



Sample Oral Case Abstract # 1

Cancer as a "Growth" Experience for a Palliative Care Fellow (TH312-A)

Franciska Kiraly, MD, Summa Health Systems, Akron, OH

Objectives:

1. Recognize issues of role identity, ambiguity and loss of objectivity in the ill physician.
2. Identify characteristics of dual-relationships between the ill physician and patients.

Background: Being able to empathize with seriously ill patients is a strong and positive characteristic of hospice and palliative providers. This work also makes providers more acutely aware of their mortality. If these two elements weren't challenging enough, when a palliative care physician becomes a cancer patient, it creates a new dimension to the thoughts and interactions one has with patients and families. This case examines the challenges and opportunities for growth that can be found when we allow our coworkers, patients and their families to share our vulnerability.

Case Description: A 29 year old physician, midway through her hospice and palliative fellowship, discovers she has breast cancer. While a difficult diagnosis for anyone, it is even more difficult when you are young and in this field. She spends much of the year undergoing treatment including surgery, chemotherapy and radiation. During treatment she continues to complete her fellowship. While acquiring knowledge and skills in her formal training, her cancer treatment helps her gain street smarts. No course in medical school ever tells you how to process your own illness or how to care for others while you are trying to heal yourself. Not only is a cancer diagnosis physically altering, it changes the way a person thinks and acts, sometimes unconsciously. Questions arise about how much personal information to share with patients, patients' families and even coworkers. Saying "I know how you feel" takes on a new meaning. Many unique questions and concerns arose during this year of exponential growth. For example, what do you say when, during an office visit, a patient hopes that you don't develop the same chemo-induced neuropathy that you are treating them for?

Conclusion: This case examines the challenges a provider faces and the unique opportunities that develop when confronted with a personal cancer diagnosis.

Oral Case Abstract # 2

Palliative Care in a Cardiac Surgery ICU: A Novel Idea (TH312-B)

Sharon Allan, Cardiovascular Surgical Intensive Care Unit, at Johns Hopkins, Baltimore, MD

Annemiek Urban, RN BSN, Johns Hopkins Hospital, Baltimore, MD

Thomas Smith, MD, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD

Marylou Zyra, BSN, Johns Hopkins Hospital, Baltimore, MD

(All authors listed above had no relevant financial relationships to disclose.)

Objectives:

1. Recognize how the use of a Risk Assessment Tool helps to identify Cardiac Surgery ICU patients in need of palliative care intervention.
2. Recognize that palliative care in a cardiac surgery ICU does not exclude curative care
3. Describe how an ICU based palliative care committee, use of a palliative care risk assessment tool, a process algorithm and analysis of outcomes can help to change the culture of an ICU surgical team.

Background: As our population ages, medical care is more complex, leading to an increase in ICU admissions near the end of life. (Teno JAMA 2012) Palliative care in a Cardiac Surgery ICU (CSICU) has not been studied. Cardiac surgery is deemed curative care, and palliative care is often seen by cardiac surgeons as undermining the treatment they are providing. However, 20% of our population dies in the ICU. It is important to provide symptom management of pain, delirium, anxiety, depression, and support, achieved through palliative care intervention. A new risk assessment tool (CV-RAT) to identify patients whose needs are not met with traditional critical care was developed. The CV-RAT is a checklist to assess the need for a palliative care consult.

Case Description: A 70-year-old female scheduled for AVR was admitted in CHF. History of HBP, RHD, AVR/MVR, EF 25-30%, MR & AS, depression, chronic anemia. She did not have advanced directive. She told her daughter “she would not want to live dependent on machines”. Post-op course: respiratory failure, infection, sepsis, HF, GIB, delirium, arrhythmias, cachexia, and UAPU. POD4 she scored (+) on CV-RAT. Cardiac surgeon approval to proceed with a palliative care consult was obtained on POD#10, consult done that same day. Goals of care and family’s coping mechanisms were addressed. Basal pain management, ROM, PT/OT, night/day sleep cycle. POD19 family requested referral to the inpatient palliative care unit. Transferred on POD26 as a transition to go home with hospice. Patient died with family at her bedside.

Conclusion: A multidisciplinary approach, use of the CV-RAT tool and good communication aid in the early identification of patients in need of palliative care support, symptom management, and family



support regarding EOL decisions. The process enables a continuum of care for the critically ill cardiac surgery patient without excluding curative therapy.



