างทุกข์ทรมาน ไม่อยากเป็นภาระใคร

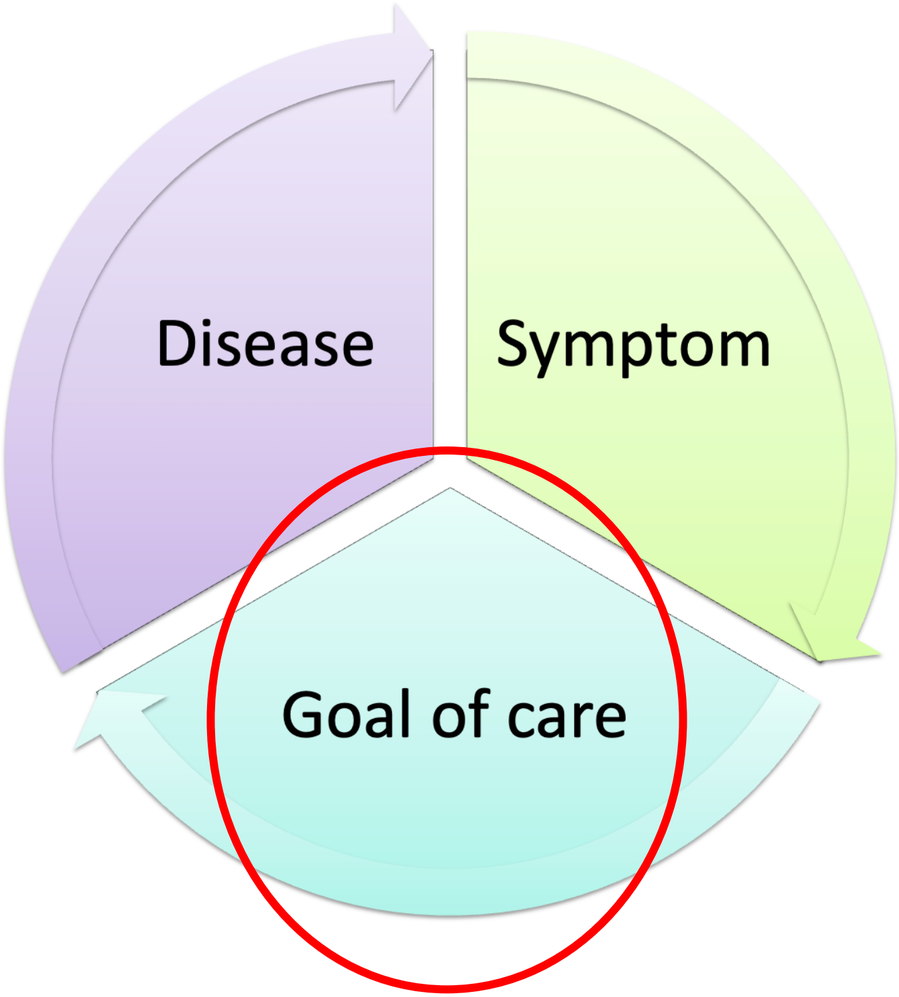
สิ่งสำคัญที่ฉันอยากบอกให้ครอบครัวได้รับรู้ และเก็บไว้ในความทรงจำ คือ

- ป๊าอยากเป็นคนตลกสนุกสนาน แต่ลูกๆ ก็ดูเครียดกับการอ่านหนังสือ อยากมีกิจกรรมที่สนุกสนานร่วมกันบ่อยๆ

เรื่องที่ทำให้ฉันมีความสุข

- ลูกชายเปลี่ยนใจอยากเรียนหมอ
- ลูกชายสอบได้ทั้งที่ศิริราช และขอนแก่น แต่กลับเลือกขอนแก่น

