Sedazione Palliativa

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Hospice Codigoro

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Punti toccati

- Sviluppo della ricerca
- Definizione
- Indicazioni
- Monitoraggio
- Prevalenza
- Durata
- Farmaci
- Impatto su sopravvivenza
- Sedazione e idratazione
- Sedazione ed eutanasia
- I familiari
- A domicilio
- Aspetti particolari
- Existential suffering
- Malpractice
- Framework
- Conclusioni

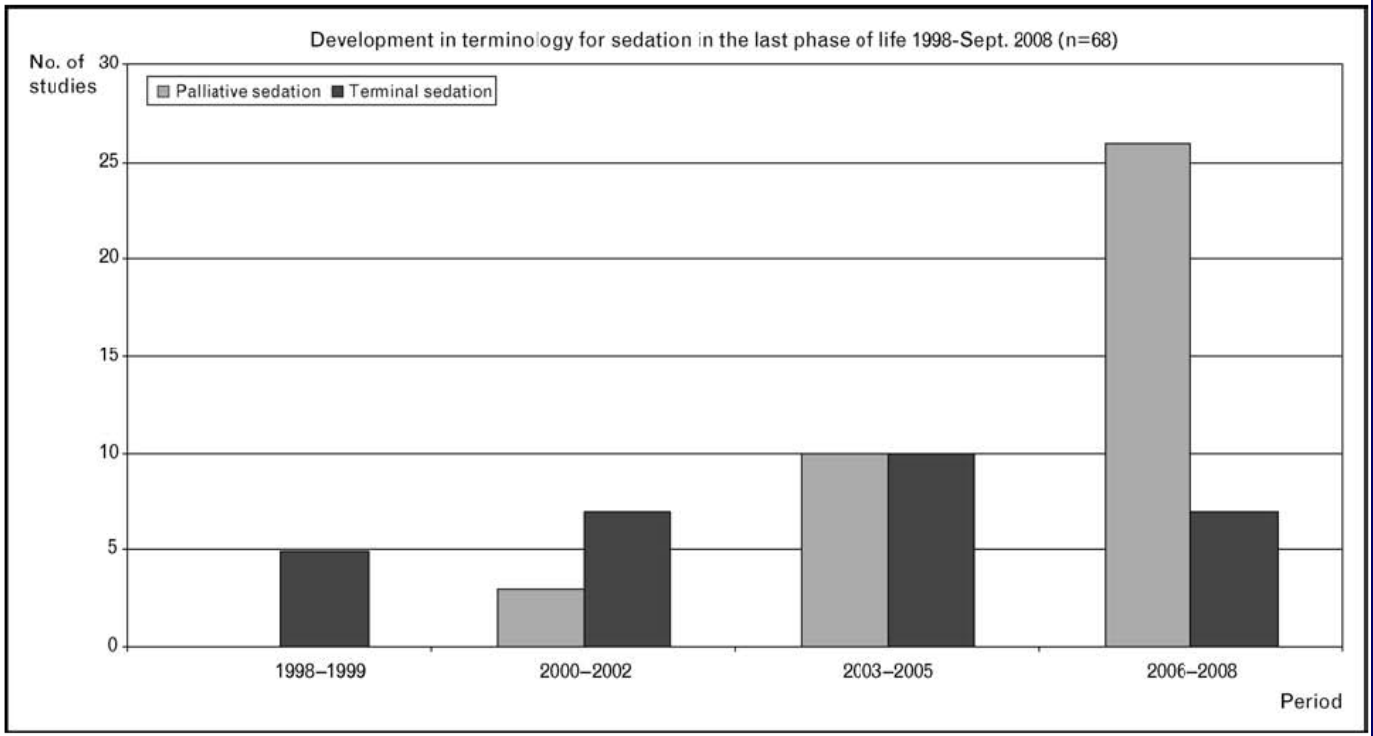
Sedazione palliativa: definizioni

- **“the use of sedative medications to relieve intolerable suffering from refractory symptoms (scopo) by a reduction in patient consciousness (mezzo)”**
- **(De Graeff A, Dean M. Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards. J Palliat Med 2007;10:67-85)**

When cancer symptoms cannot be controlled: the role of palliative sedation.

