S.S. FORMAZIONE PERMANENTE E AGGIORNAMENTO

Evento Formativo Residenziale

CURE PALLIATIVE
NEI MALATI ONCOLOGICI

DATE

Ediz.1: 19 giugno 2018

ORARIO

Dalle ore 9.30 alle ore 16.30

SEDE

Aula Dipartimento
Rete Oncologica, Torino

ECM REGIONE PIEMONTE

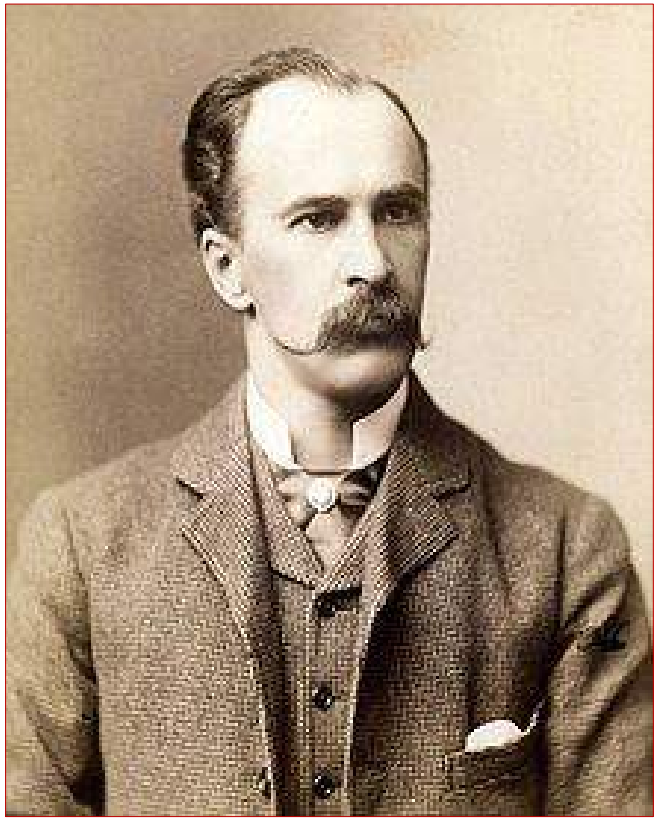
CODICE: 30044 - Crediti: 7

Il trattamento dei sintomi a domicilio

Alessandro Valle
Torino

FONDAZIONE FARO

TÜV SÜD ISO 9001 Sistema di gestione certificato UNI EN ISO 9001:2008 certificato nr. 50 100 13151



E’ più importante sapere che tipo di persona ha una malattia, piuttosto che sapere che tipo di malattia ha una persona

Sir William Osler (1849-1919)

Problematiche ambientali e organizzative delle Cure Palliative domiciliari

- **Aumento dell'età media della popolazione (e quindi anche del caregiver)**
- **Fragilità familiare nella società moderna**
- **Difficoltà ad accettare la situazione ed oppiofobia**
- **Impiego di assistenti familiari stranieri con possibili difficoltà linguistiche**
- **Narrazione delle problematiche sintomatologiche a cura del caregiver o dell'assistente familiare (se paziente con deterioramento cognitivo)**
- **Procedure assistenziali non specialistiche affidate al caregiver**
- **Personale di assistenza non presente fisicamente 24h/24h (a differenza delle strutture residenziali)**

Dalla teoria….

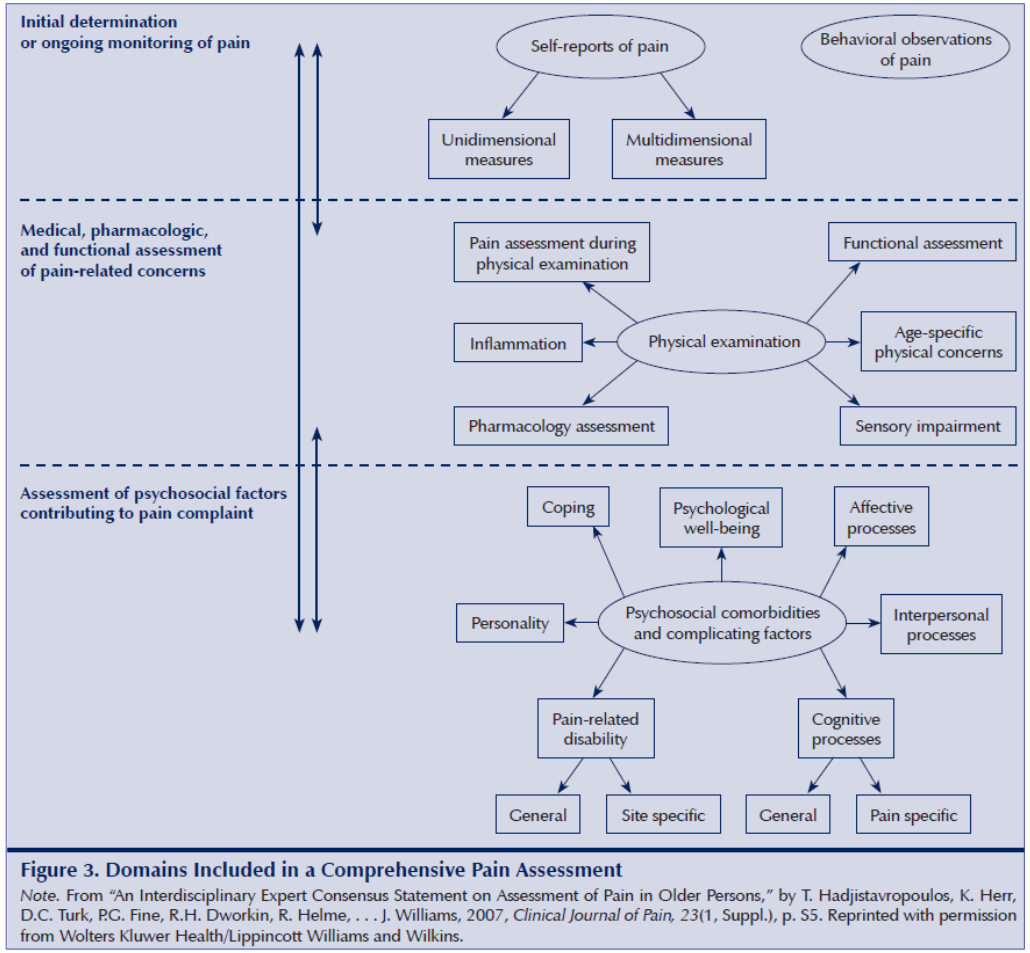
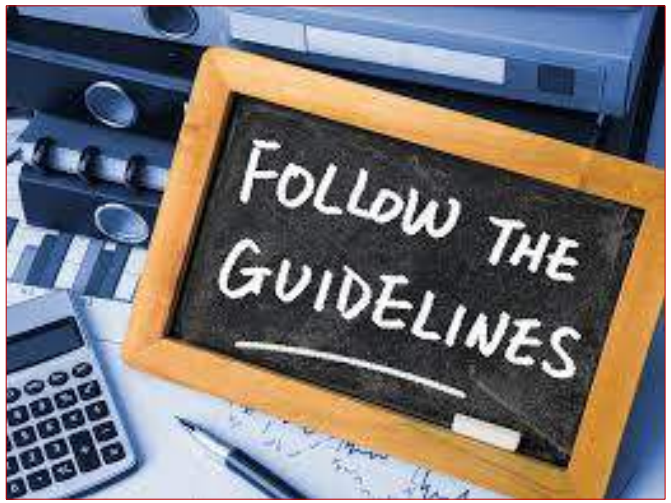


Figure 3. Domains Included in a Comprehensive Pain Assessment

Note. From "An Interdisciplinary Expert Consensus Statement on Assessment of Pain in Older Persons," by T. Hadjistavropoulos, K. Herr, D.C. Turk, P.G. Fine, R.H. Dworkin, R. Helme, . . . J. Williams, 2007, *Clinical Journal of Pain, 23*(1, Suppl.), p. S5. Reprinted with permission from Wolters Kluwer Health/Lippincott Williams and Wilkins.

Alla pratica «domiciliare»…


FOLLOW THE
GUIDELINES

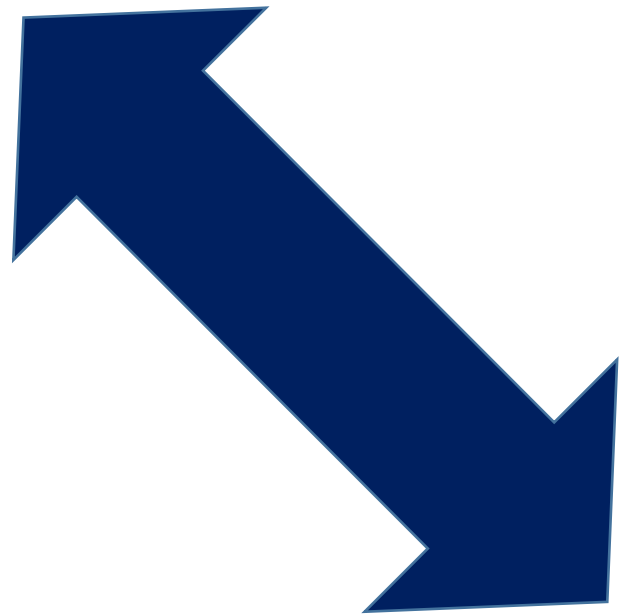


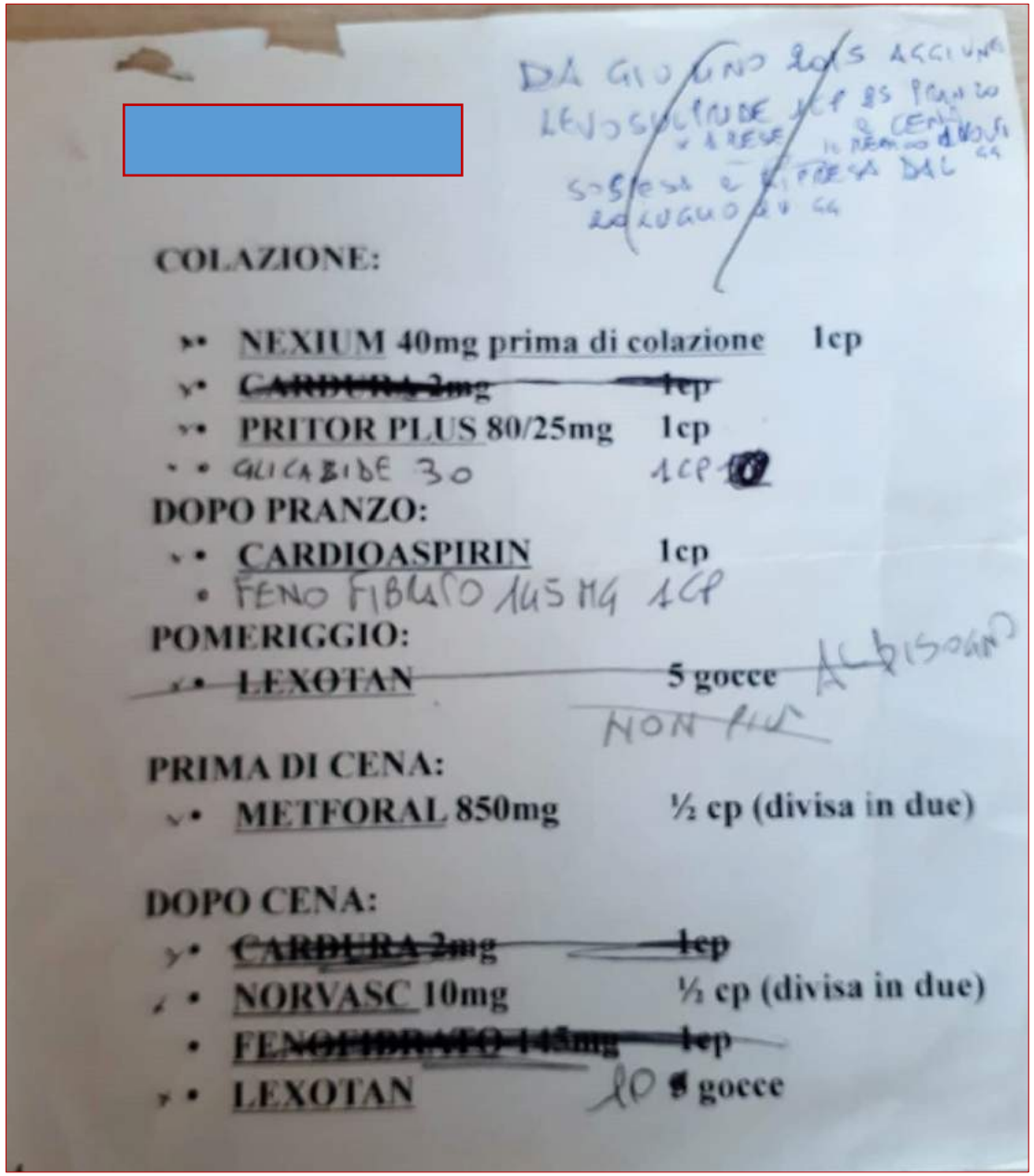
Table 2
Symptom prevalence in descending order at T1, with number and percentages of patients experiencing a symptom, symptom scores and scores for frequency, severity and distress.

Symptom	No. of patients with symptom $N = 103$[a]	% of patients with symptom	Symp. score (0–4)	Freq. score (1–4)	Severity score (1–4)	Distress score (0–4)
Lack of energy[b]	82	80.4%	2.81	3.13	2.74	2.60
Feeling drowsy[b]	79	77.5%	2.51	2.96	2.58	1.96
Worrying	75	72.8%	2.39	2.55	2.43	2.18
Pain[b]	72	71.3%	2.98	3.12	2.96	2.98
Dry mouth[b]	65	65.0%	2.38	2.66	2.44	2.03
Lack of appetite	63	61.8%	2.58	3.06	2.73	1.90
Difficulty sleeping	54	52.9%	2.67	2.85	2.74	2.44
Feeling sad	51	51.0%	2.19	2.20	2.42	2.00
Weight loss[b]	49	48.0%	1.93	n. a.	2.35	1.53
Difficulty concentrating	48	47.1%	2.09	2.25	2.06	1.98
Feeling nervous	48	47.1%	2.19	2.38	2.19	2.06
Shortness of breath	46	44.7%	2.60	2.76	2.64	2.42
Sweats	45	43.7%	2.12	2.27	2.32	1.78
Nausea	43	42.2%	2.19	2.33	2.28	1.98
Constipation	43	42.2%	2.33	n. a.	2.52	2.19
"I don't look like myself"[b]	41	40.6%	1.92	n. a.	2.25	1.57
Cough	40	39.2%	2.10	2.33	2.13	1.89
Feeling bloated	40	39.2%	2.57	2.75	2.60	2.35
Dizziness[b]	38	37.3%	2.23	2.39	2.34	1.95
Change in the way food tastes	36	35.3%	2.39	n. a.	2.58	2.19
Numbness/tingling in hands/feet[b]	33	32.4%	2.20	2.58	2.19	1.84
Feeling irritable	33	32.7%	2.14	2.39	2.05	2.03
Swelling of arms or legs	31	30.1%	2.26	n. a.	2.53	1.92
Diarrhea	30	29.4%	2.27	2.43	2.39	2.14
Problems with urination	25	24.5%	2.24	2.36	2.28	2.08
Vomiting	25	24.5%	1.89	1.84	2.04	1.80
Mouth sores	25	24.3%	2.04	n. a.	2.12	1.96
Itching	24	23.3%	1.73	2.04	1.87	1.37
Difficulty swallowing	22	21.6%	2.45	2.86	2.32	2.18
Changes in skin	19	18.8%	2.01	n. a.	2.24	1.83
Hair loss	17	17.0%	2.10	n. a.	2.59	1.62

Abbreviations: Symp., symptoms; Freq., frequency; n. a., not applicable.
[a] For single symptoms, data from 100 to 103 patients were available due to missing values.
[b] For these symptoms, some correlations of frequency, severity and distress scores were >0.5, for dry mouth and feeling drowsy >0.4, while correlations for all other symptoms were >0.6.

Coniugare semplicità ed appropriatezza diagnostica e terapeutica

Magari non così …



COLAZIONE:

- NEXIUM 40mg prima di colazione 1cp
- ~~CARDURA 2mg 1cp~~
- PRITOR PLUS 80/25mg 1cp
- GLICABIDE 30 1 CP

DOPO PRANZO:

- CARDIOASPIRIN 1cp
- FENO FIBRATO 145 MG 1 CP

POMERIGGIO:

- ~~LEXOTAN 5 gocce~~ AL BISOGNO

NON PIU'

PRIMA DI CENA:

- METFORAL 850mg ½ cp (divisa in due)

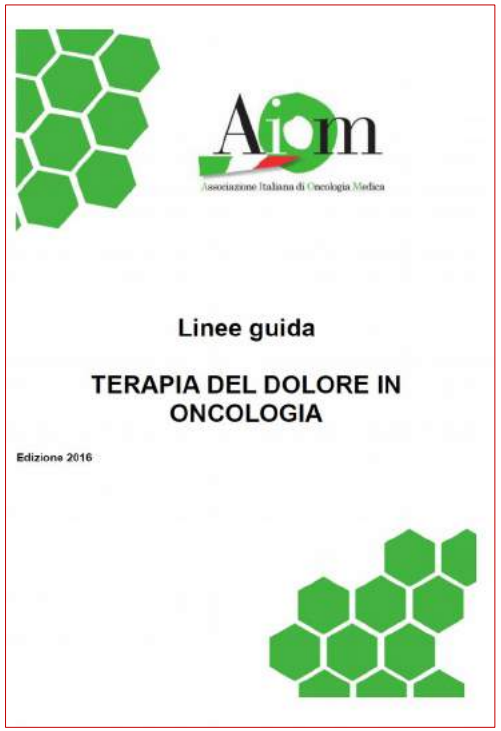
DOPO CENA:

- ~~CARDURA 2mg 1cp~~
- NORVASC 10mg ½ cp (divisa in due)
- ~~FENOFIBRATO 145mg 1cp~~
- LEXOTAN 10 gocce

Garantire il tempo necessario per la relazione con la famiglia

Partendo dall’assessment….