Specific treatment
Trajectory
Complication
Prognostigation



Specific treatment
Trajectory/function
Complication

Best & Worse case synario
Patient preference
Psycho-social-spiritual

Family meeting

Family meeting

Perception

ผู้ป่วยประครอบครัวรับทราบเรื่องการเป็นมะเร็ง ก่อนหน้านี้ 2 ปี เป็นมะเร็งที่ลิ้น รักษาด้วยการผ่าตัดและดีขึ้น 2 ปีต่อมา ตุลาคม 66 โรคกลับมาเป็นซ้ำ มีการลุกลามไปกระพุ้งแก้มด้ายซ้าย ร่วมกับมีอาการปวด ได้รับการฉายแสงครบ 35 แสง หลังจากนี้ plan ให้ CMT 6 ครั้ง ครั้งนี้มาให้เป็นครั้งแรก ผู้ป่วยคาดหวังว่าการให้ยาเคมี 6 ครั้งนี้จะช่วยทำให้ก้อนยุบลงและไม่ขยายใหญ่ขึ้น

Expectation:

ครอบครัวคาดหวังว่าอยากให้ผู้ป่วยหายขาด หรือหากไม่หายขาดก็ขอให้ดีขึ้น ไม่เจ็บไม่ปวด ผู้ป่วยเคยคุยกับครอบครัวไว้ว่าหากเจ็บป่วยหนักขอไม่ CPR แต่เรื่องรายละเอียดอื่นยังไม่เคยคิดหรือคุยกันมาก่อน

Family meeting: Topic discussion

1. Left carotid blow out: ผู้ป่วย และลูกชายรับทราบว่า สามารถทำ Embolization ได้ แต่อาจจะทำให้เกิด stroke ที่มี Hemiparesis แล้วยังผลให้เกิด Aphasia ได้ เนื่องจากเกิดทางด้านซ้าย
จึงขอเลือกไม่ทำในครั้งแรก ทาง PC จึงได้มีการปรึกษาNeurosurgeon ว่ามีทางทำอะไรเพิ่มเติมได้หรือไม่

(***ผู้ป่วยรับไม่ได้ ที่จะต้องอ่อนแรงติดเตียง พูดไม่ได้ หรือไม่มีสติรู้ตัวในสภาวะผัก)

2. Palliative sedation (PS): รับรู้ว่าทำให้หลับ ไม่รู้สึกตัว อ.จึงแจ้งเพิ่มเติมเรื่อง PS ว่ามีทั้งแบบ Partial Vs. Totally(ความตื้น/ลึกของ Conscious)/ Intermittent Vs.Continuous
แต่เราจะทำ PS ได้ ก็ต่อเมื่อเราผ่านการทำทุกอย่างมาหมดแล้ว

Family meeting: Topic discussion

2. Palliative sedation (PS): อ. อธิบายต่อว่า หน้าที่ของทีมประคับประคอง คือจัดการอาการรบกวนที่ไม่สุขสบาย จนในที่สุดอาการนั้นไม่สามารถทำอะไรได้เพิ่มเติมเราถึงจะทำ PS

(***ลูกชายแจ้งว่า: ผู้ป่วยไม่อยากเห็นสภาพตนเอง มีเลือดออกเต็มตัว ก่อนจะเสียชีวิต)

3.Invitation เรื่องสารอาหาร/น้ำ/IV (Parenteral):

หากเลือก “ไม่มี” สารน้ำ/อาหาร: - Few week (1-2-3wk)

หากเลือก “มี” สารน้ำ/อาหาร: - Few months (1-2 mo)

ลูกชายอธิบายให้ ผู้ป่วยฟังอีกทีว่า การทำ PS ไม่ได้ไปในทันที ป๊าอาจจะต้องตัดสินใจเรื่องสารน้ำ/อาหารอีกครั้งว่าจะทำยังไงต่อ

(***ลูกชาย และผู้ป่วย แจ้งว่ายังไม่เคยคุยกันเรื่องนี้ ว่าหลังจาก PS จะเกิดอะไรขึ้นต่อ)

อ. แจ้งเพิ่มเติมว่า ผู้ป่วยจะต้องเป็นผู้ตัดสินใจเอง เพราะลูกๆ และคนที่อยู่ข้างหลังจะลำบากใจที่จะต้องเป็นฝ่ายตัดสินใจ

Family meeting:

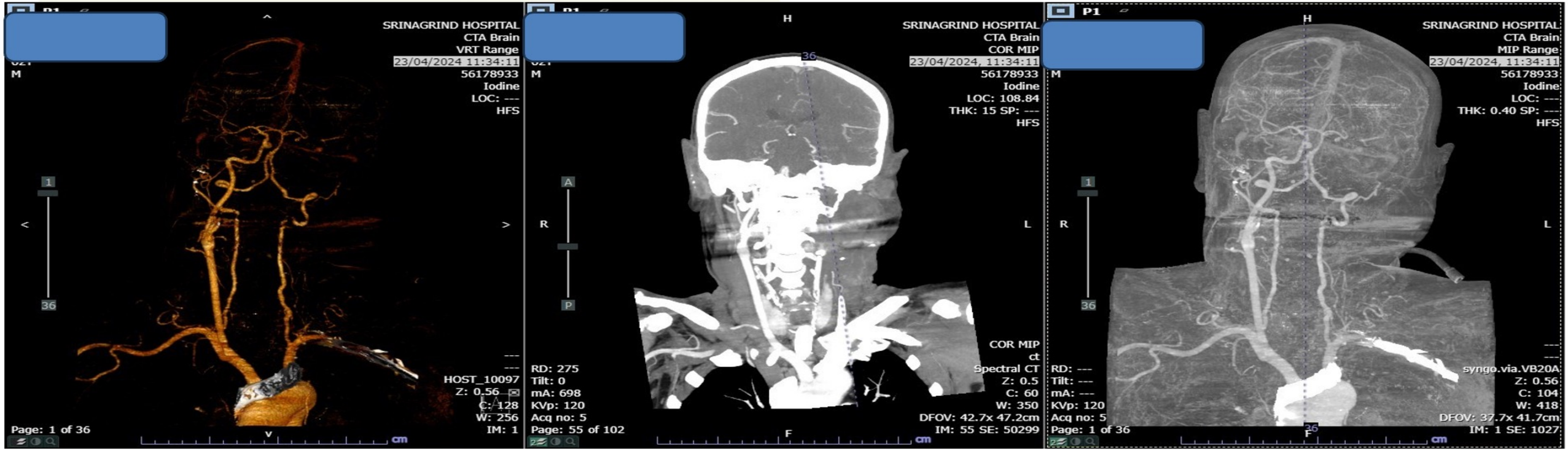
5. Packing Bleeding: anterior + posterior nasal + ในปากที่ผู้ป่วยต้องกัดไว้ตลอดเวลา

- หากเลือก “Repacking” เปลี่ยนตาม Protocol: อาจจะต้องยังอยู่ที่ ENT เนื่องจากมี Specialist + ทีม + หากเกิด Bleed ที่ไม่หยุด มีแผน PS ให้ (Suggest Dose PS at Ward ENT)

- หากเลือก “ใส่ไว้ไม่เอาออก”: ก็ต้องรับความเสี่ยงเรื่องการติดเชื้อ อาจจะปวดมากขึ้น+ PS สามารถย้ายมาที่ กว7/1 ได้

***แต่ Renotify ENT Emer ได้เสมอ หากมีการไอ/จาม หรือทำให้ guaze หลุดโดยบังเอิญ

- หากเลือก “off packing”: จะต้องเป็นการ Off ที่ ENT ก่อน เพื่อ Observe bleeding หลัง Off ว่าจะเกิดอะไรขึ้นได้บ้าง + PS + พิจารณา ย้ายกว 7/1 อีกครั้ง



IMPRESSIONS:

