

Palliative Medicine

Staab Symposium

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Disclosures

- I have no disclosures

Objectives

- Discuss role of a Palliative Care consult that may not include end of life care
- Discuss the development of a comprehensive pain management plan, including various pharmacotherapy that may or may not include opioids. Be familiar with appropriate dosing, side effects, dose titrations and rotation.
- Discuss patient's illness understanding, values and goals, and available treatment options to ensure goals are concordant with care
- Assess and address physical, psychological, social, and spiritual suffering in patients and families facing serious illness.

What is Palliative Medicine?

- Palliative Medicine is specialized medical care for people with serious illness.
- It focuses on providing relief from the symptoms and stress of a serious illness.
- The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially-trained team of doctors, nurses, social workers, chaplain, pharmacists, and other specialists who work together with a patient's doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Myths about Palliative Medicine

- It is the same as hospice
- You cannot receive aggressive treatments/therapies
- You cannot see other physicians
- Only patients can receive benefit from this care model
- Talks are negative/focus on death

Case Report

- 66 year old male with squamous cell carcinoma of the tonsil
- First treated in Oregon in 2013
- Moved to Tulsa and found to have recurrence in 2023 at HMC
- Tonsillectomy and treatment with remission attained after that

Case Report

- Admitted to Saint Francis in April 2025 for facial swelling
- Found to have recurrence again
- Bilateral modified radical neck dissection with partial mandibulectomy and free flap formations
- Trach and peg placement at same time
- T:4 (invaded mandible bilat) N:1 (1 node-level 2 on right) M:0
 - Stage IVa

Case Report

- Lost to follow up after rehab
- Significant weight loss (BMI 12.3) and failed to utilize PEG for nutrition
- Lived alone with minimal social support
- Significant debility

Case Report

- Admitted to Saint Francis Yale from 11/17/25-12/30/25
- Significant re feeding syndrome
- GI bleed with near fatal results and continued oozing for weeks after
- Improved and stabilized

Case Report

- Symptoms
 - Consulted for goals of care and significant pain
 - Oxycodone 15mg q4 utilized for pain control
 - Prior failures of gabapentin, pregabalin, and tca for neuropathic pain
 - Atropine ophthalmic 1% SL for secretion management (off-label use)
 - Anxiety and depression from family stressors and financial issues
 - Significant interpersonal issues with son

Case Report

- Plan of Care
 - Goal was for continued treatment given prior responses
 - Gain weight and increase strength
 - Education on disease and prognosis
 - ~50% 5 year prognosis¹
 - Physical stature was the biggest concern after GIB

Case Report

- Swing bed at dc given frailty and need for continued close monitoring
- Still alive but yet to follow up in cancer clinic
- Some improvement with relationship to family and support structure
- Has improved weight (BMI 14 now) and activity-ECOG 3 at time of discharge

Case Report

- Ideally needed a LCSW to help with family issues and anxiety
- More aggressive PT/OT/ST needed
- Some form of continuity once outpatient

Comprehensive Pain Assessment

- Total pain concept
 - Social
 - Emotional/Psychological
 - Spiritual
 - Physical

Pain Assessment

- Numeric Pain Rating Scale
- Visual Analog Scale
- Pain Assessment in Advanced Dementia (PAINAD)
- Wong-Baker Faces scale

Social Pain

- Fear of dependency or isolation
- Loss of dignity and self worth
- Family conflict
- LCSW plays an active role

Emotional/Psychological Pain

- Anxiety/despair over diagnosis
- Can be exacerbated by social issues
- Disengage with care team
 - Isolates from family and friends
- Interdisciplinary team meeting to help discuss care plan and disease

Spiritual Pain

- Realization life is finite
- Diagnosis can lead to feeling of abandonment
 - “Why me?”
- Chaplain, Social work, Psychology
 - Help explore what is meaningful

Spiritual Pain

- FICA
 - Faith
 - Importance/Influence
 - Community
 - Address in Care
- Do you feel at peace?²

Physical Pain

- Cancer related bone pain
- Neuropathic pain
- Somatic pain
- Visceral pain

Physical Pain

- P-palliative/provocative
- Q-Quality
- R-Radiation/region
- S-Severity
- T-Temporal factors

Cancer-Related Bone Pain

- Achy
- Destruction of sensory fibers
- Usually resistant to opioids
- Activation of osteoclasts
 - Hypercalcemia
- Worse with movement/weight bearing

