Palliative Care in Obstetrics and Gynecology

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Question 1:

You discussed that integrating palliative care as a routine early intervention significantly improves clinical outcomes such as quality of life and cost savings. How do you recommend oncologists broach the topic of palliative care with asymptomatic patients who are undergoing active cancer treatment? Could patients and caregivers get the impression that the provider is giving up?

Response from Dr. Lefkowits:

In my experience, which is in line with data from Schenker et al,1 while patients may not request palliative care referral, patient willingness to accept palliative care referral if the oncologist recommends it is generally high. When explaining palliative care to patients, I like using the vocabulary from the Center to Advance Palliative Care’s definition, particularly the phrase “extra layer of support.” I expect the patient described here—asymptomatic undergoing anticancer treatment—would be referred to specialty palliative care only if that oncologist’s practice was to refer all patients to specialty palliative care (or at least all patients with the example patient’s disease characteristics). In that case, I would recommend describing palliative care referral as a routine part of care. So I might say something like, “the next time you’re here to see me, I’d also like you to see our palliative care team. I routinely recommend that my patients see palliative care during their treatment to get an extra layer of support around some of the stresses and symptoms that come with cancer.”

Where I would go with the conversation from there depends on the patient response. If she and her family seem fine with the idea, then I wouldn’t necessarily elaborate further. If I sense any hesitancy, I would go...
on to ask if the patient has heard of palliative care before, or what she’s heard about palliative care. I might even bring up the idea that some patients confuse palliative care with hospice or end-of-life care and go on to explain how palliative care and hospice are different and how having her see the palliative care team will not change the oncology care that I’m providing, it will just augment it, by allowing me to focus on recommendations related to disease-directed therapy while knowing that her symptoms and support needs will be appropriately addressed. Depending on the patient, I might even mention that there are studies that suggest that integrating palliative care with routine oncology care improves quality of life and symptom management. Another strategy that some institutions use is to replace the term palliative care with supportive care. There are some data to suggest the term supportive care may be more acceptable to patients and providers and facilitate increased referrals. In my experience, if the oncologist is uncomfortable with the idea of routine palliative care referral, the patient is likely to sense that and be uncomfortable with it. If the provider believes that palliative care will help optimize the patient’s overall cancer care, recommends it in that spirit, and is willing to clarify any misconceptions the patient might harbor, then it is likely to be well received.

Question 2:

When a patient elects home hospice but requires extensive assistance with symptom management, you mentioned that hospice offers an option of “continuous home care,” defined as short-term management of acute symptoms by providing in-home nursing care for a minimum of 8 hours per 24-hour period. What is the timeframe for “continuous home care?” After this option has expired, what options do the patient and their caregivers have?

Response from Dr. Lefkowits:

As far as I know (and I phoned a hospice medical director friend to double check) there is no official limit on allowed duration of continuous home care. However, it is designed to try to maintain the patient at home during brief periods of crisis only, so it is not usually provided for more than a day or two. Additionally, just logistically, most hospice agencies would not have the resources to provide continuous home care for more than a day or two, after which either the crisis will have resolved and the patient would return to regular home hospice status, or if a high level of need persists, could be transferred to inpatient hospice.

Question 3:

In your article, you mentioned that having conversations about goals of care and advance care planning have been associated with improved clinical outcomes. When and how do you suggest having this conversation with patients?

Response from Dr. Lefkowits:

In terms of the when, I like the model being used by Atul Gawande’s group in the Serious Illness Care Program trial of using the “surprise question” as a trigger for advance care planning conversations. If the answer to the surprise question (would you be surprised if this patient died within the next year) is no, then that’s a good time to be thinking about talking about advance care planning. Branch points in care where there are decisions to be made about which path to take also present an opportunity to elicit patient goals and values to assure that the treatment plan is matched to those goals and values.

In terms of the how, I think that’s an entire skill set that needs to be explicitly taught, observed, and practiced ideally both in training and in practice. Models for teaching oncologists to have advance care planning and goals of care discussions include the Serious Illness Care Program, where oncologists in the intervention group receive dedicated training on advance care planning discussions, and the Oncotalk/VitalTalk model of teaching communication skills, including goals of care discussions, in a workshop format. The Vital Talk format uses the acronym REMAP (see http://www.vitaltalk.org/sites/default/files/quick-guides/REMAPforVitalTalkV1.0.pdf) to guide goals of care conversations that occur at branch points in care, where clinical circumstances have changed and next steps need to be planned.
**Question 4:**

It is common for patients with advanced stage gynecologic malignancies to have neuropathic pain. What are the treatment options for neuropathic pain? What are the most common side effects? Can these treatment options be combined with opioids? Could procedures such as nerve blocks be helpful?

**Response from Dr. Lefkowits:**

Opioids are first-line therapy for moderate or severe pain in patients with active cancer and can be used for neuropathic pain. The term adjuvant analgesic is often used to describe medications for which the primary marketed indication is not pain, but which can be used to treat pain. Adjuvant analgesics can be used either in conjunction with, or sometimes (particularly in patients without active cancer) in place of, opioid therapy to treat neuropathic pain.