(Hasselaar JG, Curr Opin Support Palliat Care. 2009 Mar;3(1):14-23)

Figure 3 Development of terminology in literature

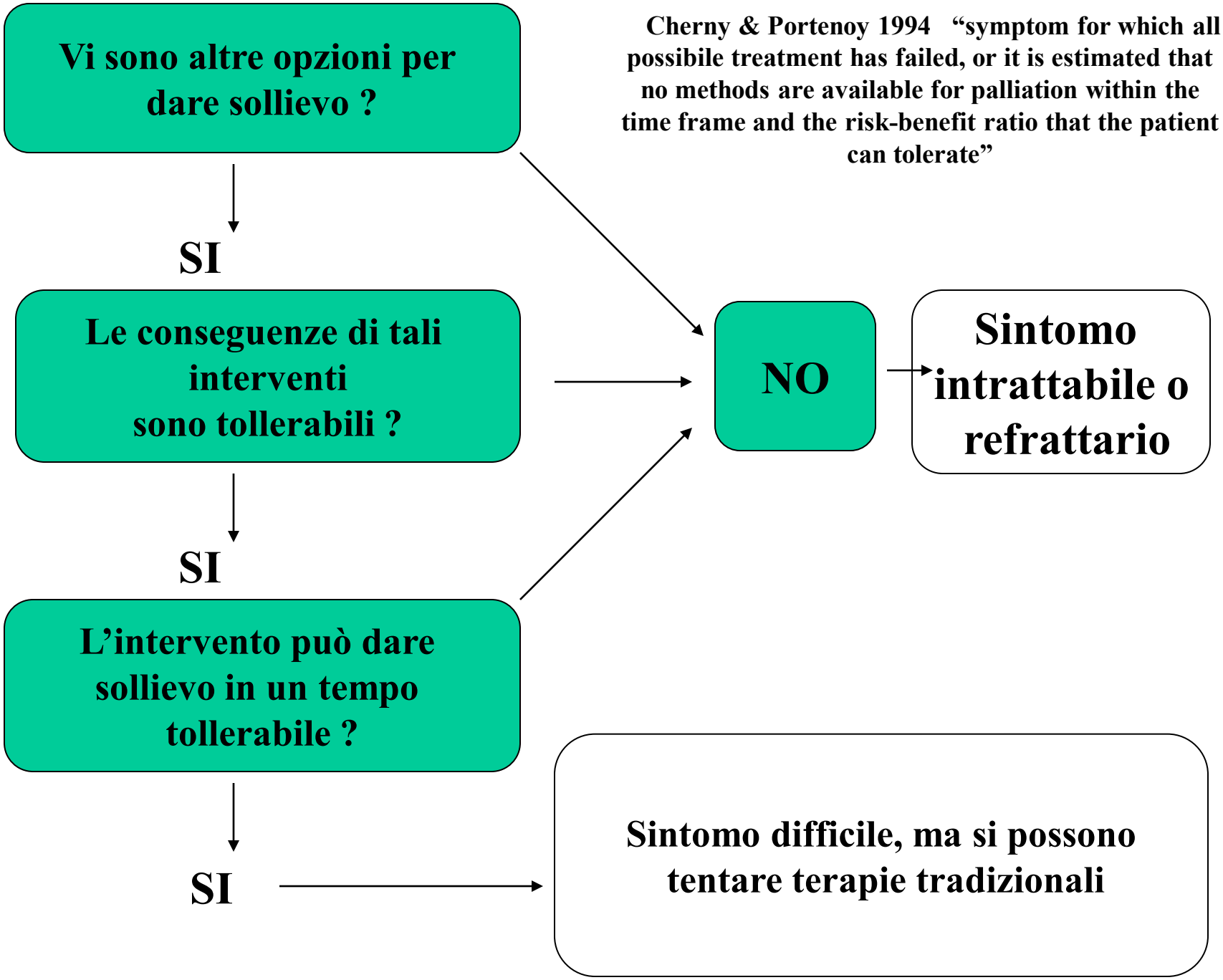


, Palliative sedation; , Terminal sedation.

