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Networking topics for palliative care

Palliative care pharmacists from the UK recently met for their annual networking day. A varied programme reflected the wide range of subject areas that pharmacists working in this field need to be aware of. **Margaret Gibbs**, senior pharmacist at St Christopher's Hospice, London, reports

Pharmacists can make a difference in palliative care by communicating with patients and carers about drugs and, possibly, visiting them at home, post discharge according to Mary Allen, one of the founders of the Hospice Pharmacists' Association. Mrs Allen talked about interface issues. Gone are the days when services to local hospices were provided mainly by community pharmacists — the majority of pharmaceutical services to hospices are now provided by hospital departments. But although this balance has shifted, most people want to stay and die at home and it is still the community pharmacist who sees the patient and their carers throughout the course of their illness.

Cancer patients see many prescribers — in hospital oncology departments, palliative care units and general practice — and Ms Allen gave several case histories to demonstrate how poor communication between these prescribers can cause problems. For example, one patient was admitted to the hospice because it was assumed he was dying. On investigation, his "twitchiness", first thought to be cancer- or morphine-related, was, in fact, serotonin syndrome, which had occurred because his oncologist had prescribed fluoxetine without realising the patient was already being prescribed paroxetine by his GP. There is a need for better communication between hospice and community pharmacists, Ms Allen stressed. It is also important to appreciate that because hospice pharmacists can work in hospital or community practice, they can have different perceptions of the patient's situation at home.

In addition, there is a need for increased pharmacist input in hospices, for example, a pharmacist taking drug histories on admission might reduce the drug-related problems that patients experience, she added.

Palliative care for non-cancer patients

Patients without cancer do not receive the same palliative care as those with cancer, said Louise Gibbs, a consultant at St Christopher's Hospice. Dr Gibbs presented statistics showing the inequity in the specialist palliative care (SPC) offered to patients with non-malignant disease. In 2001–02, almost one in two cancer patients received SPC while only 1 in 59 patients with heart failure received SPC.

Most cancer patients have a fairly predictable, rapid deterioration in their last few months while heart failure patients typically have a number of acute episodes, slow recoveries and a far more gradual decline. This makes prognosis more difficult. However, symptoms and needs for both groups of patients show surprising similarities, Dr Gibbs said, with fatigue, weakness, pain and nausea being common problems regardless of type of illness. Much of the experience at St Christopher's in providing palliative and supportive care to cancer patients could (with thought, planning and training) be applied to other patients. The issue of SPC for non-cancer patients is climbing the political agenda and national initiatives, such as guidance from the National Institute for Clinical Excellence and national service frameworks, are now addressing the need for non-cancer patients to receive good quality end-of-life care.

A new formulation for alfentanil

Alfentanil is being used successfully for the management of breakthrough and incident pain. Neile Taylor, pharmacist for the Three Pilgrim's Hospice in Kent, described how he sourced this unlicensed formulation from Torbay Hospital manufacturing department. The spray is fast in onset and has a short duration of action. It is available in a bottle that comes with the option of a nasal or buccal attachment, which delivers 140μg per spray. The usual starting dose is two sprays and this can gradually be increased as required. The dose needs to be titrated according to the patient's pain rather than being correlated to their regular opioid. Mr Taylor is now involved with a multi-centre audit of its use.

Medicines management in hospices

The highs and lows of introducing a medicines management scheme into St Benedicts hospice in Sunderland were described by Inga Andrew. Lows included general resistance to change as well as specific issues associated with the practice of palliative care. A major problem was changes in medication regimens, which necessitated relabelling and changing items more frequently than in a general medical situation. Another problem was lack of space in individual medicine lockers because most patients require multiple medicines for symptom control. However, the time taken to administer drugs and respond to symptoms was reduced and patient satisfaction increased.

New treatments for bone pain in cancer

Bone is the third most common site of metastases and it is clinically evident in 20 per cent of cancer patients. But why bone metastases hurt remains a largely unanswered question, said Victor Pace, a consultant at St Christopher's. Although we are aware that pain sensitisers such as prostaglandins, kinins and substance P are secreted, we also suspect that nociceptors in the periosteum and unidentified receptors in bone medulla may be involved and also that osteoclasts play an important role. Dr Pace said that radiotherapy is one of the most effective treatments with a single fraction being as effective as multiple doses. He then went on to dispel some myths:

- It is a myth that bone pain is not opioid responsive
- The use of non steroidal anti-inflammatory drugs on bone pain in cancer has never been confirmed in randomised, controlled trials
- There is no evidence for the use of calcitonin for pain relief, according to a Cochrane review

Dr Pace went on to explain the differences between the bisphosphonates, and suggested that the newer drugs such as zoledronate and ibandronate could provide longer lasting protection from bone complications in breast cancer, myeloma and prostate cancer.

Herbals in cancer and palliative care

Around a third of cancer patients have been shown in surveys to make use of complementary and alternative medicine (CAM) during their illness, said Katja Schmidt, researcher at the Peninsula Medical School, Exeter. Ms Schmidt talked about the three dimensions of CAM in relation to cancer: prevention, treatment and palliation. She said that although some of the evidence from the "alternative cancer cures" seems encouraging, most is far from compelling. Moreover, some of these cures are associated with significant risk.

The evidence for the effectiveness of some CAMs in preventing cancer seems more encouraging. For example, a recent meta-analysis has shown that a high intake of raw and cooked garlic may be protective against stomach and colorectal cancers while a Korean study in 1995 showed that cancer incidence was lower among ginseng users.

Ms Schmidt gave examples of herbs that have been used for cancer-related symptoms. For example, ginger can reduce nausea and vomiting during chemotherapy and turmeric and cumin extracts have provided symptomatic relief in external dry cancerous lesions. However, we must be aware of potential drug interactions, Ms Schmidt said.

One area of concern is the quality of information about CAM in cancer provided on various websites. Research she has been carrying out looked at 32 websites. Of these, only two stood out for their excellent quality while three offered potentially dangerous advice.

The **annual networking day for palliative care pharmacists** was held at St Christopher's Hospice in south east London, on 17 September