Dolore oncologico



Qualità dell'evidenza SIGN	Raccomandazione clinica R1	Forza della raccomandazione clinica
D	Per un'adeguata gestione del dolore da cancro si raccomanda la misurazione dell'intensità, delle eventuali esacerbazioni del dolore e del sollievo dato dalle terapie riferiti alle 24 ore precedenti; la valutazione di altri aspetti deve essere introdotta senza creare disagio al paziente. (4)	**Positiva forte**

Qualità dell'evidenza SIGN	Raccomandazione clinica R2	Forza della raccomandazione clinica
D	Per la misurazione dell'intensità dolore oncologico si raccomanda l'uso della scala numerica a 11 livelli (0= nessun dolore, 10 peggior dolore immaginabile); in pazienti con disfunzioni cognitive si consiglia l'uso della scala verbale a 6 livelli (Nessun dolore, dolore molto lieve, dolore lieve, dolore moderato, dolore forte, dolore molto forte). (2)	**Positiva forte**

Qualità dell'evidenza SIGN	Raccomandazione clinica R3	Forza della raccomandazione clinica
D	Per la valutazione delle esacerbazioni si raccomanda di misurare la presenza di picchi di dolore più intenso nelle 24 ore precedenti la rilevazione. In caso di risposta affermativa, approfondire la valutazione al fine di arrivare ad una diagnosi di presenza o assenza di dolore episodico intenso secondo una definizione prestabilita. (4)	**Positiva forte**

Qualità dell'evidenza SIGN	Raccomandazione clinica R4	Forza della raccomandazione clinica
D*	Per la valutazione del sollievo dal dolore dato dai trattamenti si raccomanda l'uso di una scala specifica che rileva l'entità del sollievo nelle 24 ore precedenti la rilevazione; al fine di evitare confusione per il paziente, se l'intensità del dolore è stata rilevata con una scala numerica, per il sollievo si raccomanda di utilizzare una scala di valutazione verbale (nessun sollievo, sollievo leggero, sollievo moderato, sollievo elevato, sollievo completo).	**Positiva forte**

Dolore oncologico

Journal of medical ethics, 1978, **4**, 112–116

The assessment of pain in advanced cancer

Robert G Twycross *The Churchill Hospital, Headington, Oxford*

Table 1 *The* PQRST *characteristics of pain*[1]

'Tell me about your pain.'
'Where is it?'

P alliative / *P* rovocative factors	'What makes it less intense?' / 'What makes it worse?'
Q uality	'What's it like?'
R adiation	'Does it spread anywhere else?'
S everity	'How severe is it?'
T emporal factors	'Is it there all the time, or does it come and go?'

[1]Gray, J (1977). A pain in the neck – and shoulder. *Pain Topics*, **1**, No. 3, 6.

Dolore oncologico

Vol. 23 No. 1 January 2002 Journal of Pain and Symptom Management 31

Original Article

Factors Associated with the Accuracy of Family Caregiver Estimates of Patient Pain

Ellen M. Redinbaugh, PhD, Andrew Baum, PhD, Carol DeMoss, RN, MSN, Maryann Fello, RN, MEd, and Robert Arnold, MD
University of Pittsburgh Cancer Institute (E.M.R., A.B.), University of Pittsburgh Medical Center Hospice Home Care (C.D.), Forbes Family Hospice (M.F.), and University of Pittsburgh School of Medicine (R.A.), Pittsburgh, Pennsylvania, USA

Higher caregiver pain ratings were related to poorer patient existential QOL, greater patient ADL care needs, greater caregiver distress, and greater caregiver burden.

Table 2
Descriptive Statistics for Measured Variables ($n = 31$)

Variable Name	Mean (SD)	Range
Patient Pain Rating	3.4 (2.9)	0–9
Caregiver Rating of Patient Pain	6.1 (3.4)	0–10

A paired *t*-test compared patient ratings to caregiver ratings and indicated that caregivers' estimates were significantly higher than patients' pain ratings ($t = -4.9$, $P < 0.01$). These findings are consistent with previous studies that found that family members overestimate patient pain.[6–9]

Dolore oncologico

70 Journal of Pain and Symptom Management Vol. 35 No. 1 January 2008

Original Article

Family Caregivers' Assessment of Symptoms in Patients with Advanced Cancer: Concordance with Patients and Factors Affecting Accuracy

Christine J. McPherson, RN, PhD, Keith G. Wilson, PhD, CPsych, Michelle M. Lobchuk, RN, PhD, and Susan Brajtman, RN, PhD
School of Nursing (C.J.M., S.B.), Faculty of Health Sciences, University of Ottawa, Ottawa; Institute for Rehabilitation Research and Development (K.G.W.), The Rehabilitation Centre, The Ottawa Hospital, Ottawa; and Faculty of Nursing (M.M.L.), University of Manitoba, Winnipeg, Canada

Agreement Between Patients and Family Caregivers on Symptoms at the Individual Level

	Patient	Family Caregiver	Agreement
	Mean (SD)		ICC[c]
Pain			
Frequency	1.94 (1.55)	2.12 (1.37)	0.44
Severity	1.36 (1.09)	1.80 (1.17)	0.42
Distress	1.77 (1.41)	2.04 (1.37)	0.36
Total	1.69 (1.28)	1.94 (1.21)	0.44

<u>Caregiver:</u> fattori influenzanti negativamente la concordanza con quanto riferito dall'ammalato:

- **Umore (depresso)**
- **Genere (maschile)**
- **«Burden» assistenziale**

Dolore oncologico

1. ‘By mouth’ – oral forms of analgesics is preferred wherever possible
2. ‘By the clock’ – analgesic should be given at regular intervals rather than on demand.
3. ‘By the ladder’ – The principles of the ladder should be adhered to.
4. ‘For the individual’ – there is no standardised dosage and therapy and should be based around the level of the patient’s reported pain.
5. ‘Attention to detail’ – refers to the close monitoring of the patient’s pain as well as the biopsychosocial factors that may be impacting upon their pain.

Quando la via orale è utilizzabile, è preferibile a elastomeri e syringe driver (ed è anche meno costosa….)

Dolore oncologico

TITOLAZIONE DEGLI OPPIACEI

R11. Le formulazioni orali di morfina, ossicodone, idromorfone a immediato e a lento rilascio possono essere utilizzate per la titolazione della dose. Gli schemi di titolazione per entrambi i tipi di formulazione dovrebbero essere integrati con oppioidi orali a rilascio immediato somministrati al bisogno.

RACCOMANDAZIONE POSITIVA DEBOLE

R12. La via sottocutanea è semplice ed efficace per la somministrazione di morfina e dovrebbe essere la prima scelta di via alternativa per pazienti che non possono ricevere oppioidi per via orale o transdermica; l'infusione endovenosa deve essere considerata quando l'infusione sottocutanea è controindicata (ad esempio, a causa di edema periferico, disturbi della coagulazione, deficit della circolazione periferica, esigenza di elevati volumi e dosi, ecc); la somministrazione endovenosa deve essere usata per la titolazione degli oppioidi, quando è richiesto un rapido controllo del dolore.

RACCOMANDAZIONE POSITIVA FORTE


Review

Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC

TITOLAZIONE DEGLI OPPIACEI

Recommendation for opioid titration

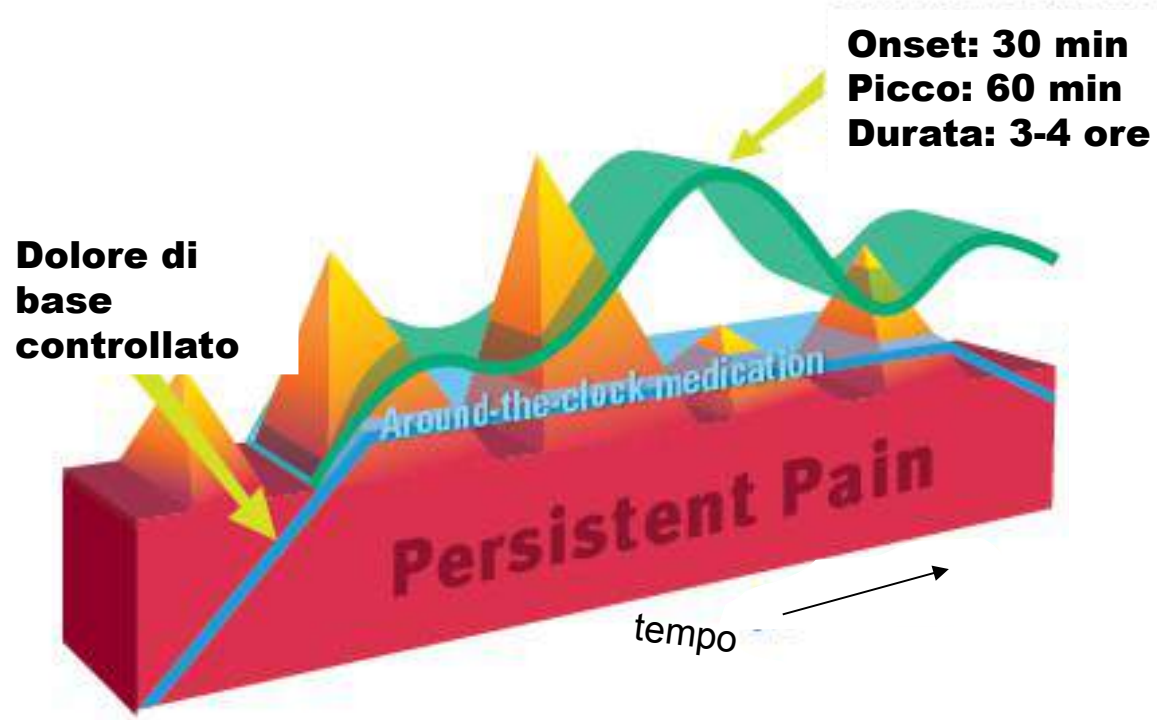
The data permit a weak recommendation that immediate-release and slow-release oral formulations of morphine, oxycodone, and hydromorphone can be used for dose titration. The titration schedules for both types of formulation should be supplemented with oral immediate-release opioids given as needed.

IL BREAKTHROUGH CANCER PAIN (BTcP)

An episode of severe pain intensity in patients receiving an adequate treatment with opioids that are able to provide at least mild background analgesia

TRATTAMENTO DEL BTcP: I SAO

"La farmacocinetica e la farmacodinamica degli oppioidi per via orale non rispecchiano il profilo temporale della maggior parte degli episodi di BTcP, ovvero una rapida insorgenza (pochi minuti) e una breve durata (30-60 minuti)"



Mercadante S et al. RiCP. 2010

TRATTAMENTO DEL BTcP: LA MORFINA ENDOVENOSA

- **Inizio d'azione rapidissimo, pochi minuti (anche se, essendo idrofila, attraversa la barriera ematoencefalica meno rapidamente del fentanyl, lipofilo)**

- **Però, analogamente alla morfina solfato a rapido rilascio, la farmacocinetica della morfina endovenosa, soprattutto per l'emivita (circa 4 ore), può non rispecchiare il profilo temporale della maggior parte degli episodi di BTcP**

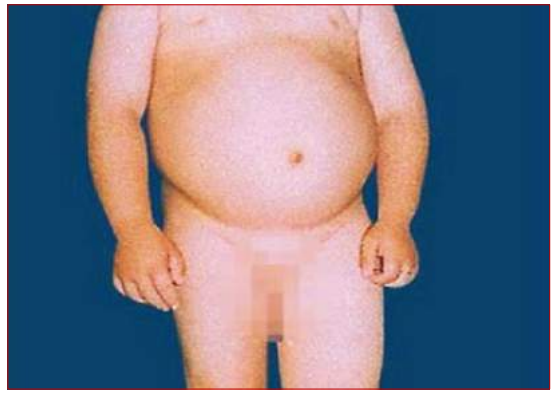
- **Inoltre, la morfina endovenosa può essere poco maneggevole in un setting domiciliare, ove dovrebbero (vorrebbero …) essere assistiti la maggior parte dei pazienti oncologici in fase avanzata di malattia**

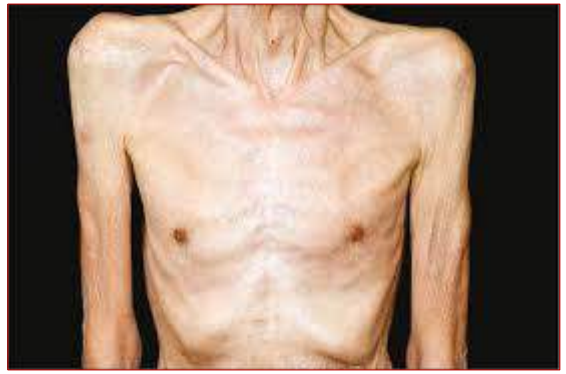
Davies AN et al. Eur J Pain. 2009

TRATTAMENTO DEL BTcP: LA MORFINA SOTTOCUTANEA

Onset intermedio tra morfina solfato a rapido rilascio e morfina endovenosa (ma attenzione al paziente gravemente cachettico, gravemente ipoteso o in stato anasarcatico)

Resta invariato il problema dell'emivita troppo lunga…





IL FARMACO IDEALE PER IL BTcP

- Efficace
- Inizio d'azione rapido
- Durata d'azione relativamente breve
- Ben tollerato
- Pratico da usare

Vol. 35 No. 5 May 2008 Journal of Pain and Symptom Management 563

Clinical Note

Opioids for Cancer Breakthrough Pain:
A Pilot Study Reporting Patient Assessment
of Time to Meaningful Pain Relief

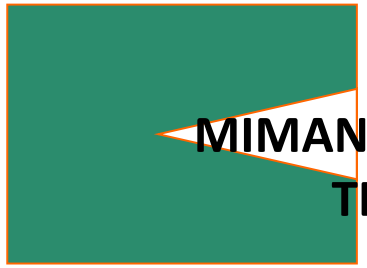
Giovambattista Zeppetella, FRCP
St. Clare Hospice, Hastingwood; and Princess Alexandra NHS Trust, Harlow, United Kingdom

Zeppetella G. J Pain Symptom Manage. 2008

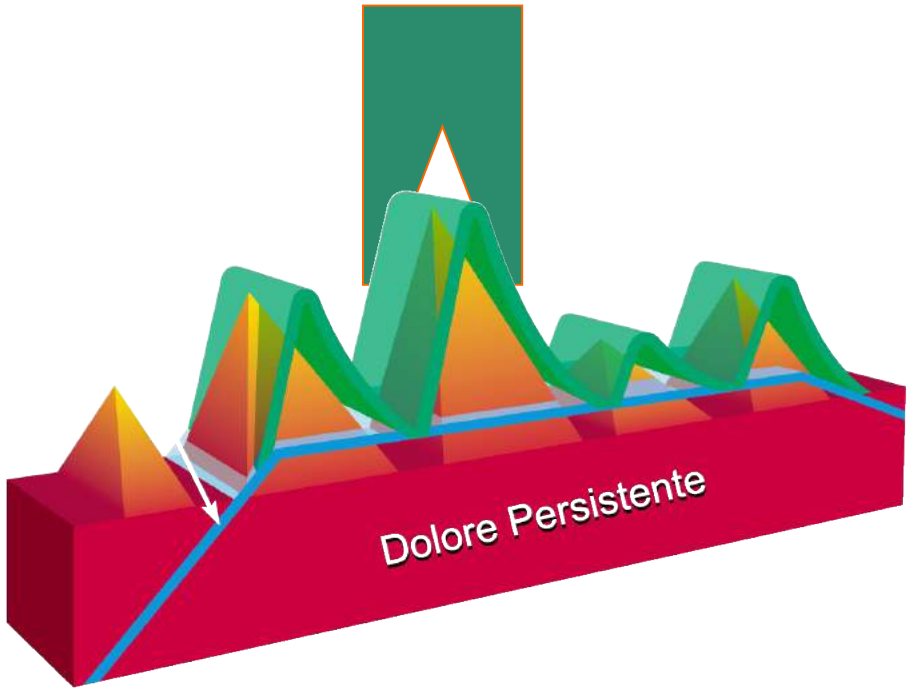
TRATTAMENTO DEL BTcP: I ROOs

ROOs (Rapid Onset Opioids)

- Rapido inizio d'azione
- Buona efficacia
- Durata dell'effetto analgesico paragonabile a quello del BTcP
- Praticità d'uso



MIMANO L'ANDAMENTO NEL TEMPO DEL BTcP



"Indeed the studies identified in this review suggest that fentanyl can be used successfully in patients using a variety of oral ATC opioids including morphine, oxycodone, hydromorphone, and methadone"

Zeppetella G. Palliat Med. 2011

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP

European Journal of Pain 13 (2009) 331–338

Contents lists available at ScienceDirect

European Journal of Pain

journal homepage: www.EuropeanJournalPain.com

ELSEVIER

Review

The management of cancer-related breakthrough pain: Recommendations of a task group of the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland

Andrew N. Davies [a,*], Andrew Dickman [b], Colette Reid [c], Anna-Marie Stevens [d], Giovambattista Zeppetella [e]

[a] Royal Marsden NHS Foundation Trust, Department of Palliative Medicine, Downs Road, Sutton SM2 5PT, United Kingdom
[b] Marie Curie Palliative Care Institute, Liverpool, United Kingdom
[c] Gloucestershire Hospitals NHS Trust, United Kingdom
[d] Royal Marsden NHS Foundation Trust, London, United Kingdom
[e] St. Clare Hospice, Hastingwood, United Kingdom

Linee guida Association for Palliative Medicine of Great Britain and Ireland. *2009*

Oral opioids are not the optimal rescue medication for most breakthrough pain episodes

A variety of commercial buccal, sub-lingual, nasal and pulmonary opioid preparations are currently under development. <u>It is likely that these new products will offer significant advantages over the current products</u>

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP

clinical practice guidelines

Annals of Oncology 23 (Supplement 7): vii139–vii154, 2012
doi:10.1093/annonc/mds233

Management of cancer pain: ESMO Clinical Practice Guidelines†

C. I. Ripamonti[1], D. Santini[2], E. Maranzano[3], M. Berti[4] & F. Roila[5], on behalf of the ESMO Guidelines Working Group*

[1]*Supportive Care in Cancer Unit, Fondazione IRCCS, Istituto Nazionale Tumori, Milan, Italy;* [2]*Oncologia Medica, Università Campus Bio-Medico, Rome, Italy;* [3]*Department of Oncology, Radiation Oncology Centre, S. Maria Hospital, Terni, Italy;* [4]*Anaesthesiology Intensive Care and Pain Therapy, University Hospital Parma, Parma, Italy;* [5]*Department of Medical Oncology, S. Maria Hospital, Terni, Italy*

Linee guida ESMO. *2012*

RECOMMENDATIONS

Intravenous opioids; buccal, sublingual and intranasal fentanyl drug delivery have a shorter onset of analgesic activity in treating BTP episodes in respect to oral morphine [I, A]

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP

Review

Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC

Augusto Caraceni*, Geoffrey Hanks*, Stein Kaasa*, Michael I Bennett, Cinzia Brunelli, Nathan Cherny, Ola Dale, Franco De Conno, Marie Fallon, Magdi Hanna, Dagny Faksvåg Haugen, Gitte Juhl, Samuel King, Pål Klepstad, Elvar A Laugsand, Marco Maltoni, Sebastiano Mercadante, Maria Nabal, Alessandra Pigni, Lukas Radbruch, Colette Reid, Per Sjogren, Patrick C Stone, Davide Tassinari, Giovambattista Zeppetella, for the European Palliative Care Research Collaborative (EPCRC), on behalf of the European Association for Palliative Care (EAPC)

Here we provide the updated version of the guidelines of the European Association for Palliative Care (EAPC) on the use of opioids for the treatment of cancer pain. The update was undertaken by the European Palliative Care Research Collaborative. Previous EAPC guidelines were reviewed and compared with other currently available guidelines, and consensus recommendations were created by formal international expert panel. The content of the guidelines was defined according to several topics, each of which was assigned to collaborators who developed systematic literature reviews with a common methodology. The recommendations were developed by a writing committee that combined the evidence derived from the systematic reviews with the panellists' evaluations in a co-authored process, and were endorsed by the EAPC Board of Directors. The guidelines are presented as a list of 16 evidence-based recommendations developed according to the Grading of Recommendations Assessment, Development and Evaluation system.