Caratteristiche della “Palliative Sedation Therapy”

- **Sedazione palliativa**
- **(Sedazione terminale)**
- **Sedazione superficiale, intermedia, o profonda**
- **Sedazione continua o intermittente**
- **Sedazione primitiva o secondaria**
- **Sedazione progressiva o rapida**

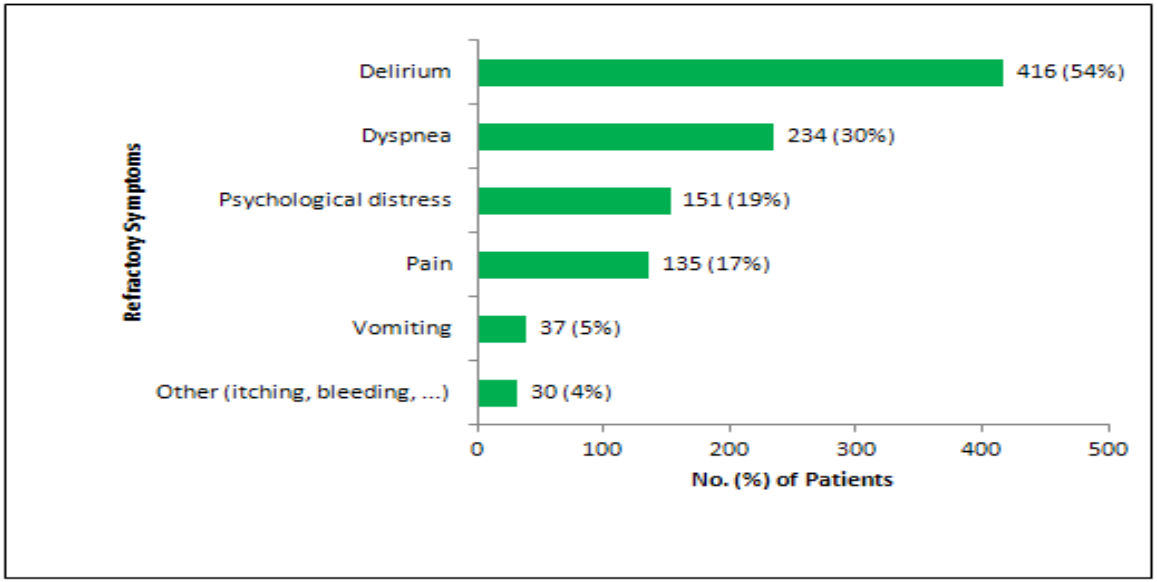
Cherny & Portenoy 1994 "symptom for which all possibile treatment has failed, or it is estimated that no methods are available for palliation within the time frame and the risk-benefit ratio that the patient can tolerate"



Palliative sedation in end-of-life care and survival: a systematic review

(Maltoni M, J Clin Oncol. 2012 Apr 20;30(12):1378-83)

Figure 2.