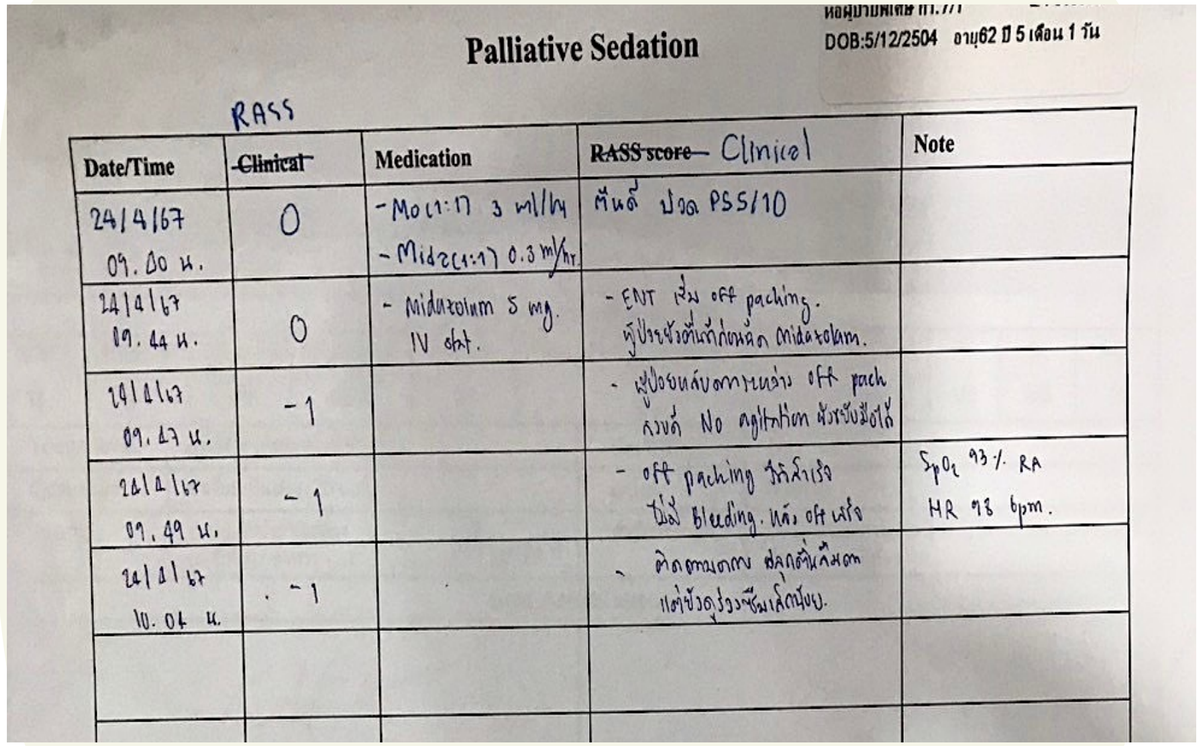
- No CTA evidence of active contrast extravasation
- Left carotid auto-sacrification from left CCA to left ICA; possibly total tumoral encasement.
- Relative decreased contrast opacification in left MCA, with collateral flow from anterior communicating artery and left PCA.
- Tumor encasement at proximal left ECA and its proximal branches
- Progression of bleeding residual tumor at left deep neck space, extending to left neck space, and invading left-sided sphenoid bone.
- Progression of metastatic lymph nodes at bilateral cervical regions
- No gross brain mass or abnormal leptomeningeal enhancement
- Lacunar infarction at left frontal lobe

Patient decided to “off packing”

During Removing Packing

- Midazolam 1mg iv stat ก่อน off packing
- ทีม ENT,PC at ENT ward
- ครอบครัวอยู่ด้วยในกระบวนการ (พร้อมสวดมนต์)