Introduction

Moderate to severe pain in cancer is common and affects 70–80% of patients with advanced disease. We have the means and the knowledge to relieve most pain in cancer for most patients,[1] but evidence from surveys and observational studies shows that many patients have troublesome or severe pain and do not get adequate relief.[2]

The skilled use of opioid analgesics is crucial to the relief of cancer pain, but there is a shocking lack of evidence to support clinical practice. The so-called analgesic ladder is the central idea of the WHO 1996 guidelines on cancer pain relief,[3] in which the choice of analgesic is determined by the severity of the pain. The WHO method has been adopted worldwide but the lack of up-to-date evidence, knowledge, and opioid availability have obstructed the path to effective relief of cancer pain.[3,4]

Randomised controlled trials (RCTs) in patients with cancer pain are beset by difficulties.[5] In the absence of hard evidence from RCTs, expert consensus and clinical guidelines might be helpful, because cancer pain relief is a specialist area but most care is delivered by non-specialist practitioners. The European Association for Palliative Care (EAPC) research network published its first guidelines on the use of morphine and alternative opioids in cancer pain in 1996,[6] and published an update in 2001.[7] In this Review we present further work done to strengthen the scope of the EAPC recommendations by the application of rigorous, evidence-based methodology.

Development of recommendations

A comprehensive list of relevant topics on opioid use for cancer pain was derived from a comparison of the previous EAPC recommendations with other available guidelines on cancer pain relief. This list was submitted to a formalised expert consensus process that led to 30 practical clinical questions being summarised in 22 topics.[8,9] The subsequent guidelines development process followed the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[10,11]

Each of the 22 topics was assigned to a group of collaborators who did a systematic review according to a standardised method (appendix). The results were presented at the Fifth Bristol Opioids Conference, Bristol, UK, Feb 8–9, 2010. 19 reviews have since been published.[12–31] Within each topic the evidence profile for each relevant outcome was determined and this formed the basis for a final recommendation.

In the review of opioids in liver failure[32] and on the use of opioid combinations,[33] evidence did not reach sufficient quality to support a recommendation and, therefore, these areas were not included in this guideline. Our literature review on the treatment of opioid-related constipation completely overlapped with a Cochrane review[34] and it was not submitted for publication. Finally one topic on the role of ketamine was not included because of the lack of resources to complete the work. Thus, 16 recommendations have been included in this summary paper by the writing committee, on the basis of the evidence profiles, modified to take into account individual judgments and evaluations. They have been circulated to the Scientific Advisory Board of the European Palliative Care Research Collaborative, the Board of Directors of the EAPC and to each collaborator for comment and modification as necessary. With this feedback the recommendations were revised by the writing committee and circulated to the whole group once more for comment and final approval.

In this paper and associated publications we have adopted the terms step II opioids and step III opioids to differentiate between low-potency drugs, such as codeine and tramadol, and higher-potency drugs, of which morphine is the prototype. This terminology relates directly to the WHO cancer pain relief ladder and is widely understood.

www.thelancet.com/oncology Vol 13 February 2012

Lancet Oncol 2012; 13: e58–68

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USE OF OPIOIDS ANALGESICS IN THE TREATMENT OF CANCER PAIN: EVIDENCE-BASED RECOMMENDATIONS FROM THE EAPC. *2012*

Recommendation for opioids for breakthrough pain
Breakthrough pain (eg, incident pain) can be effectively managed with oral, immediate-release opioids or with buccal or intranasal fentanyl preparations. In some cases the buccal or intranasal fentanyl preparations are preferable to immediate-release oral opioids because of more rapid onset of action and shorter duration of effect.

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP

La Rivista Italiana di Cure Palliative

Articoli

Raccomandazioni per la gestione del Breakthrough cancer Pain (BTcP)

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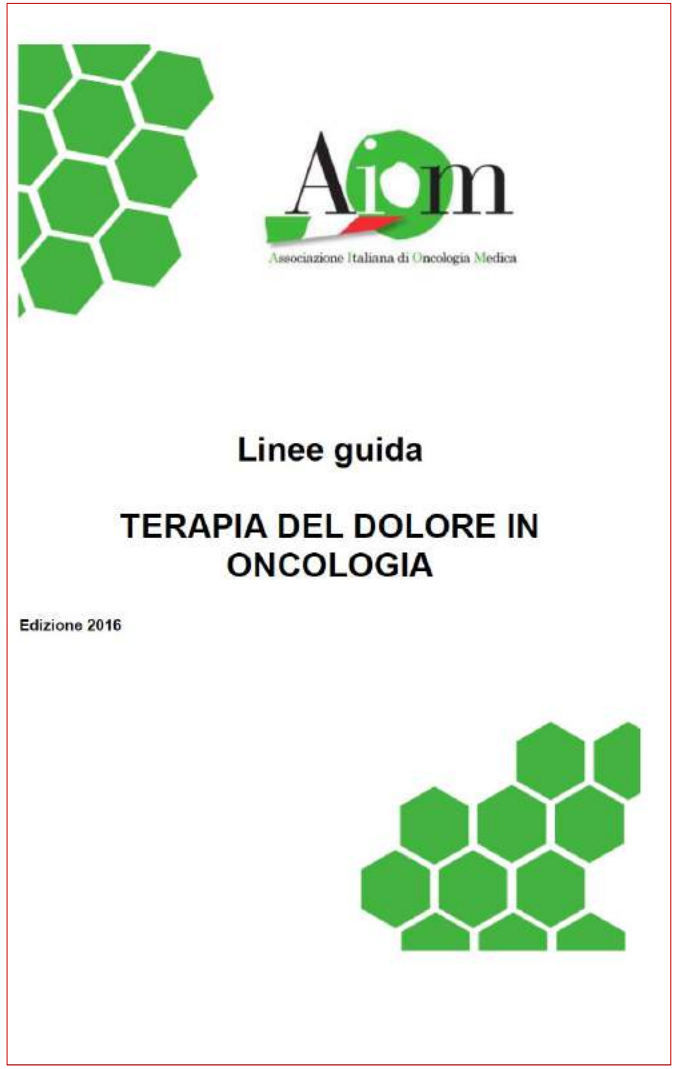
Responsabile Struttura Complessa di Cure Palliative e Medicina del Dolore. Azienda Ospedaliera G. Salvini, Garbagnate Milanese, Milano

Position Paper SICP. *2010*

R6. Nel trattamento del BTcP nuove formulazioni di fentanyl citrato, come quelle orosolubile, sublinguale e intranasale, offrono oggi sostanziali vantaggi dal punto di vista sia farmacocinetico (rapido assorbimento, maggiore biodisponibilità ed efficacia) sia della compliance (più facile via di somministrazione)

R5. La morfina orale può essere raccomandata solo per il trattamento di episodi che si instaurano lentamente, prevedibili o procedurali, della durata di oltre 60 minuti. La somministrazione deve avvenire circa trenta minuti prima dell'evento, per esempio prima di iniziare l'attività

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP



Linee guida AIOM. *2016*

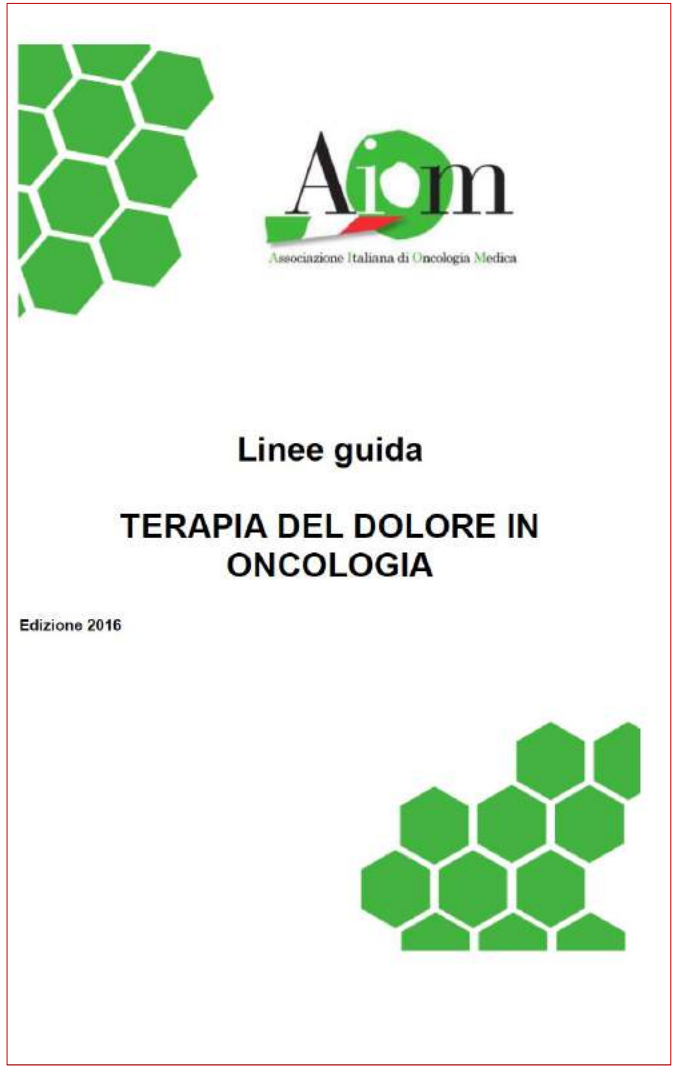
È raccomandabile l'utilizzo della morfina o di altri oppioidi nel trattamento del dolore episodico intenso?

R30. L'utilizzo della morfina o di altri oppioidi per via orale a rapido rilascio, o della morfina per via parenterale nel controllo del DEI dovrebbe essere preso in considerazione.

Raccomandazione Positiva <u>DEBOLE</u>

(metodo GRADE)

LINEE GUIDA PER IL TRATTAMENTO DEL BTcP



Linee guida AIOM. *2016*

E' raccomandabile l'utilizzo del fentanyl transmucosale per il controllo del dolore episodico intenso?

R 28. L'utilizzo del fentanyl transmucosale nel controllo del dolore episodico intenso rispetto alla morfina dovrebbe essere preso in considerazione. Non vi sono al momento evidenze di letteratura sufficienti ad orientare nella scelta della formulazione di fentanyl.

Raccomandazione Positiva <u>DEBOLE</u>

(metodo GRADE)

Drugs (2016) 76:315–330
DOI 10.1007/s40265-015-0519-2

THERAPY IN PRACTICE

What to Do, and What Not to Do, When Diagnosing and Treating Breakthrough Cancer Pain (BTcP): Expert Opinion

Working Group Nientemale DEI · R. Vellucci[1] · G. Fanelli[2] · R. Pannuti[3] · C. Peruselli[4] · S. Adamo[5] · G. Alongi[6] · F. Amato[7,8] · L. Consoletti[9] · L. Lamarca[10] · S. Liguori[11] · C. Lo Presti[12] · A. Maione[13] · S. Mameli[14] · F. Marinangeli[15] · S. Marulli[16] · V. Minotti[17] · D. Miotti[18] · L. Montanari[19,20] · G. Moruzzi[21] · S. Palermo[22] · M. Parolini[23] · P. Poli[24] · W. Tirelli[25,26] · A. Valle[27] · P. Romualdi[28]

healthcare resource management [13]. In the latter, it is essential to weigh the absolute cost of the drugs used to treat BTcP against those arising from poor management, which will entail more frequent and longer periods of hospitalisation and consultation, as well as indirect costs for the healthcare providers and patients [27, 28].

Nausea e vomito

Support Care Cancer (2017) 25:333–340
DOI 10.1007/s00520-016-3371-3

SPECIAL ARTICLE

2016 Updated MASCC/ESMO consensus recommendations: Management of nausea and vomiting in advanced cancer

Declan Walsh[1,2,3] · Mellar Davis[4] · Carla Ripamonti[5] · Eduardo Bruera[6] · Andrew Davies[7] · Alex Molassiotis[8]

Nausea e vomito

Table 2 Antiemetic guidelines in advanced cancer

Recommendation	MASCC/ESMO level of evidence
Drugs of choice The antiemetic drug of choice in advanced cancer is metoclopramide (titrated to effect).	MASCC level of consensus: high MASCC level of confidence: moderate ESMO level of evidence: III ESMO grade of recommendation: C
Alternative options include haloperidol, levomepromazine, or olanzapine.	MASCC level of consensus: high MASCC level of confidence: low ESMO level of evidence: V ESMO grade of recommendation: D
The use of cyclizine* or 5-HT3 receptor antagonists is poorly defined to date and may be used where dopamine antagonists are contraindicated or ineffective.	MASCC level of consensus: low MASCC level of confidence: low ESMO level of evidence: V ESMO grade of recommendation: D
Bowel obstruction The drug recommended in a bowel obstruction is octreotide, dosed around the clock and given alongside an antiemetic (with the committee recommending haloperidol).	MASCC level of consensus: high MASCC level of confidence: high ESMO level of evidence: II ESMO grade of recommendation: A
If Octreotide plus antiemetic is ineffective, the use of anticholinergic antisecretory agents (e.g., scopolamine butylbromide, glycopyrronium bromide) and/or corticosteroids is recommended as either adjunct or alternative interventions.	MASCC level of consensus: high (moderate for corticosteroids) MASCC level of confidence: moderate (low for corticosteroids) ESMO level of evidence: IV ESMO grade of recommendation: D
The use of cyclizine* or 5-HT3 receptor is poorly defined in this setting**. Metoclopramide should be used with caution in partial bowel obstruction and should not be used in complete bowel obstruction.	MASCC level of consensus: low MASCC level of confidence: low ESMO level of evidence: V ESMO grade of recommendation: D
Opioid-induced nausea and vomiting No recommendation can be made for specific antiemetics, although various antiemetics may help. Opioid rotation and route switching may be effective approaches. There is no data to support prophylactic antiemetics in this situation.	MASCC level of consensus: high MASCC level of confidence: low ESMO level of evidence: V ESMO grade of recommendation: D

*Unavailable in some countries

**Caution should be exercised because of the risk of drug interactions

Nausea e vomito

Review

Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC

Recommendation for treatment of opioid-related emesis

The data permit a weak recommendation that some antidopaminergic drugs (eg, haloperidol) and other drugs with antidopaminergic and additional modes of action (eg, metoclopramide) should be used in patients with opioid-induced emesis.

Nausea e vomito

1 compressa di domperidone ~ 0,15 Euro

1 compressa di metoclopramide ~ 0,25 Euro

1 compressa di ondansetron 4mg ~ 4,50 Euro

1 fiala di metoclopramide ~ 0,30 Euro

1 fiala di ondansetron 4mg ~ 6,80 Euro

Stipsi

Curr Gastroenterol Rep (2013) 15:334
DOI 10.1007/s11894-013-0334-4

NEUROMUSCULAR DISORDERS OF THE GASTROINTESTINAL TRACT (S RAO, SECTION EDITOR)

Opioid Induced Bowel Disease: a Twenty-first Century Physicians' Dilemma

Considering Pathophysiology and Treatment Strategies

Ankush Sharma · M. Mazen Jamal

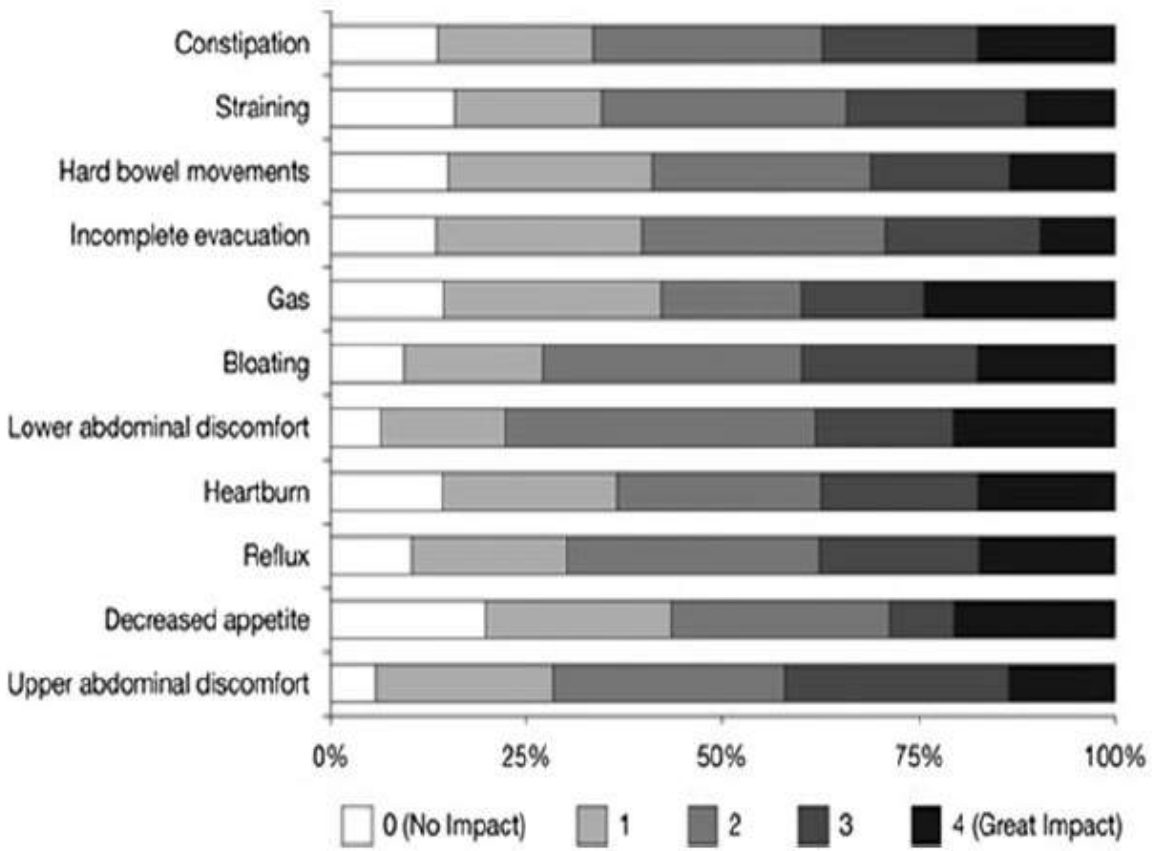


Fig. 2 Impact of the most common symptoms of OBD on ADL. (Reprinted from Bell et al., with permission from American Academy of Pain)

