

# Home palliative sedation checklist may ease concerns

February 18 2010

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Los Angeles, London, New Delhi, Singapore and Washington DC (February 18, 2010) - Can patients near death safely receive sedation at home, fully respecting their own and their families' wishes? This practice, which is on the rise, is coming under increasing scrutiny and debate by palliative care researchers and practitioners. Now palliative care specialists from a team based in Spain have documented their experiences and data, and developed a standard checklist to help other clinicians. Their research appears in the journal *Palliative Medicine*.

Physicians use specific sedatives to relieve intolerable suffering as patients near death - a practice known as palliative sedation (PS). The rate of PS use varies widely from 3-52% in terminally ill patients according to the literature - a wide range considering it is considered ethical and legally acceptable for those with irreversible and advanced disease. This raises questions over whether the definition of PS, or its setting could be behind these differences.

Despite a trend for PS in patients' homes increasing in recent years, academics know very little about what kinds of sedation are administered - or who is receiving it - at home. Some fear that using PS, particularly at home, should not replace thorough assessment and treatment of patients' physical symptoms, or their psychological or spiritual distress. A set of standard guidelines offers one solution.

Alberto Alonso-Babarro from Hospital Universitario La Paz, Madrid led the study into home PS, which was conducted in Madrid by a palliative

home care team (PHCT) composed of two physicians, two nurses, a nurse assistant, a part-time social worker, and an administrative clerk. The PHCT regularly follows up patients with progressive, incurable diseases with many symptoms who are referred by acute care hospitals, medical oncologists or family physicians.

Alonso-Babarro and his team retrospectively reviewed [medical records](#) from 370 patients, all of whom had been followed by a palliative home care team. They developed a decision-making and treatment checklist, which they used to assess how frequently PS was used for cancer patients dying at home, and how effective it was. A total of 245 patients (66%) died at home, and 125 patients (34%) died at a hospital or hospice.

Twenty-nine of 245 patients (12%) who died at home received PS. Those who received it had a younger mean age (58) than those who did not (69), but there were no other differences detected between these two patient groups. The most common reasons for using PS were delirium (62%) and dyspnea (laboured breathing), in the case of 14% of patients. The vast majority of patients were given the sedative drug midazolam for PS, with less than a tenth receiving levomepromazine, an anti-psychotic sedative used in Europe and Canada, but not currently registered in the US.

On average, patients died 2.6 days after PS, and in almost half of cases the decision to use PS was taken with both the patient and his or her family. In other cases the family made the decision. Importantly, the authors concluded that using PS does not hasten death.

Other interesting findings were that at home, PS was used at a lower rate than in hospital (where 20-50% of palliative patients have PS). Hospitalised patients often have a greater symptom burden, or may be more agitated and so prone to delirium than in a home setting, the

authors suggest.

There is also controversy in the palliative care literature around psycho-existential suffering, where cultural context appears to play a role. In particular, a multi-centre study found that patients in Spain had a higher rate of PS for this reason than in other countries. Alonso-Babarro suggests that lack of agreement on treatment between the patients and their families in Spain could be a significant factor in this distress.

"Incorporating the patient's wishes regarding PS in advanced directives or discussing these issues with patients prior to the final days of their lives may help avoid unnecessary patient and caregiver stress and burden," he suggests.

"We concluded that palliative sedation may be used safely and efficaciously to treat dying cancer patients with refractory symptoms at home," said Alonso-Babarro, who added: "To our knowledge, this is one of first studies addressing PS in the home setting to demonstrate the safety and efficacy of at-home PS administered by a PHCT."

The checklist his team developed recommends beginning PS with midazolam followed by levomepromazine if midazolam proves ineffective. If both midazolam and levomepromazine fail, phenobarbital is the next option to consider. The team also recommends these medications should be injected.

The team hope that their checklist will provide other researchers and clinicians with an easy-to-use decision aid and treatment tool to facilitate the PS process. Researchers will need to carry out further multi-centre prospective home-based studies to replicate their findings.

In some cases, PS may be the only way to achieve a peaceful death at home, thus ensuring that the wishes of the [patients](#) and their caregivers are respected.

**More information:** At-home palliative sedation for end-of-life cancer patients by Alberto Alonso-Babarro, Maria Varela-Cerdeira, Isabel Torres-Vigil, Ricardo Rodríguez-Barrientos, Eduardo Bruera is published in Palliative Medicine published by SAGE, [DOI: 10.1177/0269216309359996](https://doi.org/10.1177/0269216309359996) and will be available free of charge for a limited time at [pmj.sagepub.com/cgi/rapidpdf/0269216309359996v1](http://pmj.sagepub.com/cgi/rapidpdf/0269216309359996v1) .

Provided by SAGE Publications

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