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Original Contributions

PALLIATIVE CARE SYMPTOM MANAGEMENT IN THE EMERGENCY DEPARTMENT: THE ABC'S OF SYMPTOM MANAGEMENT FOR THE EMERGENCY PHYSICIAN

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☐ **Abstract—Background: Palliative care is a rapidly evolving area of emergency medicine. With an estimated 5,000 to 10,000 baby boomers per day reaching retirement age, emergency departments (EDs) are treating more patients with chronic and serious disease. Palliative care offers comprehensive care for patients with advanced medical illness, aims to alleviate suffering and improve quality of life, and plays an important role in caring for these patients in the ED. Objectives: We sought to increase the emergency physician's knowledge of and comfort with symptom control in palliative and hospice patients. Discussion: Having the skills to deliver efficient and appropriate palliative and hospice care is imperative for emergency physicians. Palliative care should be considered in any patient suffering from symptoms of a life-limiting illness, whereas hospice care should be considered in the patient with likely <6 months left to live. Palliative care is appropriate earlier in the course of disease, and is appropriate when the practitioner would not be surprised if the patient died in the next 2 years ("The Surprise Question"). This article discusses management in the ED of pain, nausea, dyspnea, agitation, and oral secretions in patients appropriate for hospice and palliative care. Conclusion: The need for palliative and hospice care in the ED is increasing, requiring that emergency physicians be familiar with palliative and hospice care and competent in the delivery of rapid symptom management in patients with severe and life-limiting disease.** © 2017 Elsevier Inc. All rights reserved.

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☐ **Keywords—emergency medicine; end of life; palliative care; symptom management**

INTRODUCTION

Palliative care is a new frontier in emergency medicine (EM). Traditionally, EM focuses on acute disease-specific issues and life-sustaining treatments. However, with the aging of the American baby boomer population and increasing numbers of people seeking care for chronic conditions in the emergency department (ED), the need for palliative care in the ED is now. Medicare enrollment continues to climb; in 1966, enrollment was roughly 19.1 million, with numbers rising to 56.5 million for the fiscal year 2016 (1). These patients are more medically complex. For instance, the number of Medicare enrollees with end-stage renal disease has increased from 110,000 in 1985 to 496,900 through 2014—a 352% increase (2).

In addition to the noble goal of improving quality of life, palliative care saves money by decreasing medical costs and inpatient duration of stay while improving overall patient satisfaction. Many studies have shown that costs go down when palliative care is involved in end of life care in the ED (3,4). Given the need for emergency physicians to have basic palliative care skills, this article will review concepts in palliative care and management of pain and nonpain symptoms.

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Case 1

An 89-year-old woman with advanced dementia presents to the ED with her daughter. Her daughter tells you she is having trouble caring for her mother at home. The daughter says, "Over the past several months, Mom has seemed agitated. She argues about having to eat, is often incontinent of urine, and she wanders and yells, especially at night. I'm not sure what to do now." The patient appears agitated in the ED but has normal vital signs. After more discussion, the daughter tells you she does not have much help with her mother and has been trying to manage her mother's decline with only the assistance of the primary care doctor.

What are your next steps?

1. Admit the patient for nursing home placement
2. Discuss the benefits of palliative care and arrange an outpatient appointment
3. Check her mother's blood work and urine analysis to ensure there is no treatable underlying issue
4. Work with the daughter on a regimen of haloperidol and risperidone to alleviate her mother's agitation, and arrange for outpatient palliative care follow-up for long-term management

Case 2

A 71-year-old man with a history of congestive heart failure presents to the ED with severe shortness of breath. He has a known ejection fraction of 15%, an automated implantable cardioverter defibrillator, and is unable to ambulate at home without becoming symptomatic. He has been admitted 3 times in the past year for heart failure exacerbations and was intubated once during these admissions. His oxygen saturation is 84% on a nonrebreather mask. He is agitated. His wife states that the patient requested orders to do not resuscitate/do not intubate.

What are your next steps?

1. Explore with the patient and his wife the patient's understanding of his life expectancy and his goals of care
2. Start a morphine drip and admit the patient to an inpatient hospice unit
3. Start the patient on bilevel positive airway pressure, initiate a nitroglycerin drip, and give a low dose of morphine and lorazepam
4. Call a palliative care consult from the ED to assist with management of the patient's agitation and dyspnea

Case 3

A patient with advanced dementia presents to the ED with an exacerbation of her chronic arthritis knee pain. She is on a home regimen of sustained release oral morphine 30 mg 2 times daily, prescribed by her geriatrician. She tolerates the morphine but her son thinks it makes her sleepy. The patient does not seem distressed in the ED.

What are your next steps?

1. Increase her dose of morphine and discharge home
2. Transition her to a different opiate that she has not developed a tolerance to and discharge home
3. Continue her dose of morphine and add oxycodone for breakthrough pain and discharge home
4. Admit the patient to the hospital for pain management

BACKGROUND

Palliative care is comprehensive care for people with advanced medical illness, especially chronic and progressive, life-limiting conditions. The goal of palliative care is to prevent and relieve suffering while supporting the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. This means that patients can benefit from palliative care services even if they are actively receiving potentially curative therapies, such as chemotherapy or radiation in the case of malignancy, or are suffering an advanced chronic illness, such as heart failure or chronic obstructive pulmonary disease.

Hospice care is a subset of palliative care. Whereas both focus on symptom management, hospice care is the most appropriate service for a patient who has ≤6 months to live or who no longer desires curative treatment. In contrast, palliative care is appropriate earlier in the course of a life-limiting illness. If you as the practitioner answer affirmatively to the "surprise question"—"You would not be surprised if s/he died within the next 2 years"—then you should consider a palliative care referral. There is no limiting time frame for palliative care.

In general, patients with early hospice enrollment live longer than those without hospice (5). Although the use of hospice and other palliative care services at the end of life has increased in recent years, many patients are enrolled in hospice <3 weeks before their death, which limits the benefit they may gain from these services.

Fiscal Imperatives

Palliative care as a specialty in the ideal outpatient setting attends to the physical, spiritual, and psychosocial needs of patients at or near the end of life. Palliative care in the ED must happen in a much shorter timeframe, with the more limited goals of alleviating physical and psychological suffering to the best of our abilities, within the often chaotic, cacophony that is the ED. While doing so, we can