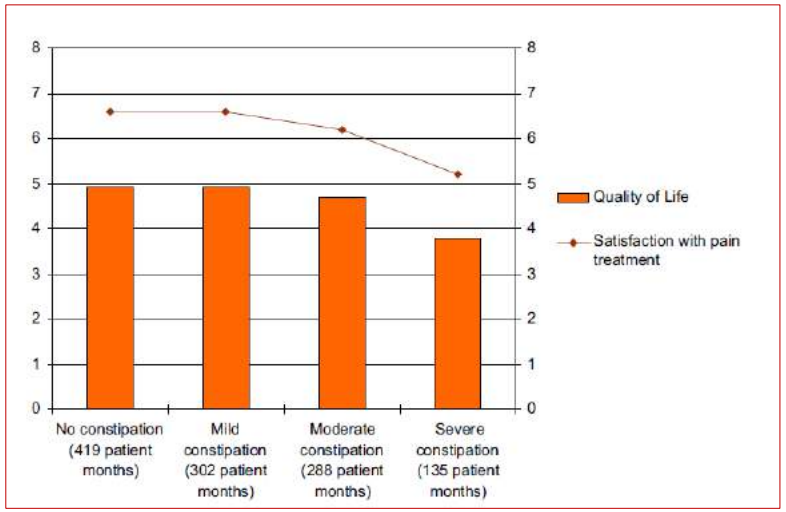
Stipsi

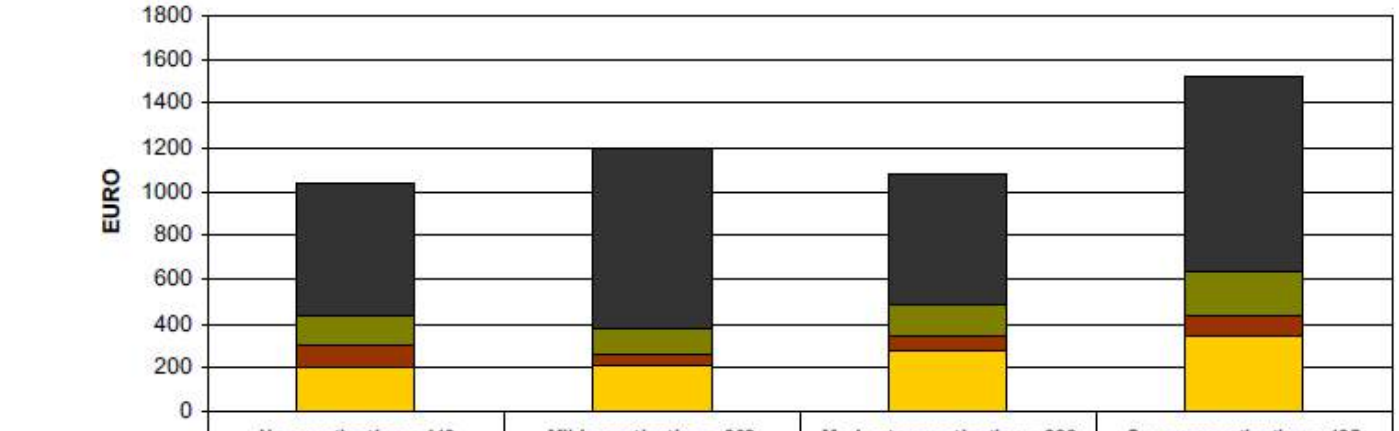
696 Journal of Pain and Symptom Management Vol. 40 No. 5 November 2010

Original Article

The Direct and Indirect Costs of Opioid-Induced Constipation

Frida Hjalte, MSc, Anna-Carin Berggren, MSc, Henrik Bergendahl, MD, and Catharina Hjortsberg, PhD
The Swedish Institute for Health Economics (F.H., C.H.), Lund; Mundipharma AB (A.-C.B.), Gothenburg; and Department of Anaesthesiology, Intensive Care and Pain Medicine (H.B.), Karolinska University Hospital, Huddinge, Stockholm, Sweden





	No constipation = 419 patient months	Mild constipation = 302 patient months	Moderate constipation = 288 patient months	Severe constipation = 135 patient months
Indirect costs	596 (1181)	819 (1401)	611 (1263)	897 (1393)
Drug costs	140 (176)	119 (121)	138 (148)	196 (192)
Inpatient costs	102 (424)	54 (295)	64 (524)	96 (496)
Outpatient costs	196 (224)	204 (233)	275 (450)	336 (459)

Stipsi

Therapeutic Advances in Chronic Disease — Review

Opioid-induced constipation: advances and clinical guidance

Alfred D. Nelson and Michael Camilleri

Ther Adv Chronic Dis
2016, Vol. 7(2) 121–134
DOI: 10.1177/2040622315627801
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(1) Lack of awareness among clinicians about OIC in patients on opioid therapy.
(2) If clinicians are aware, they may not ask patients questions about constipation.
(3) Patients might feel ashamed to disclose their symptoms to clinicians.
(4) Absence of universal diagnostic criteria for OIC.
(5) Efforts to screen patients based on Rome III criteria may not cover the whole spectrum of OIC that might present with abdominal pain.
(6) Absence of a standard protocol for the treatment of OIC.

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Bowel Function Index (BFI)

Please complete all items in this assessment.

1. Ease of defecation (NAS) during the last 7 days according to patient assessment:

0 = easy / no difficulty
100 = severe difficulty

Ask the subject: *"During the last 7 days, how would you rate your ease of defecation on a scale from 0 to 100, where 0 = easy or no difficulty and 100 = severe difficulty?"*

If the subject requires clarification, ask: *"During the last 7 days, how easy or difficult was it to have a bowel movement on a scale from 0 to 100, where 0 = easy or no difficulty and 100 = severe difficulty?"*

2. Feeling of incomplete bowel evacuation (NAS) during the last 7 days according to patient assessment:

0 = not at all
100 = very strong

Ask the subject: *"'During the last 7 days, how would you rate any feeling of incomplete bowel evacuation on a scale from 0 to 100, where 0 = no feeling of incomplete evacuation and 100 = a very strong feeling of incomplete evacuation?"*

If the subject requires clarification, ask: *"During the last 7 days, how strongly did you feel that you did not empty your bowels completely? Please indicate how strong this feeling was on a scale from 0 to 100, where 0 = not at all and 100 = very strong"*

3. Personal judgement of patient (NAS) regarding constipation during the last 7 days:

0 = not at all
100 = very strong

Ask the subject: *"During the last 7 days, how would you rate your constipation on a scale from 0 to 100, where 0 = not at all and 100 = very strong"*

If the subject requires clarification, ask: *"During the last 7 days, how would you rate how constipated you felt on a scale from 0 to 100, where 0 = not at all and 100 = very strong"*

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REVIEW

Pharmacological treatment of constipation in palliative care

Table 4. Laxatives and opioid antagonists dosage refers to symptom control in cancer patients

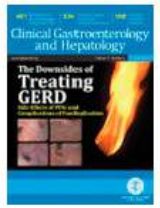
Mode of action	Group	Substance	Dosage	Latency (h)
I Bulking agents		Wheat bran Indian flea seed (Plantago) Linseed	10–30 mg	Initially 24–72, afterwards 8–24
		Sodium sulfate = Glauber's salt		
	Sugar alcohols	Mannit/mannitol sorbital, glycerol	1 clysma	0.5–2
	Sugar	Lactulose	1 clysma	0.5–2
			10–40 g	Initially 10–72, afterwards 8–24
	Polyethylenglycol	Macrogol 3350	13–40 g	Initially 48–72, afterwards 8–24
III Antiresorptive and hydragogue laxatives	Anthraglycoside	Sennoside B	2–3 pills	12
	Phenolphthalein	Bisacodyl	10 mg	Per orem 5–10
		Sodium picosulfate	15–40 drops	Per rectum 15–60 min
				2–4 (–8)
	Castor oil	Castor oil	4–6 g	2–6
V Laxatives with effect on the defecation reflex	Alcohols	Sorbitol	1 clysma	0.5–1
		Glycerol	1 suppository	0.5–1
Binds to mu-opioid receptor in the gastrointestinal tract	Peripherally acting mu-receptor antagonist	Methylnaltrexone bromide	8–12 mg/0.6 ml s.c	30–60 min

Terapia aspecifica

- Prescrizione sostenuta da pochi studi e di modesta qualità
- Caratteristiche organolettiche sgradite a numerosi pazienti
- Effetti collaterali fastidiosi (crampi addominali, flatulenza, ecc.)
- Necessità frequente di somministrare di alti dosaggi, non sempre efficaci

Stipsi

Accepted Manuscript



Efficacy of Treatments for Opioid-induced Constipation: A Systematic Review and Meta-Analysis

Judy Nee, Mohammed Zakari, Michael A. Sugarman, Julia Whelan, William Hirsch, Shahnaz Sultan, Sarah Ballou, Johanna Iturrino, Anthony Lembo

PII: S1542-3565(18)30087-9
DOI: 10.1016/j.cgh.2018.01.021
Reference: YJCGH 55657

To appear in: *Clinical Gastroenterology and Hepatology*
Accepted Date: 11 January 2018

This meta-analysis confirms the overall safety of these medications in over 5,000 patients receiving u-opioid antagonists while maintaining opioid analgesic affect.

Three trials using lubiprostone and one using prucalopride demonstrated that both agents were efficacious in the treatment of OIC; however, both drugs were comparatively less efficacious when compared to u-opioid receptor antagonists, supporting previous findings.

The NNT of lubiprostone was higher at 15 compared to other u-opioid receptor antagonists.

Despite Food and Drug Administration (FDA) approval for the u-opioid antagonists naloxegol, methylnatrexone, fixed-dosage oxycodone/naloxone, and naldemedine no formal guidelines exist for their usage in clinical practice; thus, making them underutilized. While some consensus is developing in regards to utilizing these agents in clinical practice for those patients with chronic pain on opiate treatment, this provides further evidence demonstrating the efficacy and safety of u opioid receptor antagonists and lubiprostone in the treatment of OIC

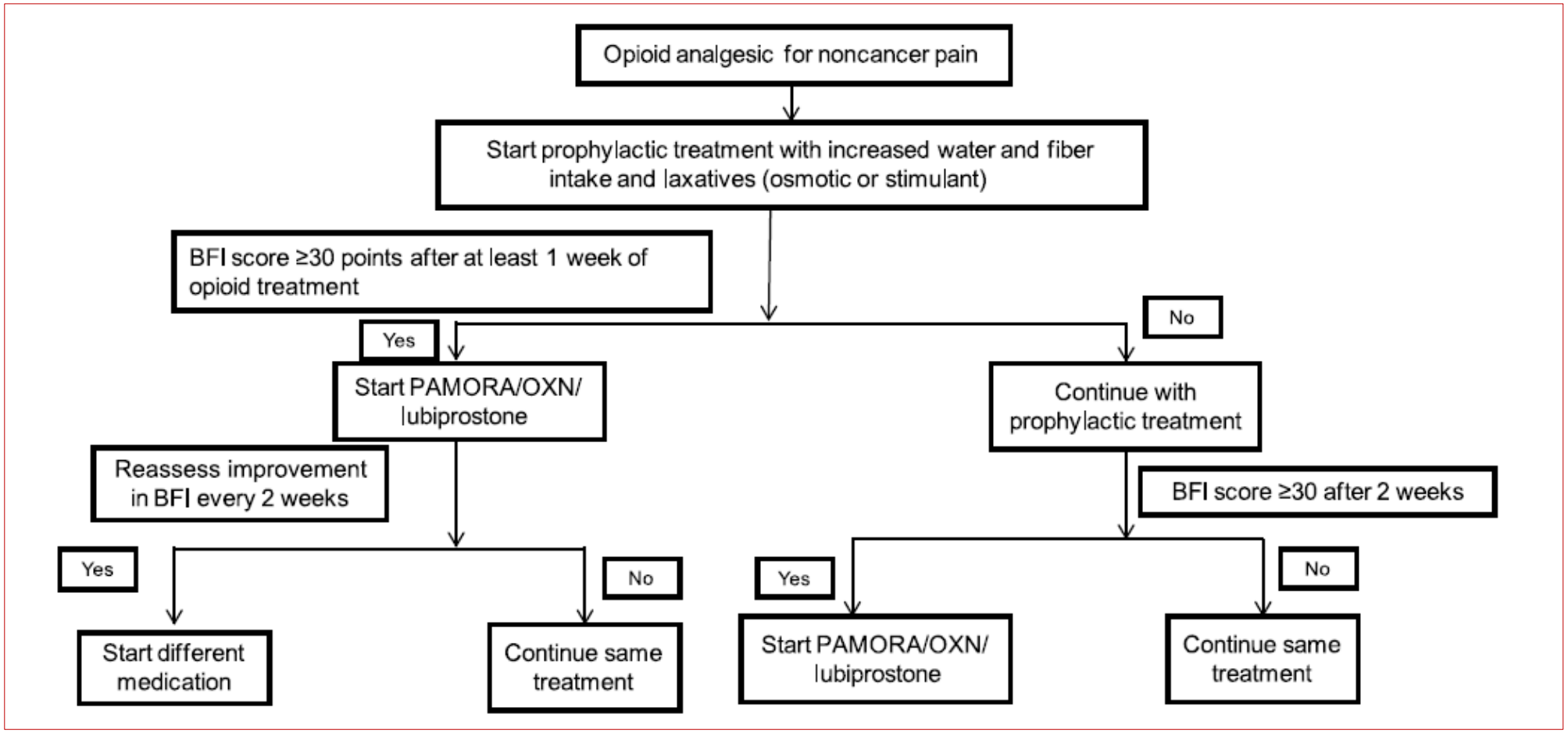
Stipsi

Therapeutic Advances in Chronic Disease — *Review*

Ther Adv Chronic Dis
2016, Vol. 7(2) 121–134
DOI: 10.1177/2040622315627801

Opioid-induced constipation: advances and clinical guidance

Alfred D. Nelson and Michael Camilleri



Dispnea

JOURNAL OF PALLIATIVE MEDICINE
Volume 14, Number 10, 2011
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2011.0109

Dyspnea Review for the Palliative Care Professional: Assessment, Burdens, and Etiologies

Arif H. Kamal, M.D.,[1] Jennifer M. Maguire, M.D.,[2] Jane L. Wheeler, MSPH,[1] David C. Currow, M.P.H.,[3] and Amy P. Abernethy, M.D.[1,3]

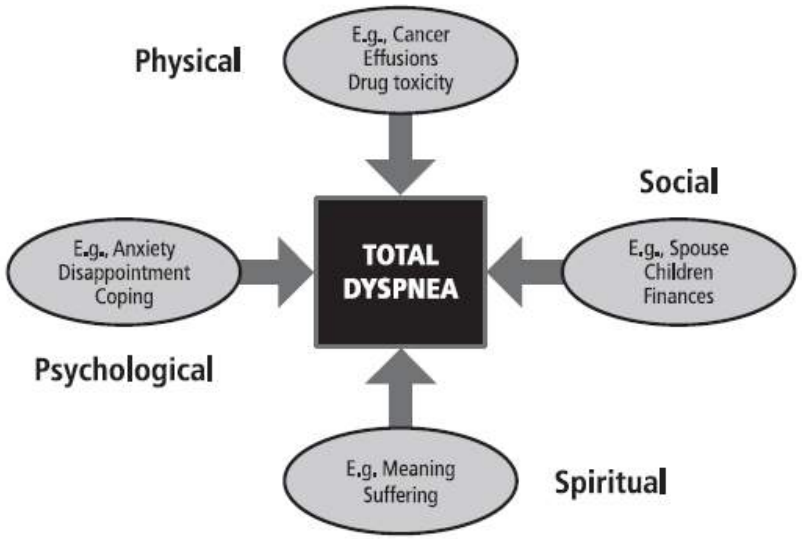


FIG. 1. Elements of the biopsychosocial model of "total dyspnea."

Depression, sadness

Yearning (for peace, rest, forgiveness, etc)

Social issues (with family, community, etc)

Physical problems

Nonacceptance or spiritual distress

Economic or financial distress

Anxiety, anger

FIG. 2. Mnemonic of the biopsychosocial elements of dyspnea.

Non è solo il dolore ad essere «totale»...

Dispnea

Interventi specifici

REVIEW
www.nature.com/clinicalpractice/onc

The etiology and management of intractable breathlessness in patients with advanced cancer: a systematic review of pharmacological therapy

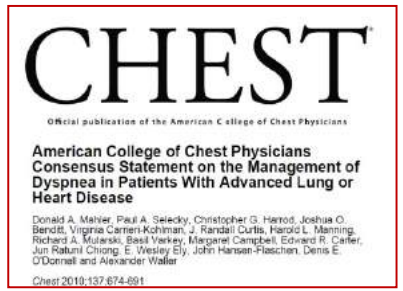
Sara Booth*, Shakeeb H Moosavi and Irene J Higginson

Table 1 The causes of breathlessness in advanced cancer.