[Main refractory symptoms requiring sedation in 774 sedated patients from 10 studies (5–9,11–15)]

Palliative sedation therapy does not hasten death: results from a prospective multicenter study

(Maltoni M, Ann Oncol 2009 Jul;20(7):1163-9)

Table 3. Refractory symptoms requiring PST

Variable	Cohort A (PST)	
	n	%
Refractory symptom		
Delirium and/or agitation	210	78.7
Dyspnea	52	19.5
Pain	30	11.2
Vomiting	12	4.5
Psychological and physical distress	50	18.7
Only psychological distress	16	6.0
Others	10	3.7
Number of refractory symptoms		
1	168	62.9
2	89	33.3
3	9	3.4
4	1	0.4

Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards

(De Graeff A, J Palliat Med, 2007; 10 (1) 67-81)

- **Outcomes and monitoring**

- **16. The effect of PST on the patients' comfort should be assessed daily. Attention should be paid to distress and sedation levels, adverse effects of sedation and also the needs of family. PST and support of the family should be modified as deemed necessary (grade D)**

- **17. The indication, aim, type and dose of sedatives and oucomes of PST should be carefully documented (grade D)**

Table 1 Four different sedation assessment scales with validity and reliability in adult patients

Ramsay Scale [2]	Sedation-Agitation Scale [4]	Motor Activity Assessment Scale [3]	Richmond Agitation Sedation Scale [5,6]
6 No response	1 Unarousable (minimal or no response to noxious stimuli, does not communicate or follow commands)	0 Unresponsive (does not move in response to noxious stimuli)	-5 Unresponsive (no response to voice or physical stimulation)
5 Patient asleep with a sluggish response to a light glabellar tap	2 Very sedated (arouses to physical stimuli but does not communicate or follow commands, may move spontaneously)	1 Responsive only to noxious stimuli (opens eyes or raises eyebrows or turns head toward stimulus or moves limb in response to noxious stimulus)	-4 Deep sedation (no response to voice, but any movement to physical stimulation
4 Patient asleep with a brisk response to a light glabellar tap	3 Sedated (difficult to arouse, awakens to verbal stimuli or gentle shaking but drifts off again, follows simple commands)	2 Responsive to touch or name (open eyes or raises eyebrows or turns head toward stimulus or moves limb when touched or when name is loudly spoken)	-3 Moderate sedation (any movement, but no eye contact to voice)
3 Patient responds to commands only	4 Calm and cooperative (calm, awakens easily, follows commands)	3 Calm and cooperative (no external stimulus is required to elicit purposeful movement and patient follows commands)	-2 Light sedation (briefly, less than 10 seconds, awakening with eye contact to voice)
2 Patient cooperative, oriented, and tranquil	5 Agitated (anxious or mildly agitated, attempting to sit up, calms down to verbal instructions)	4 Restless and cooperative (no external stimulus is required to elicit movement and patient is picking at sheets or tubes or uncovering self and follows commands)	-1 Drowsy (not fully alert, but has sustained, more than 10 sec, awakening with eye contact to voice)
1 Patient anxious or agitated or both	6 Very agitated (does not calm, despite frequent verbal reminding of limits; requires physical restraints, bites endotracheal tube)	5 Agitated (no external stimulus is required to elicit movement and patient is attempting to sit up or moves limbs out of bed and does not consistently follow commands)	0 Alert and calm
	7 Dangerous agitation (pulling at endotracheal tube, trying to remove catheter, climbing over bed rail, striking at staff, thrashing side to side)	6 Dangerously agitated, uncooperative (no external stimulus is required to elicit movement and patient is pulling at tubes or catheters or thrashing side to side or striking at staff or trying to climb out of bed and does not calm down when asked)	1 Restless (anxious or apprehensive but movements not aggressive or vigorous)
			2 Agitated (frequent nonpurposeful movement or patient-ventilator dysynchrony)
			3 Very agitated (pulls on or removes tubes or catheters or has aggressive behavior toward staff)
			4 Combative (overly combative or violent, immediate danger to staff)

Uso di oppioidi e sedativi nelle cure di fine vita

(Sykes N and Thorns A, Lancet Oncol, 2003; 4: 312-318)

La prevalenza della PST è molto variabile da 1% (Fainsinger, J Pall Care 1998) a 72% (Turner, J Pall Care 1996)

Utilizzando la classificazione di Porta in:

-sedazione proporzionale 45% (media)

-sedazione rapida 16% (media)

