



Palliative Sedation Therapy
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Case: You are asked to see Mrs. RT, a 44-year old woman with end-stage COPD. She was admitted to inpatient hospice with increased anxiety, hopelessness, and pain “all over.” She says she is tired of being sick and exhausted, and wants to be “put to sleep.” She has heard about “terminal sedation” and is angry it hasn’t been offered. She lives with her husband and adult children who work full-time and is upset they can’t all stay home with her. She experiences dyspnea with activity, and uses a wheelchair, but can independently transfer to bed and toilet. Your exam reveals she is awake and alert, neither delirious by the confusion assessment score (CAM), nor suicidal. She is cachectic, tachypnic, and has generalized muscle atrophy. She lacks signs of infection or localized pain. You estimate her prognosis in months. She takes medications erratically for symptom control.

What is Palliative Sedation Therapy (PST)?

Patients and families sometimes have heard or been told about “terminal sedation,” but it is a frequently misunderstood term and therapy. The term “terminal sedation” suggests the goal of the therapy is hastening death for terminally ill patients, when in fact the goal is symptom relief. Therefore, the term “palliative sedation therapy (PST)” is much preferred since the goal of PST is relief from intolerable and untreatable symptoms, not shortening a patient’s life. An international panel of palliative care experts recently reviewed the medical literature on PST and published their recommendations for standardizing our understanding of this therapy¹. They recommend the following definition: “Palliative sedation therapy is the use of specific sedative medications to relieve intolerable suffering from refractory symptoms by a reduction in patient consciousness.” They emphasize that palliative sedation is distinct from euthanasia while acknowledging lively debate on this issue.

The panel’s position is based on their assertion that hastening a terminally ill patient’s death is not the goal of PST. Other points of difference between PST and euthanasia are the principle of titration to comfort rather than to death, and PST’s reversibility.

What are refractory symptoms?

Refractory symptoms are considered symptoms for which all possible treatments have failed. A patient experiencing refractory symptoms must be differentiated from a patient who has symptoms that are difficult to treat. Refractory symptoms are symptoms that the palliative care physician and team determine cannot safely be relieved by invasive or non-invasive interventions. Expert panel members recommend Cherney’s definition of refractory symptoms: “Refractory symptoms are symptoms for which all possible treatment has failed, or it is estimated that no other therapies exist within the patient’s time-frame or tolerable risk-benefit ratio.”

When is PST considered?

PST is considered for patients with refractory symptoms only after discussions with the patient and/or family, the caregiving team, and the palliative care expert. The most frequent reasons for PST have been refractory delirium or restlessness, dyspnea, pain, and nausea/vomiting. The use of PST or psychological or existential distress is rare, and initiated only under exceptional circumstances.

PST is considered only in the last hours to days of life.

Experts recommend a systematic and inclusive process to determine if PST appropriate, which includes the patient, if possible, designated surrogate and caregivers, and addresses the patient’s values, beliefs, and goals. If PST is chosen, then the specific intervention is discussed and reviewed, instituted, and carefully monitored. Decisions about nutrition and hydration are discussed separately from the decision to offer PST.

Medications used for PST include benzodiazepines (usually midazolam), except for delirious patients, phenobarbital, or propofol. Opioids are not recommended for PST because even high doses may not result in sedation.

Since the aim of PST is the relief of refractory symptoms, doses of sedatives are carefully chosen to relieve distress by reducing a patient’s level of consciousness and are not excessive. The degree of sedation can vary from superficial to deep sedation. Initial doses of sedatives should be small enough to allow a patient to communicate periodically.

For palliative care consultations please contact the *Palliative Care Program* at PUH/MUH, 647-7243, beeper 8511, Shadyside Dept. of Medical Ethics and Palliative Care, 623-3008, beeper 263-9041, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, 641-2108, beeper 917-9276, VA Palliative Care Program, 688-6178, beeper 296. For ethics consultations at UPMC Presbyterian-Montefiore, and Children’s page 958-3844. With comments about “Case of the Month” call David Barnard at 647-5701.



Refractory symptoms may respond to temporary sedation, since a patient's ability to tolerate symptoms may be improved following rest provided by sedation. Experts identify three levels of continuous sedation. With mild sedation, the patient is awake, but has a lowered level of consciousness. Moderate sedation results in stupor, so that the patient is asleep, but can be awakened to communicate briefly. With deep PST, the patient is unconscious and unresponsive. PST is frequently monitored and assessed, with attention to the needs and goals of both patient and family.

Back to the case:

You convene a meeting with the patient, her family, and the palliative care team. After asking open-ended questions and listening to concerns, you offer information about PST but say that you think her symptoms can be treated. You offer medication changes including around-the-clock rather than as needed opioids for relief of dyspnea and pain, and a comprehensive treatment plan for her anxiety and depression. Her family finds ways for her to be less isolated, and the hospice team offers additional services and frequent monitoring. Although she is skeptical, she is willing to consider these options as possibly improving the quality of her life.

References:

1. De Graeff A. Dean M: Palliative Sedation Therapy in the Last Weeks of Life: A Literature Review and Recommendation for Standards. *Journal of Palliative Medicine* 2007; Vol10 (1); 67-84.
2. Cherny NI. Portenoy RK: Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *Journal of Palliative Care* 1994;10;31-38.

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