Causes in patients with cancer	Specific management
Infection/pneumonia	Antibiotics and other standard therapies when appropriate
Comorbid conditions associated with increased dead space, e.g. pulmonary vascular disease, COPD	Optimize medical management of pre-existing/ coincident conditions
Deconditioning (lack of exercise)	Rehabilitation (see text)
Anemia	Erythropoietin, blood transfusion where appropriate
Cachexia possibly leading to breathlessness by an unknown mechanism	Prevention of cachexia: activity plus possibly some dietary supplements
Comorbidities associated with respiratory muscle weakness, e.g. myasthenia gravis	Optimum treatment of all comorbid conditions
Respiratory muscle syndromes associated with cancer, e.g. Lambert–Eaton syndrome	Treatment of underlying disease is most effective treatment
COPD associated with lung (and therefore thoracic) hyperinflation, leading to inefficiency of respiratory muscles	Optimum treatment and palliation of COPD
Lymphangitis carcinomatosis	Treatment of cancer, often palliative care, although trial of high-dose steroids (60 mg prednisolone then taper) often used
Tumor obstructing an airway, pleural effusions, pleural disease, e.g. mesothelioma	Standard oncological/surgical treatment according to patient's condition, e.g. radiotherapy and/or stenting, etc.
Fibrosis following pulmonary emboli, radiotherapy, chemotherapy (e.g. bleomycin)	Prevention of fibrosis where possible by early standard intervention in these conditions (e.g. anticoagulation or steroids) or prevention by surveillance during cancer therapy and careful control of chemoradiation dosage
Conditions affecting the compliance of the chest wall/ diaphragm, such as hepatomegaly/ascites splinting diaphragm, pleural disease, e.g. mesothelioma, or chest wall infiltration by tumor	Treat as appropriate
Comorbid conditions, e.g. asthma, COPD, interstitial lung disease	Ensure optimum treatment of comorbid conditions
Pulmonary congestion, e.g. from SVCO, heart failure, pulmonary emboli, pericardial effusion	Standard therapy for underlying cancer or treatment of complication of cancer, prevention where possible (e.g. LMWH in high-risk patients)
Hypoxia is a consequence of many conditions associated with cancer including pulmonary emboli, pleural effusions, lymphangitis carcinomatosis, diaphragmatic splinting (e.g. in ascites or hepatomegaly), infections	Assess contribution of hypoxia to breathlessness in that individual and treat conditions as appropriate
Anxieties associated with dyspneic episode reminding the patient they have cancer and are very ill: ▪ Anxiety of dying gasping for breath ▪ Fear/anxiety provoked by idea that breathlessness is in itself harmful ▪ Fear/anxiety because breathlessness at some point may be uncontrollable ▪ Fear/anxiety provoked by the feeling of being breathless ▪ Memory of relative dying with unrelieved breathlessness	Anxiety management using the following alone or in combination: ▪ Nonpharmacological anxiety management strategies (see text) ▪ Pharmacological management of fear and anxiety by phenothiazines, butyrophenones, or benzodiazepines ▪ Cognitive approaches such as cognitive behavioral therapy or education ▪ Availability of clinicians skilled in the management of the symptom

Abbreviations: COPD, chronic obstructive pulmonary disease; LMWH, low-molecular-weight heparin; SVCO, superior vena cava obstruction.

Dispnea



CHEST

Official publication of the American College of Chest Physicians

American College of Chest Physicians Consensus Statement on the Management of Dyspnea in Patients With Advanced Lung or Heart Disease

Donald A. Mahler, Paul A. Selecky, Christopher G. Harrod, Joshua O. Benditt, Virginia Carrieri-Kohlman, J. Randall Curtis, Harold L. Manning, Richard A. Mularski, Basil Varkey, Margaret Campbell, Edward R. Carter, Jun Ratumi Chiong, E. Wesley Ely, John Hansen-Flaschen, Denis E. O'Donnell and Alexander Waller

Chest 2010;137:674-691

JOURNAL OF PALLIATIVE MEDICINE
Volume 15, Number 1, 2012
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2011.0130

Palliative Care Review
Feature Editor: Vyjayanthi S. Periyakoil

Dyspnea Review for the Palliative Care Professional: Treatment Goals and Therapeutic Options

Arif H. Kamal, M.D.[1] Jennifer M. Maguire, M.D.,[2] Jane L. Wheeler, MSPH[1] David C. Currow, M.P.H., FRACP,[3] and Amy P. Abernethy, M.D.[1,3]

Non-pharmacological interventions for breathlessness in advanced stages of malignant and non-malignant diseases (Review)

Bausewein C, Booth S, Gysels M, Higginson IJ

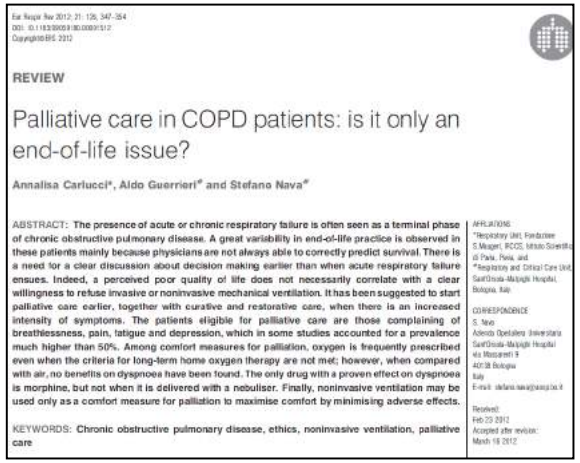
THE COCHRANE COLLABORATION®

VOLUME 26 · NUMBER 14 · MAY 10 2008

JOURNAL OF CLINICAL ONCOLOGY | REVIEW ARTICLE

Interventions for Alleviating Cancer-Related Dyspnea: A Systematic Review

Irit Ben-Aharon, Anat Gafter-Gvili, Mical Paul, Leonard Leibovici, and Salomon M. Stemmer



Eur Respir Rev 2012; 21: 126, 347–354
DOI: 10.1183/09059180.00001512
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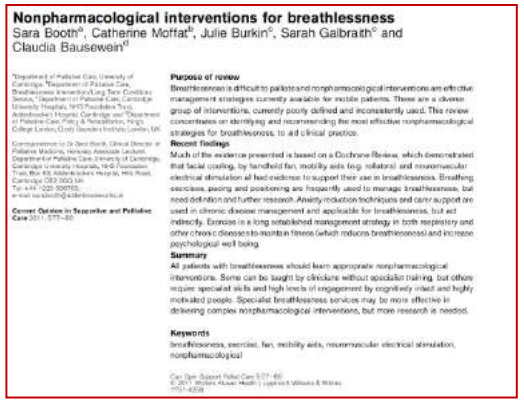
REVIEW

Palliative care in COPD patients: is it only an end-of-life issue?

Annalisa Carlucci*, Aldo Guerrieri# and Stefano Nava#

ABSTRACT: The presence of acute or chronic respiratory failure is often seen as a terminal phase of chronic obstructive pulmonary disease. A great variability in end-of-life practice is observed in these patients mainly because physicians are not always able to correctly predict survival. There is a need for a clear discussion about decision making earlier than when acute respiratory failure ensues. Indeed, a perceived poor quality of life does not necessarily correlate with a clear willingness to refuse invasive or noninvasive mechanical ventilation. It has been suggested to start palliative care earlier, together with curative and restorative care, when there is an increased intensity of symptoms. The patients eligible for palliative care are those complaining of breathlessness, pain, fatigue and depression, which in some studies accounted for a prevalence much higher than 50%. Among comfort measures for palliation, oxygen is frequently prescribed even when the criteria for long-term home oxygen therapy are not met; however, when compared with air, no benefits on dyspnoea have been found. The only drug with a proven effect on dyspnoea is morphine, but not when it is delivered with a nebuliser. Finally, noninvasive ventilation may be used only as a comfort measure for palliation to maximise comfort by minimising adverse effects.

KEYWORDS: Chronic obstructive pulmonary disease, ethics, noninvasive ventilation, palliative care



Nonpharmacological interventions for breathlessness

Sara Booth[a], Catherine Moffat[b], Julie Burkin[c], Sarah Galbraith[c] and Claudia Bausewein[d]

Purpose of review

Breathlessness is difficult to palliate and nonpharmacological interventions are effective management strategies currently available for mobile patients. These are a diverse group of interventions, currently poorly defined and inconsistently used. This review concentrates on identifying and recommending the most effective nonpharmacological strategies for breathlessness, to aid clinical practice.

Recent findings

Much of the evidence presented is based on a Cochrane Review, which demonstrated that facial cooling, by handheld fan, mobility aids (e.g. rollators) and neuromuscular electrical stimulation all had evidence to support their use in breathlessness. Breathing exercises, pacing and positioning are frequently used to manage breathlessness, but need definition and further research. Anxiety reduction techniques and carer support are used in chronic disease management and applicable for breathlessness, but act indirectly. Exercise is a long established management strategy in both respiratory and other chronic disease to maintain fitness (which reduces breathlessness) and increase psychological well being.

Summary

All patients with breathlessness should learn appropriate nonpharmacological interventions. Some can be taught by clinicians without specialist training, but others require specialist skills and high levels of engagement by cognitively intact and highly motivated people. Specialist breathlessness services may be more effective in delivering complex nonpharmacological interventions, but more research is needed.

Keywords

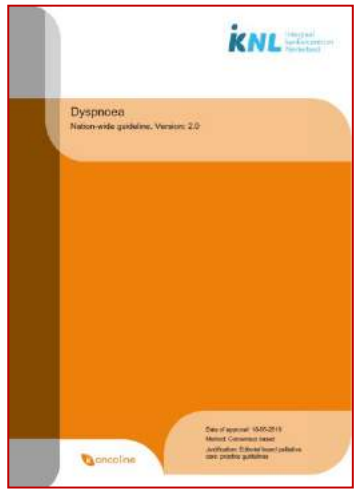
breathlessness, exercise, fan, mobility aids, neuromuscular electrical stimulation, nonpharmacological

REVIEW

www.nature.com/clinicalpractice/onc

The etiology and management of intractable breathlessness in patients with advanced cancer: a systematic review of pharmacological therapy

Sara Booth*, Shakeeb H Moosavi and Irene J Higginson

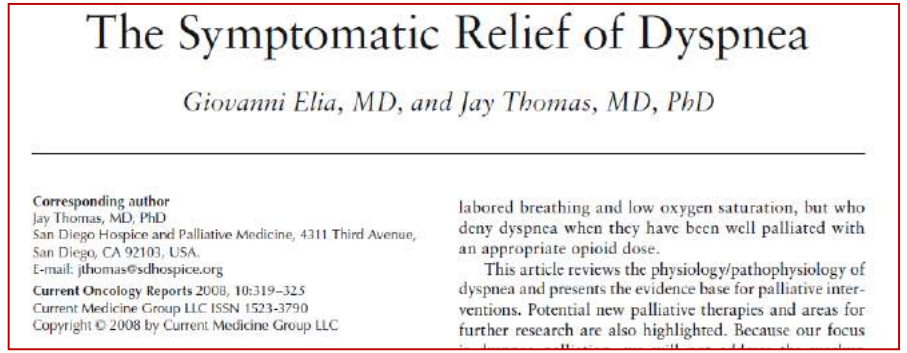


KNL

Dyspnoea

Nation-wide guideline, Version: 2.0

oncoline



The Symptomatic Relief of Dyspnea

Giovanni Elia, MD, and Jay Thomas, MD, PhD

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Current Oncology Reports 2008, 10:319–325
Current Medicine Group LLC ISSN 1523-3790
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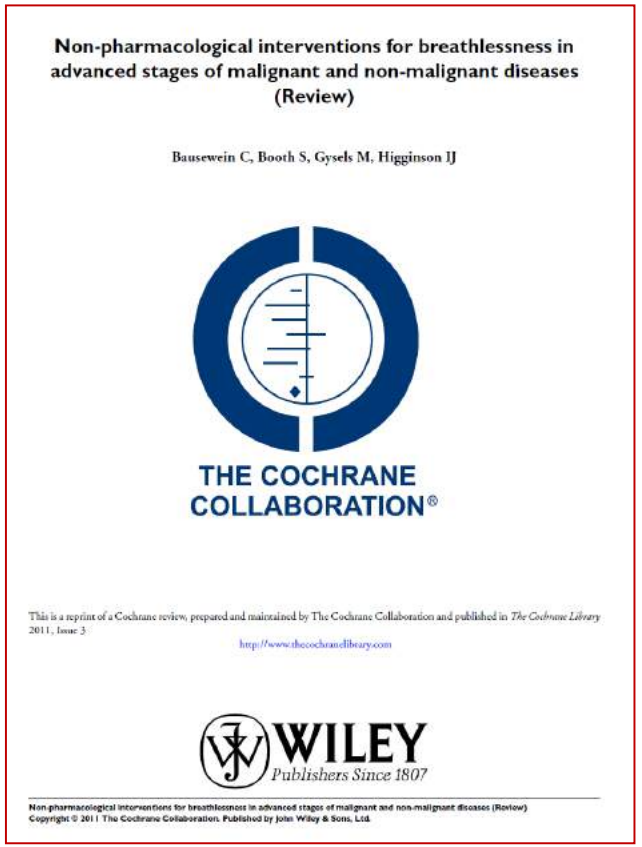
labored breathing and low oxygen saturation, but who deny dyspnea when they have been well palliated with an appropriate opioid dose.

This article reviews the physiology/pathophysiology of dyspnea and presents the evidence base for palliative interventions. Potential new palliative therapies and areas for further research are also highlighted. Because our focus

Dispnea

Authors' conclusions

Breathing training, walking aids, NMES and CWV appear to be effective non-pharmacological interventions for relieving breathlessness in advanced stages of disease.


Non-pharmacological interventions for breathlessness in advanced stages of malignant and non-malignant diseases (Review)

Bausewein C, Booth S, Gysels M, Higginson IJ

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This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2011, Issue 3

http://www.thecochranelibrary.com

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Non-pharmacological interventions for breathlessness in advanced stages of malignant and non-malignant diseases (Review)
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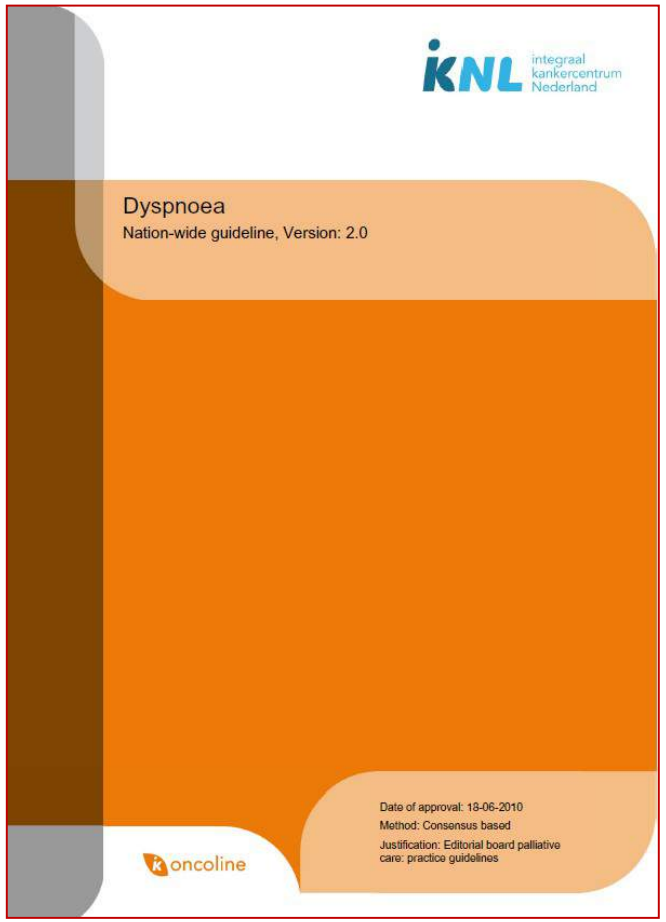
Evidenze di efficacia (assai deboli, nel paziente oncologico…)

- Ventilatore (stimolazione della branca mascellare del nervo trigemino)
- Fisioterapia respiratoria (respirazione diaframmatica)
- Tecniche di rilassamento muscolare
- Autoipnosi
- Supporto psico-sociale

Dispnea



INDICAZIONI

- **Broncospasmo**
- **Sindrome della cava superiore**
- **Linfangite carcinomatosa**
- **BPCO e fibrosi polmonare**

Attenzione alla miopatia da steroidi ed agli effetti psicomimetici!

Miopatia da steroidi, con coinvolgimento della muscolatura respiratoria

THE BASOPHIL ADENOMAS OF THE PITUITARY BODY *
AND THEIR CLINICAL MANIFESTATIONS
(PITUITARY BASOPHILISM[1]

HARVEY CUSHING, M.D.
Professor of Surgery, Harvard Medical School

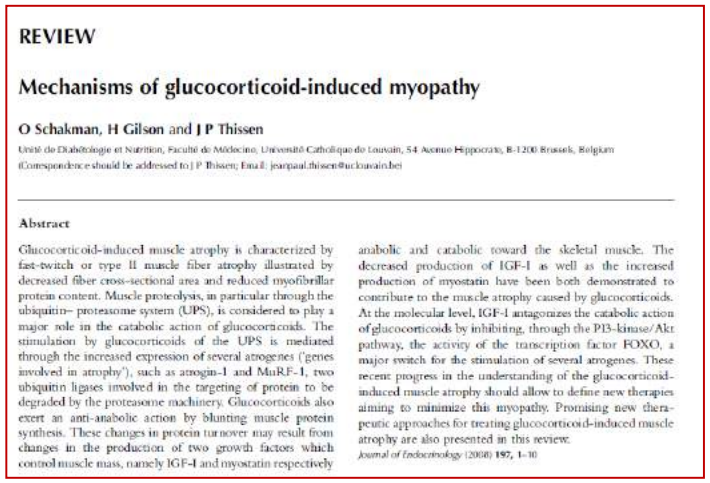
Introduction. In a long since superseded monograph on the pituitary body and its disorders, published in 1912, a section was devoted to a group of cases which showed peculiar and sundry polyglandular syndromes. It was stated at the time that the term "polyglandular syndrome" implied nothing more than that secondary functional alterations occur in the ductless-gland series whenever the activity of one of the glands becomes primarily affected; and further, that the term, as employed, was restricted to those cases in which it was difficult to tell where the initial fault lay.

That a primary derangement of the pituitary gland, whether occurring spontaneously or experimentally induced, was particularly prone to cause widespread changes in other endocrine organs was appreciated even at that early day, and it was strongly suspected that this centrally placed and well protected structure in all probability represented the master-gland of the endocrine series. The multiglandular hyperplasias of acromegaly, so evident in the thyroid gland and adrenal cortex, were already known, and the no less striking atrophic alterations in these same glands brought about by the counter state of pituitary insufficiency were coming to be equally well recognized. But in spite of these hopeful signs, we were still groping blindly for an explanation of many other disorders, obviously of endocrine origin, like those associated with pineal, parathyroid or suprarenal tumors. Out of this obscurity, those seriously interested in the subject have, step by step, been feeling their way in spite of pitfalls and stumbling blocks innumerable.

[1] The subject matter of this paper was ventilated at the New York Academy of Medicine, January 5, 1932; at the Yale Medical School, February 24, 1932, and at the Johns Hopkins Hospital Medical Society, February 29, 1932.