Palliative sedation therapy does not hasten death: results from a prospective multicenter study

(Maltoni M, Ann Oncol 2009 Jul;20(7):1163-9)

- **Sedazione:**

267 su 1068 (25.1 %)

- **Sedazione profonda e continua:**

63 (23.5 dei sedati e 5.9 % del totale)

- **Nella revisione sistematica: 1,807 consecutive patients in 10 retrospective or prospective nonrandomized studies, 621 (34.4%) of which were sedated**

Prospective observational Italian study on palliative sedation in two hospice settimgs: differences in casemixes and clinical care

(Maltoni M et al, Support Care Cancer, 2012, in press)

Table 2 PS characteristics

	Hospice		*P* value	Total
	A *N* (%)	B *N* (%)		*N* (%)
Sedation in admitted patients				
Yes	45 (21.6)	27 (22.7)		72 (22.0)
No	163 (78.4)	92 (77.3)	0.825	255 (78.0)
Deceased	119 (57.2)	107 (89.9)		226 (69.1)
Sedation in patients who died	45/119 (37.8)	27/107 (25.2)	0.043[a]	72 (31.9)
Sedated patients				
KPS at the beginning of sedation				
10–20	43 (95.6)	25 (92.6)		68 (94.4)
30–40	2 (4.4)	2 (7.4)	0.628	4 (5.6)
PS discussed with patient				
Yes	11 (24.4)	16 (59.3)		27 (37.5)
No	34 (75.6)	11 (40.7)	0.007	45 (62.5)
Median duration of PS, days (range)	2 (0–10)	1 (0–11)	0.261	1 (0–11)
Median duration of PS, h (range)	41.15 (7.10–239.0)	22.30 (2.50–253.0)	0.306	32.20 (2.50–253.0)

[a]The probability of being sedated, when adjusted for age and duration of stay in the hospice, was no longer statistically significant (P=0.746)

Variabilità della prevalenza della sedazione palliativa

- **Assetto**
- **Casemix (a parità di assetto)**
- **“Esperienza” palliativa**
- **“Manutenzione” del personale**

Studio multicentrico internazionale sulla sedazione di sintomi non controllati nei pazienti terminali

(Fainsinger, Palliat Med, 2000)

Durata	Israel	Durban	Cape Town	Madrid
Media	3.2	1.9	2.3	2.4
Mediana	3	1	2	2
Range	1-6	1-6	1-6	1-6

Palliative sedation in end-of-life care and survival: a systematic review

(Maltoni M et al, J Clin Oncol, 2012, 30(12):1378-83)