Cancer-Related Bone Pain

- Acetaminophen 650mg PO q 6 hours-routine or prn-off-label
- Ibuprofen 400mg PO q 6 hours-routine or prn-off-label
- Dexamethasone 10mg x1 then 2-4mg PO daily-off-label
- Zoledronic acid 4mg IV q month
 - Pamidronate 90mg IV q month-off-label

Cancer-Related Bone Pain

- Nasal Calcitonin-off-label
- Radio nucleotides
 - Strontium-89
 - Rhenium-188
- Can take weeks for full effect, depending on isotope used

Neuropathic Pain

- Pain in neuroanatomical distribution
- History of trauma, surgery, or tumor invasion in this area
- Burning sensation, shock-like, or tingling
- May also have allodynia, hyperalgesia, or paresthesia's

Neuropathic Pain

- Gabapentin 100-300mg PO TID
- Pregabalin 50mg PO TID
- Baclofen 5-10mg PO TID/QID-off-label
- Duloxetine 20-60mg daily-off label for chemo induced neuropathy
 - Start 20-30mg then titrate up q week

Neuropathic Pain

- Lidocaine IV 2-4mg/kg IV over 30 minutes-off-label
- Topical lidocaine preparations for cutaneous/“shallow” pain
- Ketamine 0.1-1.5mg/kg/hr-off-label
- TCA
- Interventional Pain Consult

Somatic Pain

- Injury to skin, soft tissue, bones, or joints
- Localized in nature
- Achy, throbbing, stabbing, squeezing characteristics
- Wounds, arthritis, tumor invasion as examples
- OMM

Somatic Pain

- WHO steps for pain management still apply
- Start with NSAIDS
- Increase to add adjuvant therapies-often overlap of pain types
- Opioids if unable to control or starting with moderate to severe pain
 - Bowel regimen
- Goal is functional pain levels, not pain free

Visceral Pain

- Poorly localized
- Sharp, stabbing, gnawing, pressure like, or cramp
- May be in relation to oral intake
- Various causes of this pain

Visceral Pain

- Nasogastric tube if obstruction
- Colostomy/ileostomy if distal GI obstruction
- Scopolamine patch q72-off-label
- Octreotide 100mcg sq q 8 hours-off-label
- Glycopyrrolate 100-200mcg IM/IV TID/QID-off-label
 - Oral 1-2 mg BID/TID prn

“Pain Medications”

- Phenanthrenes
 - Morphine, hydrocodone, oxycodone, hydromorphone, codeine
- Phenylpiperidines
 - Meperidine, fentanyl
- Diphenylheptanes
 - Methadone

“Pain Medications”

- Mu receptor agonist & NE reuptake inhibitor
 - Tapendalol, tramadol (partial agonist)
- Agonist/Antagonist
 - Buprenorphine

Prescribing

- Pain contract still applies
- Check PDMP
- Lowest effective dose
- Remember equianalgesia dosing
- Rotate if regimen fails

Patient Focused Care

- Shared decision making
 - What is important to each patient?
 - Prolong life, quality of life, curing illness
- Open and honest
 - If incurable then need this knowledge upfront

Patient Focused Care

- Shared decision making (cont'd)
 - May change based on stage of life
 - Whose goals are being considered
 - Family may not align with patient
 - Are they achievable, realistic, or beneficial?
 - How are they measured?

Patient Focused Care

- Prognostication
 - Not a singular event
 - A continuum as disease progresses
 - Usually over estimated by clinicians
 - Bad news does not means loss of hope³

Patient Focused Care

- What are they hoping for with treatment?
 - Cure vs palliative
 - 69% of lung cancer and 81% of colorectal cancer patients couldn't state intent of treatment for late stage disease⁴
- What are current options for treatment?
 - Need to discuss with specialists

Patient Focused Care

- How to help with symptoms with treatments?
- Is there a specific goal they are seeking to achieve?
 - Wedding, birth, graduation, etc.
- What are barriers to care or QOL improvement?
- What if not seeking any treatments?

Patient Focused Care

- Seek input on treatment options
- Regular meetings depending on trajectory
 - Reassess goals
- Palliative Performance Scale

Palliative Performance Scale

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days		
						(a)	(b)	(c)
100	Full	Normal <i>No Disease</i>	Full	Normal	Full	N/A	N/A	108
90	Full	Normal <i>Some Disease</i>	Full	Normal	Full			
80	Full	Normal with Effort <i>Some Disease</i>	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job or work <i>Some Disease</i>	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework <i>Significant Disease</i>	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work <i>Extensive Disease</i>	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	6
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death	-	-	-	--			

Family and Friends

- Not just along for the ride
- Integral caregivers
 - Fatigue
- Validate concerns
- Invite to appointments

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