* By the kind permission of The Johns Hopkins Press, pages 180 and 181 of this issue of the *Annals* are facsimiles of the title page and a concluding page from Cushing's review of his cases published in 1932 in the *Bulletin of the Johns Hopkins Hospital*, vol. 50, pages 137 *et seq.*

180



REVIEW

Mechanisms of glucocorticoid-induced myopathy

O Schakman, H Gilson and J P Thissen

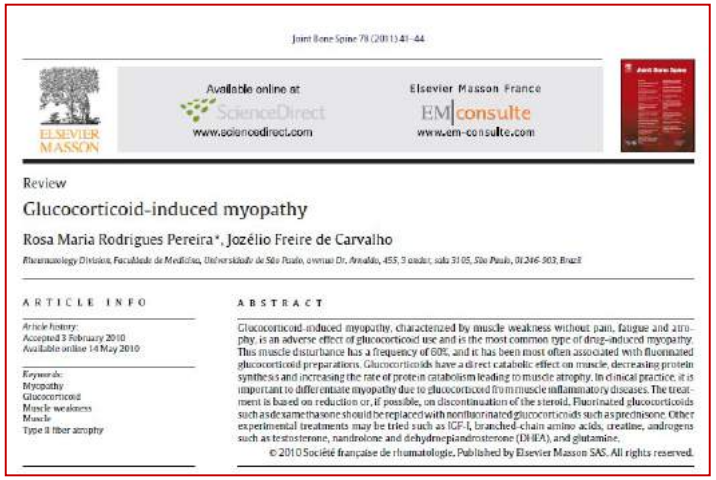
Unité de Diabétologie et Nutrition, Faculté de Médecine, Université Catholique de Louvain, 54 Avenue Hippocrate, B-1200 Brussels, Belgium

(Correspondence should be addressed to J P Thissen; Email: jeanpaul.thissen@uclouvain.be)

Abstract

Glucocorticoid-induced muscle atrophy is characterized by fast-twitch or type II muscle fiber atrophy illustrated by decreased fiber cross-sectional area and reduced myofibrillar protein content. Muscle proteolysis, in particular through the ubiquitin–proteasome system (UPS), is considered to play a major role in the catabolic action of glucocorticoids. The stimulation by glucocorticoids of the UPS is mediated through the increased expression of several atrogenes ('genes involved in atrophy'), such as atrogin-1 and MuRF-1, two ubiquitin ligases involved in the targeting of protein to be degraded by the proteasome machinery. Glucocorticoids also exert an anti-anabolic action by blunting muscle protein synthesis. These changes in protein turnover may result from changes in the production of two growth factors which control muscle mass, namely IGF-I and myostatin respectively anabolic and catabolic toward the skeletal muscle. The decreased production of IGF-I as well as the increased production of myostatin have been both demonstrated to contribute to the muscle atrophy caused by glucocorticoids. At the molecular level, IGF-1 antagonizes the catabolic action of glucocorticoids by inhibiting, through the PI3-kinase/Akt pathway, the activity of the transcription factor FOXO, a major switch for the stimulation of several atrogenes. These recent progress in the understanding of the glucocorticoid-induced muscle atrophy should allow to define new therapies aiming to minimize this myopathy. Promising new therapeutic approaches for treating glucocorticoid-induced muscle atrophy are also presented in this review.

Journal of Endocrinology (2008) **197**, 1–10



Joint Bone Spine 78 (2011) 41–44

Available online at ScienceDirect www.sciencedirect.com

Elsevier Masson France EM|consulte www.em-consulte.com

Review

Glucocorticoid-induced myopathy

Rosa Maria Rodrigues Pereira*, Jozélio Freire de Carvalho

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ARTICLE INFO

Article history:
Accepted 3 February 2010
Available online 14 May 2010

Keywords:
Myopathy
Glucocorticoid
Muscle weakness
Muscle
Type II fiber atrophy

ABSTRACT

Glucocorticoid-induced myopathy, characterized by muscle weakness without pain, fatigue and atrophy, is an adverse effect of glucocorticoid use and is the most common type of drug-induced myopathy. This muscle disturbance has a frequency of 60%, and it has been most often associated with fluorinated glucocorticoid preparations. Glucocorticoids have a direct catabolic effect on muscle, decreasing protein synthesis and increasing the rate of protein catabolism leading to muscle atrophy. In clinical practice, it is important to differentiate myopathy due to glucocorticoid from muscle inflammatory diseases. The treatment is based on reduction or, if possible, on discontinuation of the steroid. Fluorinated glucocorticoids such as dexamethasone should be replaced with nonfluorinated glucocorticoids such as prednisone. Other experimental treatments may be tried such as IGF-I, branched-chain amino acids, creatine, androgens such as testosterone, nandrolone and dehydroepiandrosterone (DHEA), and glutamine.

LA MIOPATIA DA STEROIDI….

È la più frequente miopatia indotta da farmaci

Compare in circa il 60% dei pazienti in trattamento e non risparmia la muscolatura respiratoria

Gli anziani, i pazienti fisicamente inattivi e quelli oncologici sono maggiormente predisposti

È più frequentemente determinata dai composti fluorinati (desametasone, betametasone) che dai non fluorinati (prednisone, metilprednisolone)

Pur senza una rigida correlazione dose/effetto, si manifesta più spesso con posologie sostenute

Il trattamento consiste nella riduzione graduale della posologia sino a sospensione (se possibile) e/o "rotazione" a composti non fluorinati

Sono stati tentati trattamenti sperimentali con IGF-1, aminoacidi ramificati, androgeni (testosterone, nandrolone, DHEA), glutamina, attività fisica, con risultati dubbi. Si tratta però di interventi per la maggior parte improponibili in un contesto di cure palliative

Dispnea

O2 terapia

Dispnea

JOURNAL OF PALLIATIVE MEDICINE
Volume 15, Number 1, 2012
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2011.0110

Palliative Care Review
Feature Editor: Vyjeyanthi S. Periyakoil

Dyspnea Review for the Palliative Care Professional: Treatment Goals and Therapeutic Options

Arif H. Kamal, M.D.[1], Jennifer M. Maguire, M.D.[2], Jane L. Wheeler, MSPH[1], David C. Currow, M.P.H., FRACP,[3] and Amy P. Abernethy, M.D.[1,4]

REVIEW

Palliative care in COPD patients: is it only an end-of-life issue?

Annalisa Carlucci[a], Aldo Guerrieri[a] and Stefano Nava[a]

ABSTRACT: The presence of acute or chronic respiratory failure is often seen as a terminal phase of chronic obstructive pulmonary disease. A great variability in end-of-life practice is observed in these patients mainly because physicians are not always able to correctly predict survival. There is a need for a clear discussion about decision making earlier than when acute respiratory failure ensues. Indeed, a perceived poor quality of life does not necessarily correlate with a clear willingness to refuse invasive or noninvasive mechanical ventilation. It has been suggested to start palliative care earlier, together with curative and restorative care, when there is an increased intensity of symptoms. The patients eligible for palliative care are those complaining of breathlessness, pain, fatigue and depression, which in some studies, accounted for a prevalence much higher than 50%. Among comfort measures for palliation, oxygen is frequently prescribed even when the criteria for long-term home oxygen therapy are not met; however, when compared with air, no benefit on dyspnoea have been found. The only drug with a proven effect on dyspnoea is morphine, but not when it is delivered with a nebulizer. Finally, noninvasive ventilation may be used only as a comfort measure for palliation to maximize comfort by minimizing adverse effects.

KEYWORDS: Chronic obstructive pulmonary disease, ethics, noninvasive ventilation, palliative care

Oxygen for relief of dyspnoea in mildly- or non-hypoxaemic patients with cancer: a systematic review and meta-analysis

HE Uronis[1,2], DC Currow[3], DC McCrory[2,4], GP Sarma[5,6] and AP Abernethy[2,3,7]

The aim of this study was to determine the efficacy of palliative oxygen for relief of dyspnoea in cancer patients. MEDLINE and EMBASE were searched for randomised controlled trials comparing oxygen and medical air in cancer patients not qualifying for home oxygen therapy. Abstracts were reviewed and studies were selected using Cochrane methodology. The included studies provided oxygen at rest, or during a 6 min walk. The primary outcome was dyspnoea. Standardised mean differences (SMDs) were used to combine scores. Five studies were identified; one was excluded from meta-analysis due to data presentation. Individual patient data were obtained from the authors of the three of the four remaining studies (one each from England, Australia, and the United States). A total of 124 patients were included in the meta-analysis. Oxygen failed to improve dyspnoea in mildly- or non-hypoxaemic cancer patients (SMD = −0.09, 95% confidence interval −0.22 to 0.04, P = 0.16). Results were stable to a sensitivity analysis, excluding studies requiring the use of impulse quantities. In this small meta-analysis, oxygen did not provide symptomatic benefit for cancer patients with refractory dyspnoea, who would not normally qualify for home oxygen therapy. Further study of the use of oxygen in this population is warranted given its widespread use.

British Journal of Cancer (2008) 98, 291–297. doi:10.1038/sj.bjc.6604161 www.bjcancer.com
Published online 8 January 2008

CHEST

Official publication of the American College of Chest Physicians

American College of Chest Physicians Consensus Statement on the Management of Dyspnea in Patients With Advanced Lung or Heart Disease

Donald A. Mahler, Paul A. Selecky, Christopher G. Harrod, Joshua O. Benditt, Virginia Carrieri-Kohlman, J. Randall Curtis, Harold L. Manning, Richard A. Mularski, Basil Varkey, Margaret Campbell, Edward R. Carter, Jun Ratuni Chiong, E. Wesley Ely, John Hansen-Flaschen, Denis E. O'Donnell and Alexander Waller

Chest 2010;137:674-691

Oxygen therapy for dyspnoea in adults (Review)

Cranston JM, Crockett A, Currow D

THE COCHRANE COLLABORATION®

The Symptomatic Relief of Dyspnea

Giovanni Elia, MD, and Jay Thomas, MD, PhD

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Current Oncology Reports 2008, 10:319–325
Current Medicine Group LLC ISSN 1523-3790

labored breathing and low oxygen saturation, but who deny dyspnea when they have been well palliated with an appropriate opioid dose.

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REVIEW ARTICLE

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REVIEW

www.nature.com/clinicalpractice/onc

The etiology and management of intractable breathlessness in patients with advanced cancer: a systematic review of pharmacological therapy

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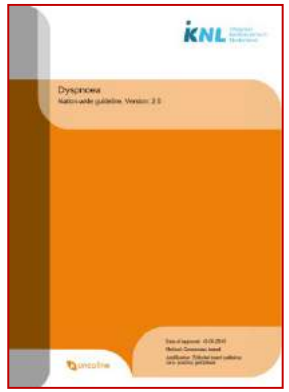

WBS

Thoracic and Cardiovascular Surgery

Palliative Care for the Patient With Mesothelioma

Janet L. Abrahm, MD

The role of palliative care in the medical management of malignant mesothelioma is multifaceted, requiring proficiency in multiple disciplines. Pain management is a key aspect of this care. The most common sources of pain are postthoracotomy syndrome, chemotherapy-induced peripheral neuropathy, involvement of the intercostal nerves by tumor invading the chest wall, and dyspnea. The palliative care provider also must be prepared to recognize and treat psychological disorders, to identify other social and spiritual sources of distress, including anxiety and depression, and to provide or arrange for counseling to patient and family for advance care planning, as well as grief and bereavement.
Semin Thorac Cardiovasc Surg 21:164-171

Update on the role of palliative oxygen

Patricia M. Davidson[a] and Miriam J. Johnson[b]

[a]Centre for Cardiovascular and Chronic Care, University of Technology Sydney, Curtin University & St Vincent's Hospital, Sydney, Australia and [b]Hull York Medical School and Honorary Consultant to St. Catherine's Hospice, Yorkshire, UK

Correspondence to Professor Patricia M. Davidson, Centre for Cardiovascular and Chronic Care, University of Technology Sydney, Curtin University & St Vincent's Hospital, Sydney, Australia
E-mail: pdavidson@curtin.edu.au

Current Opinion in Supportive and Palliative Care 2011, 5:87–91

Purpose of review
Breathlessness remains a frequent and burdensome symptom for individuals with life-limiting symptoms in both malignant and nonmalignant settings. As oxygen therapy is frequently given as part of the management of breathlessness and is associated with costs, treatment burden and potential dangers, it is timely to review the efficacy and appropriateness of palliative oxygen therapy.
Recent findings
Despite the widespread use of oxygen therapy in clinical and community settings, data supporting this approach is sparse. The benefits of long-term oxygen therapy for severely hypoxaemic people with chronic obstructive pulmonary disease are proven;

Dispnea

Nessuno nega il valore "simbolico" dell'O2, però il paziente dispnoico può non essere ipossico (componente ansiosa) o viceversa (meccanismi di compenso)…

- **Mancano prove consistenti nel sostenere con forza l'uso dell'O2 con finalità sintomatica (vs aria)**
- **Gli studi disponibili (più numerosi, nel paziente non oncologico) evidenziano la possibilità di ottenere un beneficio sintomatico <u>SOLTANTO NEL PAZIENTE IPOSSICO, A RIPOSO E SOTTO SFORZO, E CON DISPNEA SEVERA</u>**
- **Può essere opportuno un tentativo a breve termine (qualche giorno), valutandone i benefici, con un flusso di 1-5 l/min**
- **Nel caso, la maschera garantisce una minore dispersione dell'O2, ma è poco tollerata dalla maggior parte dei pazienti in fase avanzata di malattia**
- **Vi sono studi randomizzati che evidenziano la superiorità della morfina nel controllare la dispnea, rispetto all'O2, in pazienti**

Dispnea

Benzodiazepine ed altri farmaci psicotropi

Dispnea

JOURNAL OF PALLIATIVE MEDICINE
Volume 15, Number 1, 2012
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2011.0110

Palliative Care Review
Feature Editor: Vyjeyanthi S. Periyakoil

Dyspnea Review for the Palliative Care Professional: Treatment Goals and Therapeutic Options

Arif H. Kamal, M.D.,[1] Jennifer M. Maguire, M.D.,[2] Jane L. Wheeler, MSPH,[1] David C. Currow, M.P.H., FRACP,[3] and Amy P. Abernethy, M.D.[1,3]

REVIEW

www.nature.com/clinicalpractice/onc

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Sara Booth*, Shakeeb H Moosavi and Irene J Higginson

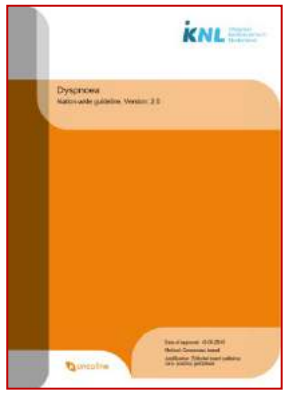
Support Care Cancer (2008) 16:329–337
DOI 10.1007/s00520-007-0389-6

REVIEW ARTICLE

The management of dyspnea in cancer patients: a systematic review

Raymond Viola · Cathy Kiteley · Nancy S. Lloyd · Jean A. Mackay · Julie Wilson · Rebecca K. S. Wong · Supportive Care Guidelines Group of the Cancer Care Ontario Program in Evidence-Based Care

Received: 1 May 2007 / Accepted: 5 December 2007 / Published online: 24 January 2008



The Symptomatic Relief of Dyspnea

Giovanni Elia, MD, and Jay Thomas, MD, PhD

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Current Oncology Reports 2008, 10:319–325
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labored breathing and low oxygen saturation, but who deny dyspnea when they have been well palliated with an appropriate opioid dose.

This article reviews the physiology/pathophysiology of dyspnea and presents the evidence base for palliative interventions. Potential new palliative therapies and areas for further research are also highlighted. Because our focus

Applicability and generalizability of palliative interventions for dyspnoea: one size fits all, some or none?

Marie Williams

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Current Opinion in Supportive and Palliative Care 2011, 5:92–100

Purpose of review
Determining which palliative interventions are appropriate within and between groups remains difficult because of the lack of prospective studies and heterogeneity in dyspnoea context, assessment and reporting. This review presents an evolution of dyspnoea theories, summarizes literature published during 2010 concerning intervention effectiveness between conditions and highlights the lag between emerging research evidence and dyspnoea assessments in clinical trials.

Recent findings
With few exceptions, first-line pharmacological agents prescribed to modify the disease with palliation of dyspnoea as consequence were unlikely to be generalizable between conditions and contexts. Two agents (supplemental oxygen in people without resting hypoxemia and benzodiazepines in advanced disease) did not significantly reduce dyspnoea. Exercise training palliated dyspnoea across conditions and contexts. Short-term reductions in dyspnoea were reported for a variety of adjunctive strategies (breathing training, electrophysical agents and psychological approaches).

Summary
Multiple interventions exist for palliation of dyspnoea in different contexts. The majority of studies assessed emotional and behavioural consequences of dyspnoea rather than dyspnoea sensation (intensity, sensory quality, unpleasantness). As a more detailed understanding of the mechanisms leading to perceptions of dyspnoea evolve, a 'back to basics' strategy for clinical assessment might provide a means of determining which interventions can be generalized or are best suited to various forms of dyspnoea.

Keywords
dyspnoea, management strategies, palliation, sensation of breathlessness

Curr Opin Support Palliat Care 5:92–100

1751-4258

American Thoracic Society Documents

An Official American Thoracic Society Statement: Update on the Mechanisms, Assessment, and Management of Dyspnea

Mark B. Parshall, Richard M. Schwartzstein, Lewis Adams, Robert B. Banzett, Harold L. Manning, Jean Bourbeau, Peter M. Calverley, Audrey G. Gift, Andrew Harver, Suzanne C. Lareau, Donald A. Mahler, Paula M. Meek, and Denis E. O'Donnell; on behalf of the ATS Committee on Dyspnea

THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY (ATS) WAS APPROVED BY THE ATS BOARD OF DIRECTORS, October, 2011

Dispnea

Authors' conclusions

Since the last version of this review, we have identified one new study for inclusion, but the conclusions remain unchanged. There is no evidence for or against benzodiazepines for the relief of breathlessness in people with advanced cancer and COPD. Benzodiazepines caused more drowsiness as an adverse effect compared to placebo, but less compared to morphine. Benzodiazepines may be considered as a second- or third-line treatment, when opioids and non-pharmacological measures have failed to control breathlessness. There is a need for well-conducted and adequately powered studies.

Dispnea

NHS Lothian

Palliative Care Guidelines: Lung Disease

Palliative Care in advanced Lung Disease

Benzodiazepines:

May relieve anxiety/ panic associated with severe breathlessness, but are less effective than opioids for breathlessness and should be a 3rd line treatment for patients with symptoms unresponsive to non-pharmacological measures and opioids.