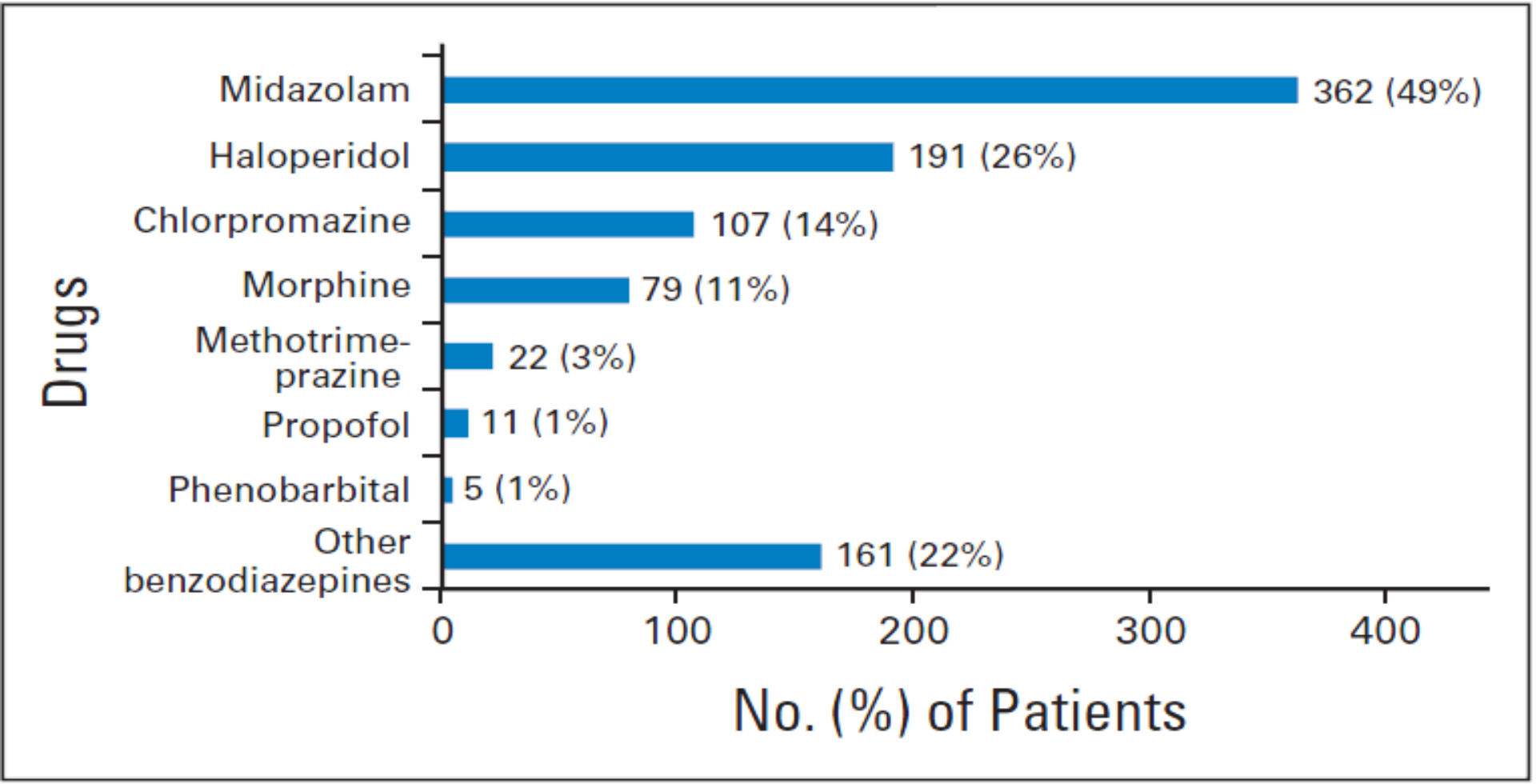


Fig 3. Sedative drugs administered to 745 patients from nine studies.[5-7,9-14]

Midazolam dosi

Dose massima		Durata (gg)
≤ 30 mg/die	61%	media 10 +/- 19
30-60 mg/die	10%	mediana 2.5 (1-90)
60-120 mg/die	21%	58% </= 3
≥ 120 mg/die	8%	21% >/= 14

La dose finale giornaliera dipendeva dall'età del paziente e dalla durata del trattamento con midazolam **(età più giovane e più lunga durata, maggiore dose)**

Morita T et al JPSM 2003, 25:369

Protocolli sedazione

- **Midazolam 5 mg in 20 cc di Fisiologica in bolo in pochi minuti, ripetibile fino a risultato. Poi Midazolam in 24 ore in vena o in sottocute 1 mg/ora -5 mg/ora (in base anche al numero di boli necessari inizialmente), da aumentare nei giorni successivi a seconda della quantità di boli richiesta (rapida tolleranza)**