Sample Poster Case Abstract # 1

Co-Operative Medicine: Methadone as a Co-Analgesic for Refractory Pain (C801)

Kara Bischoff, University of California at San Francisco, San Francisco, CA

Steven Pantilat, MD FAAHPM SFHM, UCSF Palliative Care Program, San Francisco, CA

Objectives

1. Understand mechanisms for opioid tolerance and hyperalgesia.
2. Describe potential mechanisms of action of methadone in counteracting hyperalgesia and tolerance.
3. Understand the existing data on the use of low-dose methadone for pain control in patients on other long-acting opioids.
4. Develop an approach for using low-dose methadone in the care of patients with refractory pain receiving palliative care.

Background: Research suggests that targeting multiple receptors involved in pain may allow for improved pain control with less tolerance, hyperalgesia, and adverse effects. Methadone is distinct from other opioids, as it is a mu opioid agonist and N-methyl-D-aspartate receptor antagonist. The use of low-dose methadone concurrently with other long-acting opioids has been shown to improve pain with acceptable tolerability. While promising, the data for methadone as a co-analgesic is limited.

Case Description: Ms. M. is a 23-year-old woman with a history of myelodysplastic syndrome treated with autologous stem cell transplant. Her post-transplant course was complicated by severe graft-versus-host-disease of her skin. She gradually healed but had residual 7-10/10 pain in a stocking pattern in both legs. The pain was debilitating and described as burning, tingling, throbbing, and worse with touch. She was admitted for pain control with palliative care consultation. On admission she was taking immediate release morphine sulfate 15mg every four hours as needed, gabapentin 300mg every eight hours and venlafaxine 37.5mg daily. Our team added long-acting morphine, increased the dose and frequency of her immediate release morphine and uptitrated gabapentin and venlafaxine. Over the first 21 days of her prolonged hospital stay she had persistent pain despite using up to 540mg of oral morphine equivalents per day. Because of her escalating opioid use without improvement in her pain, low-dose methadone was added, at 2.5mg every eight hours. Within three days her pain scores



decreased to 5/10, her oral morphine usage decreased to 300mg per day, and she was able to be more active.

Conclusion: Although evidence for methadone as a co-analgesic is not definitive, its NMDA receptor antagonist activity provides a mechanism for counteracting tolerance and hyperalgesia, We will review existing evidence and rationale for adding low dose methadone to patients on high doses of opioids to improve pain control.

Poster Case Abstract # 2

Persistent Vomiting and Abdominal Pain: Cyclic Vomiting Syndrome in an Adult (C802)

Karen Blackstone, MD, George Washington University, Washington, DC

Michael Reynolds, MD, George Washington University, Washington, DC

Elizabeth Cobbs, MD, George Washington University, Washington, DC

Nadia Marsh, MD, George Washington University School of Medicine, Washington, DC

Objectives

1. Describe Cyclic Vomiting Syndrome in an adult.
2. List elements of a palliative/integrative medicine approach to care for a patient with Cyclic Vomiting Syndrome.
3. Identify opportunities to add palliative/integrative medicine in care for patients with serious illness.

Background: Cyclic Vomiting Syndrome (CVS) is characterized by recurrent episodes of intense nausea, vomiting and severe abdominal pain without an identifiable cause. Although rare, CVS can lead to serious morbidity and severely impacts quality of life. When conventional treatment fails to relieve symptoms, a palliative/ integrative medicine approach may improve outcomes.

Case Description: A 28 year old veteran presented to the Emergency Department (ED) twelve times in three months with severe nausea, vomiting, and abdominal pain. Despite primary care, neurology/pain clinic, and gastroenterology assessments he experienced nearly daily severe symptoms. Pain and vomiting resolved quickly with intravenous opioids and anti-emetics. On the thirteenth ED visit Palliative/Integrative Medicine was consulted. The patient reported 4 years of symptoms, starting after his mother's death. Typically severe flank pain radiated to his lower abdomen, 8/10 severity, twice per



day and sometimes at night. Triggers included: stress, pungent smells and ingestion of red food coloring. He had no personal or family history of childhood vomiting or migraines. He was unable to work. He used marijuana for pain and nausea. Health care providers did not prescribe opiates due to his no-show clinic record and marijuana use. The patient felt that ED care was his only outlet for relief of symptoms. Palliative/Integrative Medicine team conducted a comprehensive interview and examination, and incorporated complementary modalities (massage, acupuncture, meditation) into an evidence-based person-centered care plan. After three Palliative/Integrative Medicine outpatient visits the patient experienced improved symptom relief and only one emergency department visit.

Conclusion: A Palliative/Integrative Medicine approach to care can relieve symptoms in a patient with CVS otherwise refractory to usual medical care. This presentation will review a systematic palliative/integrative medicine approach resulting in identification of person-centered goals of care, relief of severe symptoms, and meaningful outcomes for the patient, his caregivers, and the health care system.