Dispnea

- **Beneficio limitatissimo e molto discusso**
- **Possono essere indicate quando coesiste importante componente ansiosa e/o per favorire il sonno**
- **Non possono essere considerate la monoterapia di prima scelta della dispnea cronica (contrariamente a quanto avviene di solito…), anche per gli effetti avversi, come la sonnolenza**
- **Viceversa, rivestono un ruolo fondamentale NELLA SEDAZIONE PROFONDA TEMPORANEA (CRISI ASFITTICA) E CONTINUA (DISPNEA REFRATTARIA)**

Dispnea

Oppiacei

Dispnea

Opioids for the palliation of breathlessness in advanced disease and terminal illness. (Review)

Jennings AL, Davies AN, Higgins JPT, Antunes-Cabrera J, Broadley KE

THE COCHRANE COLLABORATION®

REVIEW

The etiology and management of intractable breathlessness in patients with advanced cancer: a systematic review of pharmacological therapy

Sara Booth*, Shakeeb H Moosavi and Irene J Higginson

VOLUME 26 · NUMBER 14 · MAY 10 2008

JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

Interventions for Alleviating Cancer-Related Dyspnea: A Systematic Review

Irit Ben-Aharon, Anat Gafter-Gvili, Mical Paul, Leonard Leibovici, and Salomon M. Stemmer

ACP Clinical Practice Guidelines

CLINICAL GUIDELINES

Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians

REVIEW

Palliative care in COPD patients: is it only an end-of-life issue?

KNL

Dyspnoea

Advances in the pharmacological management of breathlessness

David C. Currow, Alicia M. Ward and Amy P. Abernethy

JOURNAL OF PALLIATIVE MEDICINE
Volume 15, Number 1, 2012
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2011.0110

Palliative Care Review

Feature Editor: Vyjeyanthi S. Periyakoil

Dyspnea Review for the Palliative Care Professional: Treatment Goals and Therapeutic Options

Arif H. Kamal, M.D.,[1] Jennifer M. Maguire, M.D.,[2] Jane L. Wheeler, MSPH,[1] David C. Currow, M.P.H., FRACP,[3] and Amy P. Abernethy, M.D.[1,3]

American Thoracic Society Documents

An Official American Thoracic Society Statement: Update on the Mechanisms, Assessment, and Management of Dyspnea

Mark B. Parshall, Richard M. Schwartzstein, Lewis Adams, Robert B. Banzett, Harold L. Manning, Jean Bourbeau, Peter M. Calverley, Audrey G. Gift, Andrew Harver, Suzanne C. Lareau, Donald A. Mahler, Paula M. Meek, and Denis E. O'Donnell; on behalf of the ATS Committee on Dyspnea

THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY (ATS) WAS APPROVED BY THE ATS BOARD OF DIRECTORS, October, 2011

Acta Oncologica, 2012, 51: 906–1008

informa

ORIGINAL ARTICLE

Interventions for alleviating cancer-related dyspnea: A systematic review and meta-analysis

IRIT BEN-AHARON[1,2,*], ANAT GAFTER-GVILI[2,3,*], LEONARD LEIBOVICI[2,3] & SALOMON M. STEMMER[1,3]

WBS

Thoracic and Cardiovascular Surgery

Palliative Care for the Patient With Mesothelioma

Janet L. Abrahm, MD

The role of palliative care in the medical management of malignant mesothelioma is multifaceted, requiring proficiency in multiple disciplines. Pain management is a key aspect of this care. The most common sources of pain are postthoracotomy syndrome, chemotherapy-induced peripheral neuropathy, involvement of the intercostal nerves by tumor invading the chest wall, and dyspnea. The palliative care provider also must be prepared to recognize and treat psychological disorders, to identify other social and spiritual sources of distress, including anxiety and depression, and to provide or arrange for counseling to patient and family for advance care planning, as well as grief and bereavement.

CHEST

Official publication of the American College of Chest Physicians

American College of Chest Physicians Consensus Statement on the Management of Dyspnea in Patients With Advanced Lung or Heart Disease

Donald A. Mahler, Paul A. Selecky, Christopher G. Harrod, Joshua O. Benditt, Virginia Carrieri-Kohlman, J. Randall Curtis, Harold L. Manning, Richard A. Mularski, Basil Varkey, Margaret Campbell, Edward R. Carter, Jun Ratuni Chiong, E. Wesley Ely, John Hansen-Flaschen, Denis E. O'Donnell and Alexander Waller

Chest 2010;137:674-691

Support Care Cancer (2008) 16:329–337
DOI 10.1007/s00520-007-0389-6

REVIEW ARTICLE

The management of dyspnea in cancer patients: a systematic review

Raymond Viola · Cathy Kiteley · Nancy S. Lloyd · Jean A. Mackay · Julie Wilson · Rebecca K. S. Wong · Supportive Care Guidelines Group of the Cancer Care Ontario Program in Evidence-Based Care

Received: 1 May 2007 / Accepted: 5 December 2007 / Published online: 24 January 2008

Dispnea

Molta strada è stata percorsa dagli studi di Bruera negli anni '90...

- **Sono oramai numerosi gli studi a sostegno dell'efficacia degli oppiacei (in particolare della morfina) per via orale o parenterale nel trattamento sintomatico della dispnea (al contrario della via inalatoria)**

- **LA MORFINA È IL FARMACO CON MAGGIOR EVIDENZA DI EFFICACIA NEL TRATTAMENTO DELLA DISPNEA NEL PAZIENTE ONCOLOGICO E NON ONCOLOGICO IN FASE AVANZATA**

- **Il farmaco è assolutamente sicuro se si rispettano le "buone pratiche" di titolazione ed uso degli oppiacei. SE RISPETTATE QUESTE CONDIZIONI, IL TIMORE DELLA DEPRESSIONE RESPIRATORIA È INFONDATO**

- **Probabilmente sono efficaci anche altri oppiacei maggiori (fentanyl, idromorfone, ossicodone, metadone), ma mancano prove sufficienti a sostegno (in genere non vale la proprietà "transitiva"...)**

LA MORFINA NEL TRATTAMENTO SINTOMATICO DELLA DISPNEA

MECCANISMO D'AZIONE

- **Riduce la risposta ventilatoria all'ipossia/ipercapnia ed all'esercizio fisico**
- **Riduce il precarico cardiaco**
- **Induce una riduzione della frequenza respiratoria rendendo più efficiente la ventilazione**
- **Riduce la percezione della dispnea e l'ansia correlata**
- **Nessun problema di depressione respiratoria, se usata correttamente**

Dispnea

European Journal of Neurology 2012, **19:** 360–375 doi:10.1111/j.1468-1331.2011.03501.x

EFNS GUIDELINES

EFNS guidelines on the Clinical Management of Amyotrophic Lateral Sclerosis (MALS) – revised report of an EFNS task force

The EFNS Task Force on Diagnosis and Management of Amyotrophic Lateral Sclerosis: Peter M. Andersen[a], Sharon Abrahams[b], Gian D. Borasio[c], Mamede de Carvalho[d], Adriano Chio[e], Philip Van Damme[f], Orla Hardiman[g], Katja Kollewe[h], Karen E. Morrison[i], Susanne Petri[h], Pierre-Francois Pradat[j], Vincenzo Silani[k], Barbara Tomik[l], Maria Wasner[m] and Markus Weber[n]

[a]Umeå University, Umeå, Sweden; [b]University of Edinburgh, Edinburgh, UK; [c]Centre Hospitalier Universitaire Vaudois, University of Lausanne, Lausanne, Switzerland; [d]Hospital de Santa Maria, Lisbon, Portugal; [e]University of Turin and San Giovanni Hospital, Turin, Italy; [f]University of Leuven and VIB, Leuven, Belgium; [g]Trinity College and Beaumont Hospital, Dublin, Ireland; [h]Medizinische Hochschule Hannover, Germany; [i]School of Clinical and Experimental Medicine, University of Birmingham and Queen Elizabeth Hospital, Birmingham, UK; [j]Hôpital de la Salpêtrière, Paris, France; [k]University of Milan Medical School, Milan, Italy; [l]Jagiellonian University Medical College, Krakow, Poland; [m]Munich University Hospital, Munich, Germany; and [n]Kantonsspital St Gallen and University Hospital Basel, Basel, Switzerland

12. The medical treatment of intermittent dyspnoea should involve:

a for short dyspnoeic bouts: relieve anxiety and give lorazepam 0.5–2.5 mg sublingually;

b for longer phases of dyspnoea (> 30 min): give morphine 2.5 mg orally or s.c. (GCPP)

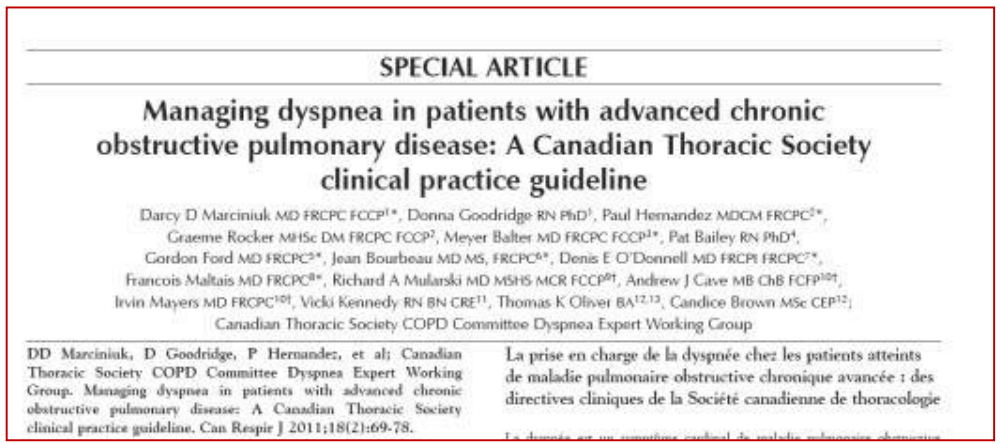
13. For the medical treatment of chronic dyspnoea, start with morphine 2.5 mg orally four to six times daily. For severe dyspnoea, give morphine s.c. or as an i.v. infusion. Start with 0.5 mg/h and titrate. If needed, add midazolam (2.5–5 mg) or diazepam for nocturnal symptom control and to relieve anxiety (GCPP).

Dispnea

TABLE 4
Suggested protocol for managing dyspnea with opioid therapy in advanced chronic obstructive pulmonary disease patients

- Initiate opioid therapy with oral immediate-release morphine syrup – titrate slowly at weekly intervals over a 4- to 6-week period
- Start therapy with morphine 0.5 mg orally twice daily for 2 days, and then increase to 0.5 mg orally every 4 h while awake for remainder of week 1
- If tolerated and indicated, increase to morphine 1.0 mg orally every 4 h while awake in week 2, increasing by 1.0 mg/week or 25% dosage increments/week until the lowest effective dose that appropriately manages the dyspnea is achieved
- Once a stable dosage is achieved (ie, no significant dose change for 2 weeks and dyspnea managed), a sustained-release preparation at a comparable daily dose could be considered for substitution
- If patients experience significant opioid-related side effects such as nausea or confusion, substitution of an equipotent dose of oral hydromorphine could be considered (1 mg hydromorphine = 5 mg morphine)
- Stool softeners and laxatives should be routinely offered to prevent opioid-associated constipation

Adapted from references 1, 109 and 115



SPECIAL ARTICLE

Managing dyspnea in patients with advanced chronic obstructive pulmonary disease: A Canadian Thoracic Society clinical practice guideline

Darcy D Marciniuk MD FRCPC FCCP[1]*, Donna Goodridge RN PhD[1], Paul Hernandez MDCM FRCPC[2]*, Graeme Rocker MHSc DM FRCPC FCCP[3], Meyer Balter MD FRCPC FCCP[4]*, Pat Bailey RN PhD[4], Gordon Ford MD FRCPC[5]*, Jean Bourbeau MD MS, FRCPC[6]*, Denis E O'Donnell MD FRCPI FRCPC[7]*, Francois Maltais MD FRCPC[8]*, Richard A Mularski MD MSHS MCR FCCP[9†], Andrew J Cave MB ChB FCFP[10†], Irvin Mayers MD FRCPC[10†], Vicki Kennedy RN BN CRE[11], Thomas K Oliver BA[12,13], Candice Brown MSc CEP[12]; Canadian Thoracic Society COPD Committee Dyspnea Expert Working Group

DD Marciniuk, D Goodridge, P Hernandez, et al; Canadian Thoracic Society COPD Committee Dyspnea Expert Working Group. Managing dyspnea in patients with advanced chronic obstructive pulmonary disease: A Canadian Thoracic Society clinical practice guideline. Can Respir J 2011;18(2):69-78.

La prise en charge de la dyspnée chez les patients atteints de maladie pulmonaire obstructive chronique avancée : des directives cliniques de la Société canadienne de thoracologie

Occlusione intestinale

Vol. 48 No. 1 July 2014 Journal of Pain and Symptom Management 75

Review Article

Recommendations for Bowel Obstruction With Peritoneal Carcinomatosis

Guillemette Laval, MD, Blandine Marcelin-Benazech, MD, Frédéric Guirimand, MD, Laure Chauvenet, MD, Laure Copel, MD, Aurélie Durand, MD, Eric Francois, MD, Martine Gabolde, MD, Pascale Mariani, MD, Christine Rebischung, MD, Vincent Servois, MD, Eric Terrebonne, MD, and Catherine Arvieux, MD, on behalf of the French Society for Palliative Care, with the French Society for Digestive Surgery, the French Society for Gastroenterology, the French Society for Digestive Cancer, and the French Association for Supportive Care in Oncology

Palliative and Supportive Care Mobile Unit (G.L.), Departments of Hepato-Gastroenterology (A.D.), Digestive Surgery (C.A.) and Oncology Day Hospital (C.R.), University Hospital Center, Grenoble; Palliative and Supportive Care Mobile Unit (B.M.-B.), HCL, Lyon; Medical House Jeanne Garnier (F.G.), Department of Medical Oncology (L.Ch.), Hospital Hôtel Dieu, APHP; Departments of Medical Oncology (L.Co.), Digestive Surgery (P.M.) and Radiology (V.S.), Institute Curie, Paris; Antoine Lacassagne Cancer Center (E.F.), Nice; Palliative Care Unit (M.G.), Hospital Paul Brousse, APHP, Villejuif; and Department of Hepato-Gastroenterology (E.T.), Hospital du haut Levêque, Pessac, France

Occlusione intestinale

Review Article

Recommendations for Bowel Obstruction With Peritoneal Carcinomatosis

Guillemette Leval, MD, Blandine Marcelin-Benazech, MD, Frédéric Guirimand, MD, Laure Chauvenet, MD, Laure Copel, MD, Aurélie Durand, MD, Eric Francois, MD, Martine Gabolde, MD, Pascale Mariani, MD, Christine Rebischung, MD, Vincent Servois, MD, Eric Terrebonne, MD, and Catherine Arvieux, MD, on behalf of the French Society for Palliative Care, with the French Society for Digestive Surgery, the French Society for Gastroenterology, the French Society for Digestive Cancer, and the French Association for Supportive Care in Oncology

Table 3

Poor Prognostic Factors for Surgical Treatment of Bowel Obstruction

- Advanced age
- Poor performance status (OMS 3 or 4)
- Poor nutritional state
- Extent of the malignant disease: diffuse peritoneal carcinomatosis, ascites, palpable masses, multiple obstacles on the small bowel…
- Obstruction of the small bowel rather than colic obstruction
- Previous abdominal or pelvic radiotherapy

Summary. When feasible, endoscopic procedures should be preferred to surgery as they have lower morbi-mortality rates (Grade C). The lesion must be accessible with the endoscopic device.

Summary. NGTs relieve intractable vomiting and gastric distension. They are absolutely necessary in patients with enteral obstruction. NGTs should not be removed if secretions exceed 1 L/24 h as abundant vomiting will result. Physicians should aim to remove the NGT as soon as possible to minimize patient discomfort (expert consensus).

Occlusione intestinale

Review Article

Recommendations for Bowel Obstruction With Peritoneal Carcinomatosis

Guillemette Leval, MD, Blandine Marcelin-Benazech, MD, Frédéric Guirimand, MD, Laure Chauvenet, MD, Laure Copel, MD, Aurélie Durand, MD, Eric Francois, MD, Martine Gabolde, MD, Pascale Mariani, MD, Christine Rebischung, MD, Vincent Servois, MD, Eric Terrebonne, MD, and Catherine Arvieux, MD, on behalf of the French Society for Palliative Care, with the French Society for Digestive Surgery, the French Society for Gastroenterology, the French Society for Digestive Cancer, and the French Association for Supportive Care in Oncology

Summary. Venting gastrostomy can be considered as a long-term alternative to maintain an NGT. It must be considered and indicated promptly providing it is feasible and the patient has agreed to undergo the procedure. Percutaneous endoscopic gastrostomy should be preferred although there are some contraindications, principally ascites. Surgical indications remain rare (experts consensus).

Summary. Even if evidence is lacking, steroid use may be suggested at the time of diagnosis. They should be administered in short courses of 5–10 days to help manage symptoms and resolve the obstruction. The mean dose is 1–4 mg/kg/d for methylprednisolone or equivalent (expert consensus of opinion).

Summary. Butylscopolamine helps to manage vomiting and colicky pain (Grade C). As it is not very expensive, it is frequently used as a first-line treatment. The mean dose is 60–120 mg/24 h (expert consensus). Scopol-

Occlusione intestinale

Review Article

Recommendations for Bowel Obstruction With Peritoneal Carcinomatosis

Guillemette Leval, MD, Blandine Marcelin-Benazech, MD, Frédéric Guirimand, MD, Laure Chauvenet, MD, Laure Copel, MD, Aurélie Durand, MD, Eric Francois, MD, Martine Gabolde, MD, Pascale Mariani, MD, Christine Rebischung, MD, Vincent Servois, MD, Eric Terrebonne, MD, and Catherine Arvieux, MD, on behalf of the French Society for Palliative Care, with the French Society for Digestive Surgery, the French Society for Gastroenterology, the French Society for Digestive Cancer, and the French Association for Supportive Care in Oncology

Palliative and Supportive Care Mobile Unit (G.L.), Departments of Hepato-Gastroenterology (A.D.), Digestive Surgery (C.A.) and Oncology Day Hospital (C.E.), University Hospital Center, Grenoble; Palliative and Supportive Care Mobile Unit (B.M.-B.), HCL, Lyon; Medical House Jeanne Garnier (F.G.), Department of Medical Oncology (L.-Ch.), Hospital Hôtel Dieu, APHP; Departments of Medical Oncology (L. Co.), Digestive Surgery (P.M.) and Radiology (V.S.), Institute Curie, Paris; Antoine Lacassagne Cancer Center (E.F.), Nice; Palliative Care Unit (M.G.), Hospital Paul Brousse, APHP, Villejuif; and Department of Hepato-Gastroenterology (C.T.), Hospital du haut Leveque, Pessac, France

Summary. Gastric antisecretory drugs, like PPIs, seem relevant in patients with obstruction or partial obstruction to reduce gastric secretion or bile reflux and relieve upper digestive symptoms (expert consensus of opinion). They should be administered continuously over 24 hours, which is not always feasible in clinical practice. The IV injection of a bolus is the most frequently used (expert consensus). Omeprazole can be administered SC.