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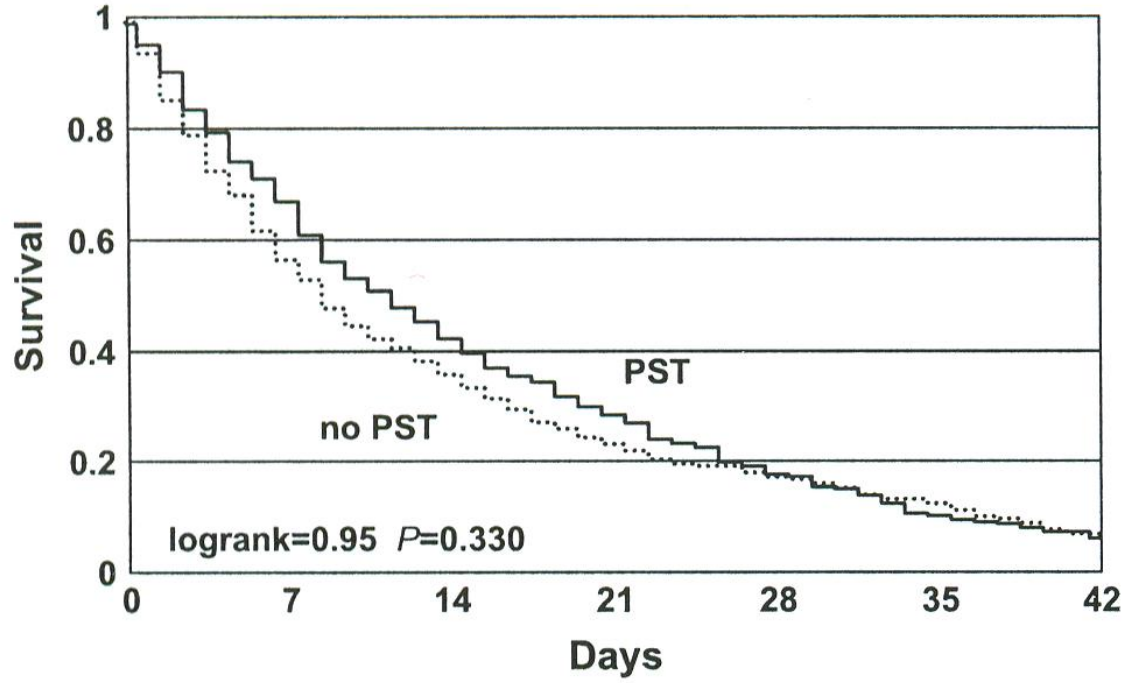

No. pts at risk							
PST	267	189	120	79	50	27	18
No PST	251	154	95	60	44	32	17

Figure 1. Kaplan–Meier survival curves for cohort A [palliative sedation therapy (PST)] and cohort B (no PST).

Reply to E. Schildmann et al

(Maltoni M et al, J Clin Oncol, Vol 30, 2012)

Table 1. Survival of Patients in Continuous Deep Palliative Sedation, As Last Step of Proportional Palliative Sedation, Compared With Controls

Participants	No. of Patients	Median OS (days)	95% CI	7-Day OS (%)	95% CI (%)	14-Day OS (%)	95% CI (%)	21-Day OS (%)	95% CI (%)	*P*
										.129
Patients	63	8	5 to 10	52	40 to 65	32	20 to 43	21	11 to 31	
Controls	190	9	7 to 12	56	49 to 63	37	30 to 44	24	18 to 30	

Abbreviation: OS, overall survival.

Continuous deep sedation: physicians' experiences in six European countries

(Miccinesi G, JPSM, 2006)

- **STUDIO EURELD: EURope End-of-Life Decisions**

- **20.480 questionari: risposte 44%(Italia)–75%(Olanda)**
- **SCP: 2,5% Danimarca – 8,5% Italia**
- **SCP: no nutrizione o idratazione:**
  35% Italia – 65% Danimarca e Olanda

Eutanasia e suicidio assistito dal medico: il documento della Task Force Etica dell'EAPC

(Palliat Med 2003; 17: 97-101)

	Sedazione palliativa	Eutanasia
Intenzione	Sollievo da sofferenza intollerabile	Uccisione del paziente
Procedura	Uso di farmaco sedativo per controllo di sintomo refrattario	Somministrazione di farmaco letale
Risultato	Sollievo dal distress	Morte immediata