After Removing Packing



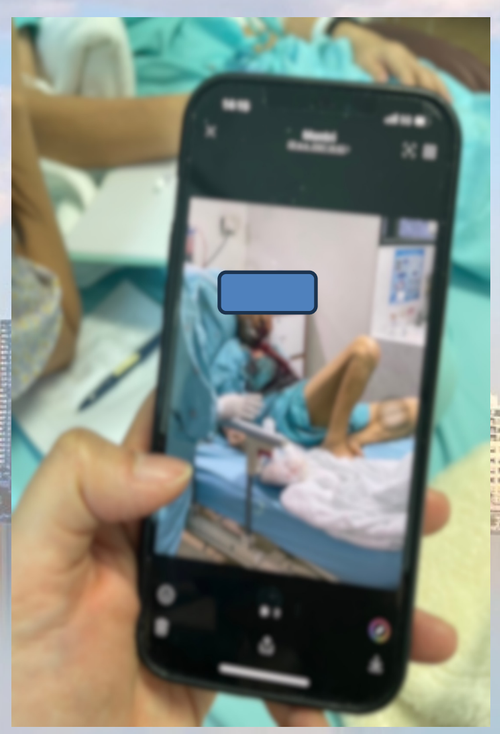
Palliative Sedation

DOB:5/12/2504 อายุ62 ปี 5 เดือน 1 วัน

RASS

Date/Time	~~Clinical~~	Medication	~~RASS score~~ Clinical	Note
24/4/67 09.00 น.	0	- Mo (1:1) 3 ml/hr - Midaz (1:1) 0.3 ml/hr	ทีมดี ปวด PSS/10	
24/4/67 09.44 น.	0	- Midazolam 5 mg. IV shot.	- ENT เริ่ม off packing. ผู้ป่วยตื่นเต็มที่ก่อนหน้า Midazolam.	
24/4/67 09.47 น.	-1		- ผู้ป่วยหลับตาระหว่าง off pack ง่วงดี No agitation ตัวแข็งมือกำ	
24/4/67 09.49 น.	-1		- off packing วิสัญญีแจ้ง ไม่มี bleeding. แห้ง off แล้ว	SpO_2 93% RA HR 98 bpm.
24/4/67 10.04 น.	-1		- ติดตามอาการ สลบตื่นดีมาก แต่ยังอยู่ในระยะเฝ้าระวัง.	

Date	Pain score (Norciceptive, Neuropathic pain)/10	Management
18/4/67 (Consult PC)	7,7 prn 3 time/day	Off fentanyl patch 12.5 mcg/hr 1 patch >>> 25 mcg/hr 1 patch
19/4/67	7,7 prn 3 time/day	Off fentanyl patch switch to - Mo 1:1 iv rate 0.4 m//hr >>> 0.8 >>> 1.2 ml/hr - Amitriptyline 25 1x1 hs
23/4/67	Family meeting	
24/4/67	7,7 prn 3 time/day	- Mo 1:1 iv rate 3ml/hr - gabapentin 300 1x1 hs
24/4/67	Removing Packing	
27/4/67	7,8 prn 3 time/day	Three day switch to methadone 20 mg/day Wean off gabapentin
8/5/67	4,4 prn 2 time/day	Discharge by improve



Thanks for Having me…

Feedback from Patient and Family

	Patient	Family
1. ในขณะที่มีเลือดออกมากมาย รู้สึกอย่างไร	ตกใจ แต่เคยทราบก่อนหน้านี้แล้วว่าหลอดเลือดจะแตก ตอนนั้นพยายามอยู่นิ่ง แต่ดูคนที่ตกใจกว่าคือ ภรรยา และคนรอบข้าง ช่วงที่เกิด Clot ก็รับทราบว่าถ้า clot หลุด เลือดก็จะไหลไม่หยุดอีก	ภรรยา: ตกใจ รู้แต่ต้องรีบมารพ. ลูกชาย: ร้องไห้ และพยายามตั้งสติ ลูกสาว: ตกใจ
2. อะไรที่ต้องทำให้นึกถึง Palliative sedation	จากที่เคยเป็นพยาบาลดมยารับรู้ว่าการดมยา จะไม่ทรมาน ไม่อยากทรมาน ไม่อยากรบกวนใคร อยากไปเกิดใหม่ในโลกแห่งความสงบ และจากที่เรียนกฎหมาย (ภรรยาก็ศึกษาเรื่องนี้ตอนเป็นผู้พิพากษา) ก็รับรู้ว่าเมืองไทยยังการุณยฆาต ไม่ได้ แต่ยังทำ Sedation ได้	ภรรยา: เห็นผู้ป่วยทรมาน ก็อยากให้หลับไม่ต้องรับรู้จะได้สงบ แล้วไปดี ลูกชาย: อยากทำให้ตามความประสงค์ของบิดา แต่ก็ยังลังเล ลูกสาว: ไม่อยากให้ผู้ป่วยเร่งตัวเอง
3.หลังจากได้รับการดูแลแบบประคับประคองในวันนั้น จนถึงวันนี้ รู้สึกอย่างไร	ก็แปลกใจที่ยังไม่ตาย ก็ต้องอยู่กันต่อไป	ภรรยา: คิดว่าปรึกษา PC ก็คงต้องตายแล้ว ตายเท่านั้น เหมือนได้ชีวิตใหม่ รู้สึกมีปาฏิหาริย์ ลูกชาย ลูกสาว: อยากให้บิดาได้รับการรักษาทางมะเร็งต่อ มีความหวังมาใหม่

Thank you for your time