Options for adjuvant analgesics for the pharmacologic management of neuropathic pain include gabapentin, pregabalin, serotonin and norepinephrine reuptake inhibitors (such as venlafaxine or duloxetine), and tricyclic antidepressants. All can be used in conjunction with opioids. There is also some evidence to suggest that methadone may be particularly useful in treating neuropathic pain. Side effects differ by medication. Many of these medications need to be titrated up over time (and titrated down in the case of discontinuation) and care must be taken to ensure that titration continues, as long as the patient is not having dose-limiting side effects, into a dose range that can be expected to be therapeutic. For example, in two randomized trials that showed gabapentin to be beneficial in treating cancer-related neuropathic pain, both used a gabapentin dose of 1,800 mg per day (600 mg three times a day). In my experience, gabapentin is not necessarily consistently titrated up to that range when prescribed for cancer-related neuropathic pain, in which case lack of efficacy may be related to underdosing.

Interventional procedures, including nerve blocks, also have an important role in managing cancer-related pain under certain circumstances, often in the setting of suboptimal pain control despite optimized medical management. For more comprehensive coverage of the topics of neuropathic pain and interventional pain management in oncology, the reader is directed to articles dedicated to these important topics.

**Question 5:**

For patients on chronic opioids, do you recommend starting a stool softener and laxative concurrently? When do you decide to use an osmotic laxative or stimulant laxatives? What is the role of enemas? What are side effects of long-term use of these medications?

**Response from Dr. Lefkowits:**

For patients on chronic opioids, I recommend use of a scheduled laxative regimen, titrated to the goal of a soft bowel movement every 1–2 days. I do not routinely recommend use of a stool softener, as there is evidence that the addition of stool softener to laxative does not improve efficacy. I generally start with senna 2 tabs at bedtime and titrate up or down as indicated. Other providers may start with an osmotic laxative such as lactulose or polyethylene glycol. Lactulose should be avoided in patients with lactose intolerance. I prefer starting with senna because it does not require regularly drinking the volume associated with polyethylene glycol, which can be problematic in patients with nausea or early satiety. I don’t think any one regimen for prevention is inherently superior to any other—the details of the regimen can be individualized for the patient—to maintain a soft bowel movement every 1–2 days and avoid the development of constipation. Senna and polyethylene glycol are appropriate for long-term use.

Management of existing constipation can include the agents above, in addition to other oral agents, suppositories, enemas, or opioid antagonists. The best studied opioid antagonist for managing refractory opioid-induced constipation...
constipation is methylnaltrexone, which is given subcutaneously and may be used as a rescue medication or, in certain cases, chronically.\textsuperscript{15}

Stimulant laxatives and methylnaltrexone should be avoided in the setting of bowel obstruction. Side effects vary by individual agent, but in general laxatives can cause abdominal cramps, bloating, diarrhea, or nausea. Some of these symptoms in the setting of laxative use may be related, at least in part, to the constipation itself. Excessive use can cause electrolyte imbalance. A Cochrane review of constipation management in palliative care showed no significant differences in efficacy among different laxative regimens.\textsuperscript{16}

Question 6:

You discussed various nonpharmacologic approaches for management of cancer-related symptoms such as cognitive behavioral therapy. Is there any evidence supporting acupuncture for treatment of chemotherapy-induced nausea, depression, and anxiety in patients with cancer?

Response from Dr. Lefkowits:

Several studies have been performed of acupuncture for a variety of indications in patients with cancer, with varying methodology and degrees of bias and sometimes with conflicting outcomes. A 2013 systemic review evaluated the efficacy of acupuncture for symptom management in patients with cancer and identified 41 randomized controlled trials involving eight symptoms (pain, nausea, hot flushes, fatigue, radiation-induced xerostomia, prolonged postoperative ileus, anxiety and mood disorders, and sleep disturbance).\textsuperscript{17} The authors concluded, based on one trial with low risk of bias (in a breast cancer population), that acupuncture may be an appropriate adjuvant treatment for chemotherapy-induced nausea and vomiting. For all other symptoms, efficacy was considered undetermined due to high risk of bias among studies.

Question 7:

How does perinatal palliative care differ from usual obstetric care in the scenario where a congenital anomaly incompatible with life is found and the parents decide to continue the pregnancy?

Response from Drs. Lefkowits and Solomon:

Perinatal palliative care is a developing field. It is provided in conjunction with usual obstetric care. It can take two forms, primary and secondary, provided by the obstetrician and a specialist, respectively. Secondary, or specialty, palliative care typically occurs in a consultation format and is often a group visit with a social worker and a neonatal nurse present. Depending on the specialty of the palliative care provider, for example, if trained as an obstetrician-gynecologist, he or she may ask a neonatologist to be present for the consultation. The purpose of the perinatal palliative care visit in this scenario is to 1) synthesize the information and assess for understanding regarding the neonatal condition and 2) plan for the birth of the child. Even in a condition deemed “incompatible with life,” the neonate may survive an undetermined amount of time. A recent review of 75 perinatal palliative care programs across 30 states in the United States found that topics commonly addressed in prenatal goals of care conversations, beyond decisions about whether to continue the pregnancy, included labor and delivery planning, care of the newborn after birth, postpartum care of the mother, and memory making.\textsuperscript{18}

Question 8:

Can perinatal palliative care be provided at the time of pregnancy termination? What would it entail?

Response from Drs. Lefkowits and Solomon:

Certainly. Perinatal palliative care for a patient undergoing termination may help address uncertainty regarding diagnosis, may help with decision-making surrounding the route of termination, and facilitate
referrals to grief counselors, genetic counselors, and social workers. The goal of palliative care in this circumstance would be to optimize the medical care and minimize the effects of stress, anxiety, and grief with the current pregnancy and in any subsequent pregnancies.

References