European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

(Cherny N, Palliat Med 2009; 23: 581-593)

- **Abuso: obiettivo diverso dal sollievo del sintomo**
- **Utilizzo non giudizioso: obiettivo adeguato, ma circostanze cliniche inappropriate (sintomo difficile, equipe stressata, richiesta familiari)**
- **Non inizio non giudizioso: ritardo eccessivo con insistenza su altri approcci per controllare il sintomo, dimostratisi non efficaci**
- **Pratica clinica non ottimale**

European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

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- **Distress per la famiglia:**
- **Riduzione interazione con il paziente**
- **Lutto anticipatorio**
- **Confusione e/o disaccordo sull'indicazione alla sedazione**
- **Percezione di decisione inappropriatamente affrettata o ritardata**
- **Percezione di accelerazione diretta o indiretta del decesso**

Responsabilità degli operatori nella fase terminale: b) il problema della sedazione palliativa

- **Messaggi per i familiari:**
- **Effettuata per il bene dei pazienti, non dei familiari**
- **In assenza di situazioni reversibili o affrontabili in altro modo**
- **Può essere interrotta in ogni momento**
- **Essa renderà il dialogo con i familiari impossibile**
- **Non è una forma, neppure mascherata, di eutanasia**
- **D'altra parte, non serve neppure a prolungare la vita**

Palliative sedation in patients with advanced cancer followed at home: a systematic review.

(Mercadante S, J Pain Symptom Manage. 2011 Apr;41(4):754-60)

- Six articles
- Although an early study reported a rate of more than 50%, the majority of the most recent literature shows an incidence of PS of 5%-36%
- Agitated delirium, dyspnea, and pain were the most common problems
- The duration was variable (the mean across studies 1-3.5 days), not associated with hastened death.
- Benzodiazepines, specifically midazolam, have been most frequently used, alone or in combination with neuroleptics and opioids

- PS at home seems to be a feasible treatment option among selected patients and makes a potentially important contribution to improving care

National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients

(Kirk T, JPSM 2010; 39: 914 – 923)

- **Existential suffering may occur much earlier in the disease trajectory**
- **The availability of, and evidence supporting, interventions of any kind for existential suffering in imminently dying patients is extremely limited and uneven**
- **Unlike intractable and refractory suffering primarily physical, with a trajectory of increasing intensity, existential suffering can be highly dynamic, following no predictable pattern of severity**
- **Caution, multiple discussion, consulting mental health and spiritual care experts, team condivision, respite rather than cointinuous**

European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care

(Cherny N, Palliat Med 2009; 23: 581-593)

1. Si raccomanda una discussione preventiva del ruolo potenziale della S.
2. Descrivere le indicazioni nelle quali S. potrebbe o dovrebbe essere considerata
3. Descrivere le necessarie procedure di valutazione e consultazione
4. Specificare i consensi ottenuti
5. Indicare la necessità di discutere il processo di decision-making con la famiglia
6. Presentare le indicazioni per la selezione della S. più adatta
7. Presentare le indicazioni su titolazione della dose, cura e monitoraggio del paziente
8. Guida per le decisioni su idratazione, nutrizione, e farmaci concomitanti
9. La cura e i bisogni informativi della famiglia
10. La cura per l'equipe

Conclusioni

- **Alcuni pazienti sperimentano sintomi refrattari durante le ultime ore o gli ultimi giorni di vita**

- **La sedazione palliativa è l'approccio per gestire ed alleviare la sofferenza, e le evidenze raccolte mostrano che essa non ha alcun impatto detrimentale sulla sopravvivenza. Solo in una minima percentuale di pazienti è necessario ricorrere alla "teoria del doppio effetto" per giustificarla**

- **Benzodiazepine e antipsicotici costituiscono le opzioni terapeutiche di prima scelta**