Somatostatin analogues can be considered for the treatment of bowel obstruction with peritoneal carcinomatosis. They are more effective than anticholinergic antisecretory drugs in controlling obstruction-induced vomiting.

Summary. Haloperidol is usually considered as a first-line treatment. If it does not prove effective, physicians can switch to chlorpromazine although it induces sedative side effects. Droperidol also can be an option (expert consensus). Metoclopramide should be administered only in patients with incomplete obstruction (expert consensus). In patients with intractable vomiting, 5-HT3 receptor antagonists can be considered as a second-line treatment. They can be administered alone or together (expert consensus).

Occlusione intestinale

SERIE GENERALE

Anno 152° - Numero 118

GAZZETTA UFFICIALE

DELLA REPUBBLICA ITALIANA

PARTE PRIMA — Roma - Lunedì, 23 maggio 2011

AVVISO ALLE AMMINISTRAZIONI

SOMMARIO

LEGGI ED ALTRI ATTI NORMATIVI

DECRETO DEL PRESIDENTE DEL CONSIGLIO DEI MINISTRI 3 marzo 2011, n. 74.

Regolamento di individuazione dei termini superiori ai novanta giorni per la conclusione dei procedimenti amministrativi di competenza del Ministero delle infrastrutture e dei trasporti, ai sensi dell'articolo 2, comma 4, della legge 7 agosto 1990, n. 241, come modificato dall'articolo 7 della legge 18 giugno 2009, n. 69. (11G0074) ..... Pag. 1

DECRETI PRESIDENZIALI

DECRETO DEL PRESIDENTE DEL CONSIGLIO DEI MINISTRI 10 marzo 2011.

Autorizzazione ad assumere e a trattenere in servizio unità di personale per le esigenze di varie amministrazioni dello Stato. (11A06561) ..... Pag. 31

ORDINANZA DEL PRESIDENTE DEL CONSIGLIO DEI MINISTRI 18 maggio 2011.

Ulteriori disposizioni per lo svolgimento del Congresso eucaristico nazionale che si terrà nel territorio della metropolia di Ancona nel mese di settembre 2011. (Ordinanza n. 3930) (11A06428) . Pag. 35

DECRETI, DELIBERE E ORDINANZE MINISTERIALI

Ministero dell'economia e delle finanze

DECRETO 2 maggio 2011.

Accertamento del tasso d'interesse semestrale dei certificati di credito del Tesoro 1° novembre 2004/2011 e 1° novembre 2005/2012 relativamente alla cedola con decorrenza 1° maggio 2011 e scadenza 1° novembre 2011. (11A06924) ..... Pag. 36

DETERMINAZIONE 18 maggio 2011.

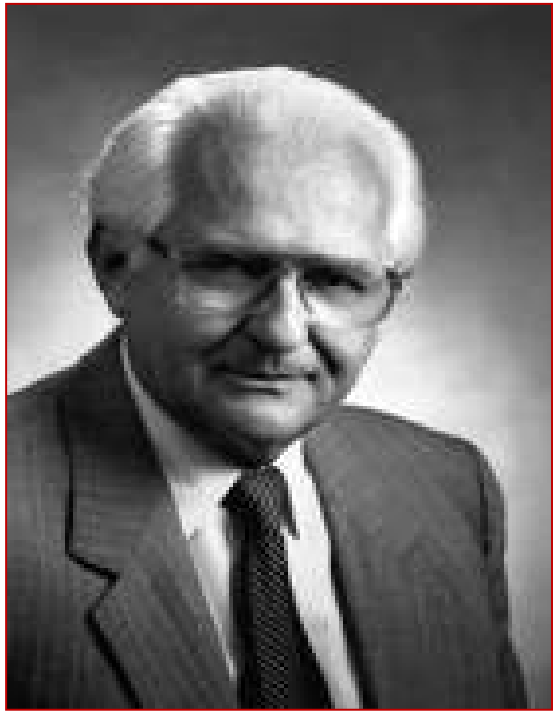
Aggiornamento dell'elenco dei medicinali, istituito con il provvedimento della Commissione Unica del Farmaco datato 20 luglio 2000, erogabili a totale carico del Servizio sanitario nazionale, ai sensi della legge 23 dicembre 1996, n. 648.

Nome Composto	*Indicazioni già autorizzate (AIC)*	*Estensione di indicazione relativa ad usi consolidati sulla base di evidenze scientifiche presenti in letteratura.*
Octreotide	Trattamento delle sindromi da tumori endocrini gastro-entero-pancreatici in particolare: - Carcinoidi (sindrome del carcinoide); - VIPomi; - Glucagonomi; - Gastrinomi / sindrome di Zollinger-Ellison (eventualmente in associazione con farmaci anti-H2, con o senza antiacidi); - Insulinomi (per la prevenzione delle crisi ipoglicemiche pre-intervento e terapia di mantenimento); - GRFomi. Per il trattamento sintomatico e la riduzione dei livelli plasmatici di GH e Somatomedina-C nei casi di acromegalia non adeguatamente controllati con terapia chirurgica, radiante o farmacologica (con	Utilizzo nel trattamento di tumori neuroendocrini in fase evolutiva in pazienti non sindromici. Utilizzo nel trattamento dell'occlusione intestinale di pazienti con neoplasia avanzata (i.e.ovaio, colon) e carcinosi peritoneale. Utilizzo nella diarrea indotta da chemioterapia e resistente a trattamento con loperamide.

Occlusione intestinale

Morfina, ossicodone, butilbromuro di ioscina, octreotide, aloperidolo miscelabili nello stesso sistema d’infusione (elastomero, syringe driver)

Delirium



SINDROME CEREBRALE ORGANICA TRANSITORIA CARATTERIZZATA DA COMPROMISSIONE ACUTA DELLA SFERA ATTENTIVA, COGNITIVA, PSICOMOTORIA E PERCETTIVA (Lipowski, *Am J Psychiatry,* 1983)

Interventi ambientali - prevenzione

Table 1. Essential approaches and practical steps of an intervention programme for the prevention of delirium

1. Identify high-risk individuals
   - Non-treatable delirium risk factors
     - Old age
     - Underlying dementia
     - Male gender
   - Previous history of delirium
   - Significant medical history
   - Poor eyesight and hearing
   - Frailty
   - Immobility
2. Initiate active preventive strategies (directed at all, but especially targeting those at high risk)
   - Identification and prompt management of any treatable delirium risk factor
   - Additional steps should include
     - Caring in an appropriately lit environment
     - Keeping number of staff caring for each individual to a minimum
     - Make patient familiar with clinical staff
     - Proper introduction and explanation by staff
     - Increase awareness among staff of delirium and its prevention
     - Increase awareness of sundowning syndrome
     - Ensure glasses and hearing aids are brought to hospital
     - Reminders to time and date
     - Review medications
3. Recognise delirium prodromal symptoms such as
   - Sudden and fine changes in mental state
   - Unexplained confusion
   - Shouting
   - Restlessness
   - Emerging hypoactivity
   - Sleeping difficulties

… non guasterebbe una valutazione dello stato cognitivo al momento della presa in carico (CAM, MDAS, intervista ai familiari)

Non vi sono evidenze sufficienti per consigliare un intervento farmacologico preventivo (Tabet, *Int J Geriatr Psychiatry*, 2009)

Interventi farmacologici – Rivedere la terapia in atto!

(ad esempio, corticosteroidi)

Delirium

Psychiatry and Clinical Neurosciences 2011; 65: 549–560 doi:10.1111/j.1440-1819.2011.02260.x

Review Article

Psychiatric complications of treatment with corticosteroids: Review with case report

Heather A. Kenna,* MA, Amy W. Poon, MD, C. Paula de los Angeles, BA and Lorrin M. Koran, MD

Department of Psychiatry and Behavioral Sciences, Stanford University Medical Center, Stanford, USA

Corticosteroids are widely used in modern medicine but can result in troubling psychiatric side-effects. Physicians and other medical professionals should be aware of the potential for these side-effects, possible means of prevention, and efficacious treatments. Herein, we review adult case report data published during the past quarter-century on adverse corticosteroid-induced psychiatric effects, and present a case of corticosteroid-induced psychotic depression. PubMed and PsychLit databases were searched using the terms 'corticosteroids', 'steroids', and the generic names of corticosteroid medications with terms for psychiatric symptoms or syndromes, including psychosis, mania, hypomania, depression, apathy, anxiety, panic, depersonalization, delirium, confusion, hallucinations, delusions, paranoia, cognitive impairment and dementia. Fifty-five cases and a number of clinical trials investigating the incidence and treatment of these psychiatric symptoms and syndromes were identified. Data on incidence, drug dose, risk factors, course of illness and treatment (when present) were tabulated. We conclude that the cumulative data indicate that psychiatric complications of corticosteroid treatment are not rare and range from clinically significant anxiety and insomnia, to severe mood and psychotic disorders, delirium and dementia. While tapering or discontinuation of the corticosteroid treatment may remedy these adverse side-effects, psychotropic medications are often required because of the medical necessity of the corticosteroid or the severity of the psychiatric symptom. Further studies are needed to better understand the deleterious psychiatric effects associated with corticosteroids.

Key words: corticosteroids, delirium, mood, anxiety, psychosis.

Riduzione o sospensione a seconda della situazione clinica, della possibilità di *restitutio quo ante,* della prognosi, ecc.

Occorrono studi clinici controllati per rispondere alle seguenti domande: come ridurre la posologia? come valutare il rischio di eventi indesiderati da sospensione?

"Treatment of corticosteroid-induced psychiatric symptoms should start whenever possible with dose reduction or stopping the drug."

- **Appenzeller. *Rheumatol Int* 2008.**
- **Brown. *J Clin Psychiatry* 2001.**
- **Lewis. *J Affect Disord* 1983.**
- **Ling. *Arch Gen Psychiatry* 1981.**
- **Patten. *Drug Saf* 2000.**
- **Sirois. *Gen Hosp Psychiatry* 2003.**
- **Warrington. *Mayo Clin Proc* 2006.**

JOURNAL OF PALLIATIVE MEDICINE
Volume 12, Number 5, 2009

DOI: 10.1089/jpm.2009.9628

Case Discussions in Palliative Medicine

Feature Editor: James Hallenbeck

Can "Steroid Switching" Improve Steroid-Induced Psychosis in a Patient with Advanced Cancer?

Nao Okishiro, M.D.,[1] Hitoshi Tanimukai, M.D., Ph.D.,[2,3] Satoru Tsuneto, M.D., Ph.D.,[4] and Noriyuki Ito, M.D.[1]

In qualche caso potrebbe avere un ruolo la «rotazione» degli steroidi?

Sedazione palliativa

"Pratica volta ad alleviare sintomi refrattari riducendo lo stato di coscienza in misura adeguata e proporzionata alle necessità, effettuata quando la morte è attesa entro un lasso di tempo compreso tra poche ore e pochi giorni"

CON IL CONSENSO DELL'AMMALATO! (SE COMPETENT)

SEDAZIONE PALLIATIVA A DOMICILIO: POSSIBILE?

Sedazione palliativa

SINTOMI REFRATTARI CHE HANNO CONDOTTO ALLA SEDAZIONE (HOME CARE)

1126 Journal of Pain and Symptom Management Vol. 43 No. 6 June 2012

Brief Report

Palliative Sedation in Advanced Cancer Patients Followed at Home: A Retrospective Analysis

Sebastiano Mercadante, MD, Giampiero Porzio, MD, Alessandro Valle, MD, Flavio Fusco, MD, Federica Aielli, MD, Claudio Adile, MD, and Alessandra Casuccio, BS, on behalf of the Home Care–Italy Group (HOCAI)
Pain Relief and Palliative Care Unit (S.M., C.A.), La Maddalena Cancer Center, Palermo; Palliative Medicine (S.M.), Department of Anesthesia & Intensive Care and Department of Experimental Biomedicine and Clinical Neuroscience (A.C.), University of Palermo, Palermo; Home Care Program (G.P., F.A.), L' Aquila per la vita, L'Aquila; Home Care Program (A.V.), Fondazione FARO, Torino; and Home Care Program (F.F.), ASL 3 Genovese, Genova, Italy

Table 1

Indications to Start PS

Reasons to Start PS	Frequency	Percentage
Delirium	26	53.1
Delirium/pain	1	2
Delirium/dyspnea	7	14.3
Dyspnea	10	20.4
Dyspnea/O	1	2
Pain	1	2
Pain/dyspnea	2	4.1
Pain/dyspnea/psychological distress	1	2
Total	49	100

PS = palliative sedation; O = other.

754 Journal of Pain and Symptom Management Vol. 41 No. 4 April 2011

Review Article

Palliative Sedation in Patients with Advanced Cancer Followed at Home: A Systematic Review

Sebastiano Mercadante, MD, Giampiero Porzio, MD, Alessandro Valle, MD, Flavio Fusco, MD, Federica Aielli, MD, and Veruska Costanzo, MD, on behalf of the "Home Care Italy" Group

Pain Relief and Palliative Care Unit (S.M.), La Maddalena Cancer Center, Palermo; Palliative Medicine (S.M.), Department of Anesthesia & Intensive Care, University of Palermo, Palermo; Home Care Program (G.P., F.A.), L'Aquila per la Vita, L'Aquila; Home Care Program (A.V.), Fondazione FARO, Torino; Home Care Program (F.F.), ASL 3 Genovese, Genova; and Home Care Program (V.C.), SAMO, Catania, Italy

FREQUENZA (HOME CARE)

Table 1
Published Articles on PS at Home

Authors/Year/Country	Design	Sample of Patients at Home, *n* (% Sedated)	Principal Drugs and Doses (mg/day)	Principal Indications	Mean Duration (days)
Ventafridda et al./1990/Italy[9]	Prospective	154 (52)	NA	Dyspnea, pain	2
Peruselli et al./1999/Italy[7]	Prospective, multicenter	100 (25)	NA	NA	NA
Bulli et al./2007/Italy[8]	Prospective	1075 (12–14.2)	Neuroleptics Midazolam Opioids	NA	1
Rosengarten et al./2009/Israel[10]	Retrospective	720 (5)	Morphine (12–240) Midazolam (12–144)	Pain, agitation	3
Porzio et al./2010/Italy[12]	Retrospective	44 (36)	Midazolam (24–48)	Delirium, dyspnea	3.5
Alonso-Babarro et al./2010/Spain[11]	Retrospective	245 (12)	Midazolam (58–97)	Delirium, dyspnea	2.5

NA = not available.

In un servizio di cure palliative bisogna preoccuparsi se la sedazione è:

- **Troppo rara (riluttanza a metterla in atto quando indicato)**
- **Troppo frequente (incapacità di controllare i sintomi difficili ma non refrattari)**

FREQUENZA (HOME CARE)

860 Journal of Pain and Symptom Management Vol. 47 No. 5 May 2014

Original Article

Palliative Sedation in Patients With Advanced Cancer Followed at Home: A Prospective Study

Sebastiano Mercadante, MD, Giampiero Porzio, MD, Alessandro Valle, MD, Federica Aielli, MD, and Alessandra Casuccio, BS, on behalf of the Home Care—Italy Group

Pain Relief and Palliative Care Unit (S.M.), La Maddalena Cancer Center, Palermo; Palliative Medicine (S.M.), Department of Anesthesia & Intensive Care and Department of Sciences for Health Promotion "G. D'Alessandro"—Hygiene Section (A.C.), University of Palermo, Palermo; Home Care Program (G.P., F.A.), L' Aquila per la vita, L'Aquila; and Home Care Program (A.V.), Fondazione FARO, Torino, Italy

"The palliative sedation was performed in 24 of 176 patients who died at home (13.6%).

Elementi indispensabili per effettuare sedazione palliativa a casa:

- Condivisione ed accordo con la famiglia
- Alta intensità assistenziale da parte della mini équipe domiciliare
- Disponibilità dei farmaci consigliati dalle linee guida

Sedazione palliativa

REGIONE PIEMONTE

DIREZIONE SANITÀ
Settore ASSISTENZA FARMACEUTICA INTEGRATIVA E PROTESICA
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Il Dirigente
Torino, 3.11.2016
Protocollo n. 38377 /A1404A
Classificazione 14.120.40

Direttori Generali
delle Aziende Sanitarie Regionali

Responsabili Servizi Farmaceutici
delle Aziende Sanitarie Regionali

LORO SEDI

OGGETTO: Dispensazione dei medicinali classificati H OSP -

La CTS ha ribadito, inoltre, che il regime di fornitura OSP individua farmaci utilizzabili **esclusivamente in ambiente ospedaliero o ad esso assimilabile.**

Come la mettiamo con il midazolam, farmaco di prima scelta per la sedazione palliativa?

Riflessioni conclusive…

- Numerose survey, effettuate intervistando persone sane e ammalate, hanno chiaramente evidenziato il desiderio prevalente di poter concludere i propri giorni a casa
- Trattare efficacemente a domicilio i sintomi dei pazienti oncologici in fase avanzata di malattia è possibile, non diversamente dai centri residenziali
- Per ottenere buoni risultati occorre équipe dedicata, in grado di garantire un elevato coefficiente di intensità assistenziale (LEA 2018, Accordo Stato-Regioni 2012) e flessibilità organizzativa
- Questi requisiti facilitano altresì la possibilità di dedicare tempo adeguato alla relazione con paziente e caregiver, quest'ultimo spesso in difficoltà nell'accettare la situazione ed a condividere i suggerimenti terapeutici («Il tempo di relazione è tempo di cura» Legge 219 - 2017).
- Per poter garantire risultati soddisfacenti occorre avere a disposizione i farmaci più efficaci, secondo i dati della letteratura più aggiornati: in caso contrario, il rischio è di accessi inappropriati in ospedale, con insoddisfazione dell'ammalato e netto incremento dei costi assistenziali

Grazie per l'attenzione