Palliative Care in Older Adults

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The goal of palliative care is to prevent and relieve suffering and to improve quality of life for people facing a serious, complex illness.

Rather than striving to halt, delay, or reverse disease progression or provide a cure, the goal of palliative care is to prevent and relieve suffering and to improve quality of life for people facing a serious, complex illness. Nonhospice palliative care does not depend on prognosis and is offered in conjunction with curative and all other appropriate forms of medical treatment. While any noncurative approach to treatment may be viewed as palliative, the 2 most familiar palliative approaches are pain management and hospice.

The goal of psychiatric care late in life is the remission of symptoms of mood, anxiety, cognitive, and behavioral disorders along with rehabilitation of psychosocial functioning and improved quality of life. Remission of symptoms may be viewed as a “cure” if it is sustained. In many patients, however, symptoms follow a waxing and waning course that requires a palliative care approach. For these patients and their families, cure may not be a reasonable goal of treatment; rather, a reduction in symptoms and an improved quality of life may be a more reasonable approach.

Although the concept of palliative care is not new, most physicians have traditionally concentrated on trying to cure patients. The term “palliative care” is increasingly used with regard to diseases other than cancer, such as chronic progressive pulmonary disorders, renal disease, chronic heart failure, HIV/AIDS, and progressive neurological and treatment-resistant psychiatric conditions.

In this article, I address 3 conditions in which psychiatrists may offer a palliative care approach to optimize the quality of life of older adults who have treatment-resistant mood disorders, pain, or moderate to advanced dementia.

Older patients with treatment-resistant mood disorders

As defined by the American College of Neuropsychopharmacology, refractory depression is the persistence of significant symptoms despite at least 2 treatment trials with drugs from different pharmacological classes, each used in an adequate dose for an adequate period. If combination and augmentation pharmacotherapy, other somatic interventions (electroconvulsive therapy [ECT], bright light therapy, transcranial magnetic stimulation), and psychotherapy have not led to significant resolution of symptoms, a palliative approach may be an option.

Using a palliative approach does not mean that the patient, his or her family, and the physician should give up hope that symptoms will improve. It may, however, involve a shift in the expectations of treatment outcome. In challenging cases, it may be helpful to approach the disorder as a chronic
condition that requires long-term management (such as diabetes or hypertension) to maintain symptoms at a tolerable level.

Patients with such chronic conditions generally require life-long treatment with 1 or more antidepressant medications, maintenance ECT, and augmentation therapies. Targeting specific symptoms with the palliative approach may enhance quality of life for both patients and their caregivers. For example, if fatigue or sedation is a prominent symptom that is resistant to traditional pharmacological and/or behavioral interventions, trials of CNS stimulants such as methylphenidate or mixed amphetamine salts may be useful. If insomnia is recalcitrant to behavioral therapy and/or pharmacotherapy with 1 agent and obstructive sleep apnea has been excluded, the use of more than 1 hypnotic, such as a benzodiazepine, and a sedating antidepressant may be required. While we do not view these interventions as curative, they may be critical in improving quality of life. Common sense must apply regarding polypharmacy, adverse effects, changes in pharmacokinetics and pharmacodynamics associated with aging, and diversion of drugs of potential abuse.

CHECKPOINTS

• For some older adults with treatment-resistant mood and anxiety disorders, advanced cognitive decline, and chronic pain, cure may not be the goal of treatment. Rather, a reduction in symptoms and an improved quality of life may be a more reasonable approach.

• Effective use of a palliative care approach often requires a multidisciplinary approach.

• When treating a patient with dementia, among the psychiatrist’s most important functions are to advocate for the patient and his or her family, to manage behavioral and mood disturbances, and to minimize caregiver burden.

Older patients with pain

Psychiatrists caring for older adults evaluate and treat patients with persistent pain in the office, nursing home, psychiatric hospital, and medical hospital. Consistent with the principles of palliative care, the psychiatric approach to persistent pain is not disease modification; rather, the goal is to reduce symptom severity and improve quality of life. Given that up to 50% of community-dwelling seniors experience pain that interferes with normal function and 45% to 80% of nursing home residents have daily pain, care of these patients should, at the least, involve routine assessment for pain severity and pain-related disability.²,³

Although some psychiatrists who work with the elderly are comfortable prescribing oral and topical analgesics and collaborating with primary care physicians and physical and occupational therapists, the majority of psychiatrists feel little “ownership” of or comfort with this area of medicine. For all psychiatrists, however, knowledge about the typical presentation and differential diagnosis of pain conditions (Table 1) will assist in precise and effective transdisciplinary communication and will allow for treatment recommendations.

In the specialized setting in which I practice, I routinely assess for and assist in the management of both the psychiatric and pain conditions of elderly patients. I have found the following steps useful when assessing a patient:

• Introduce yourself and let the patient know that you are a psychiatrist with an interest in pain management
• Take a full pain history that includes a chart review; an etiology and a description of the pain; past treatments; and the degree to which pain interferes with activities, relationships, independence, and sleep
• Assess the psychiatric chief complaint and history of the psychiatric illness
• Pay attention to psychiatric comorbidity, sleep problems, and suicidal ideation, because patients with chronic pain and psychiatric disorders are at higher risk for these conditions. Most of the prescriptions that I write are for antidepressants, anticonvulsants, benzodiazepines, stimulants, and hypnotics; however, to properly care for patients has required that I be comfortable prescribing both oral (eg, acetaminophen, opioids) and topical (eg, lidocaine patch, capsaicin, compounded creams) analgesics. When opioids are required, I usually prescribe tramadol; hydrocodone; oxycodone; or a longer-acting morphine derivative, such as the transdermal fentanyl patch. Although I occasionally prescribe NSAIDs, given their potential GI and cardiovascular toxicity, I usually leave the prescribing of these agents to pain physicians or primary care physicians. Their use, however, frequently goes into my consultation reports as treatment recommendations. Because pain is a multifactorial phenomenon, including sensory, emotional, and cognitive components, there is no one-size-fits-all treatment. Thus, to effectively care for patients and provide palliative care, I work closely with a multidisciplinary team of psychologists (who specialize in cognitive-behavioral therapy), rehabilitation specialists (physical and occupational therapists), and pain medicine physicians. We are fortunate to have all of these services under one roof. However, psychiatrists can create their own network of specialists by cultivating professional relationships with colleagues from these disciplines. Because of the multiple components of pain (sensory, emotional, cognitive), each patient requires an individualized management plan that can integrate analgesics, rehabilitation therapies, psychological interventions, and a variety of somatic treatments (eg, injections, surgery, complementary and alternative medicine). All older patients, however, should be counseled that:
  • Chronic pain is a syndrome with many potential contributors, all of which require treatment for optimal clinical outcome
  • Chronic pain can be treated but not cured; improvement is the rule, not the exception
  • Improvement in functional ability is often greater than the reduction in pain severity. It may be helpful to refer patients to a pain clinic for more intensive treatment if pain is the primary complaint, if the pain is not diminishing (or is worsening), or if “serial referrals” to specialists have been unsuccessful. There are different types of pain clinics, including single-modality clinics (eg, a nerve block clinic), syndrome-oriented clinics (eg, for low back pain or headaches), and multidisciplinary clinics that treat a variety of pain syndromes. There are no established recommendations for when to refer a patient or who should be referred to a pain clinic. In general, though, a referral is usually appropriate between 4 and 6 months after severe symptom onset in patients who also have evidence of related physical or psychosocial deterioration. In addition to reduction in pain severity and pain “bothersomeness,” treatment outcome parameters for older adults include the degree to which pain interferes with performance of basic, instrumental, and discretionary activities of daily living. Other relevant outcomes include the effect of pain on the patient’s mobility/activity, energy, appetite, sleep, mood and irritability, interpersonal functioning, attention and concentration, and...
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Older patients with moderate to advanced dementia

To date there are no disease-modifying or preventive medications for dementia, of which Alzheimer disease is the most common. In addition to memory and other cognitive deficits, the majority of patients with moderate to advanced dementia have a range of neuropsychiatric and behavioral disorders, such as depression, anxiety, disordered sleep, apathy, agitation, and psychosis.

The goal is not cure but a palliative reduction in symptom burden and an enhancement of quality of life. An important function of the psychiatrist is to teach families and caregivers about the most distressing neuropsychiatric symptoms and behaviors that can be expected, such as repetitive behavior, restlessness, incontinence, lack of inhibition, sleep problems, and suspiciousness. Table 2 lists practical recommendations for coping with these behaviors. In addition, it is important to educate patients and their caregivers so that they have reasonable expectations about disease progression and management options and to provide information about services, entitlements, and options (eg, nursing home placement, respite care, hospice, and geriatric case managers).

In working with elderly patients with dementia and their families, patient preferences regarding type and level of care should be ascertained (Table 3). This is especially useful if premorbid preferences for care in late life (when capacity to make decisions is less likely to be challenged) have been documented.

The ability of families to care for loved ones with dementia in the home varies. It is a standard of care to consistently assess caregivers for burnout and depression to ensure that their quality of life is maintained and that proper care can be provided to the patient. Minimizing patients’ neuropsychiatric and behavioral symptoms can prolong the time they can stay in their homes and can maximize the amount of meaningful time they can spend with loved ones.

Hospice is an option for severely demented patients. Key clinical indicators for hospice include:
- Progressive decline in status despite curative treatments
- Frequent hospitalizations
- Recurring or multiple infections
- Increased or uncontrolled pain
- Progressive/profound weakness and fatigue
- Shortness of breath with or without oxygen
- Profound dependency (decrease in activities of daily living)
- Alterations in mental status
- Weight loss
A patient may leave hospice care if his condition improves and reenter if the condition worsens. The goal of hospice, consistent with palliative care, is to keep the patient’s pain and suffering to a minimum. Hospice care can be delivered at home or in a hospital, nursing home, or private hospice facility. Hospice can provide companionship, spiritual care, transferral of the patient from home care to inpatient care, respite care for caregivers, family conferences, after-death services, and bereavement care.

Because pain management and symptom control may be difficult with dementia, many patients are cared for in nursing homes. The final stage can last from months to years. Medicare allows hospice care for 2 periods of 90 days, followed by an unlimited number of 60-day periods, as long as the physician recertifies that the patient is not getting better and is still terminal. Patients remain eligible for hospice services if their decline is measurable (from month to month) and their prognosis can be recertified by their primary care physician. Ways to enhance hospice enrollment for patients with advanced dementia include:

- Educating nursing homes about the appropriate time to suggest hospice services
- Educating families and physicians that dementia is terminal and about the disease process
- Increasing the comfort of physicians to certify that a patient has 6 months (or less) to live, although some patients may actually live longer
- Identifying and controlling pain symptoms in cognitively impaired patients

**Conclusion**

The palliative approach described in this article is no less aggressive in hastening treatment outcome than that used in a curative treatment model. Indeed, the imperative for symptom reduction and enhanced quality of life may be more pressing given both the urgency (eg, pain) or the terminal nature (eg, end-stage dementia) of these conditions and the profound effect on families and caregivers.

**References**


**Additional Resources**
