



survival, symptoms, function, quality of life, family and financial impact) with or without treatment. Most patients and families want to know prognosis. Since there are some patients and families that may not want to know prognosis or want it communicated in a particular way, it is essential to begin by finding out what the patient and family knows and wants to know.

Inaccurate predictions may lead to poor decision making. Indeed, physicians tend to overestimate survival in patients with advanced cancer by about 30%, and the bias is more pronounced the longer the physician-patient relationship. Overly optimistic predictions can lead to overuse of ineffective or unwanted disease-directed treatment, delay in hospice referrals, false expectations, unnecessary tests and procedures, and poor symptom control. Therefore, accurately estimating and communicating prognosis is central to optimal decision making in advanced illness and at the end of life.

In advanced illnesses, common factors found to be predictive of short-term survival (i.e., less than 6 months) include performance status, anorexia-cachexia syndrome, delirium, and dyspnea. In addition to a physician's subjective predictions of survival, there exist models to assist with prognostic estimates, including generic models for particular populations (e.g., hospice enrollees) as well as disease-specific models (e.g., cancers, heart failure, liver disease, stroke, AIDS, spinal cord compression). Hospice eligibility criteria also differ for specific diseases. While not uniformly reliable, they can be useful in formulating estimates where prognosis might be 6 months or less if the disease is allowed to run its natural course (a prognostic criterion).

For an individual patient, however, prognostic uncertainty remains the rule. Therefore, it is important to integrate both evidence and experience-based medicine, and present the information in formats tailored to the particular patient (verbal descriptions, numeric, frequencies, or graphics). Prognostic estimates should be bounded with ranges to convey realistic uncertainty, being sure to allow for exceptions in both directions. For example, *“in my experience, patients with your condition live on average a few weeks to a few months. It could be longer, but it could also be shorter.”* For survival-predominate prognoses (e.g., *“How long do I have?”*), be mindful of overly optimistic prognoses, remembering to think of and convey the lower bound (e.g., *“some may live longer, but others may, unfortunately, live shorter”*). For outcome-predominant prognoses (e.g., *“What will life be like?”*), be mindful of overly pessimistic predictions, remembering the power of adaptation and engendering hope by helping patients and families find new meaning.

● SUFFERING AND SYMPTOM MANAGEMENT

Palliative care aims to relieve suffering, which is defined as severe distress related to events that threaten the stability of personhood or interconnectedness of the physical, psychological, spiritual and social aspects of self. Beginning with simple, open-ended screening questions, such as *“In what ways are you suffering most?”* and following with more domain-related screening questions (e.g., physical, psychological, spiritual, social) may allow for more probing and multidimensional inquiries to better understand the various sources of and contributions to an individual's suffering.

One of the first steps in the care of any seriously ill patient is to control pain and other forms of physical suffering. There are

striking similarities between the burden of symptoms experienced in patients dying of cancer and non-cancer conditions. Although the profile of symptoms may differ, each disease carries with it troubling symptoms that can potentially be addressed and managed.

Physical Symptoms

Pain

Uncontrolled pain dominates all other experiences, and most pain can be relieved using basic pain management strategies. This includes a detailed history and physical examination, categorizing the likely type or types (i.e., somatic, visceral, neuropathic) and severity (rated on a 0-10 scale) of pain, knowledge about proper opioid dosing strategies, and judicious use of consultations and invasive interventions (e.g., nerve blocks, epidural analgesia). The overarching three-tiered approach is to use nonopioids (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs) for mild pain, weak opioids (e.g., hydrocodone or codeine) for mild-to-moderate pain, and strong opioids (e.g., morphine, hydromorphone, fentanyl, methadone) for moderate to severe pain.

Risk factors for potential opioid abuse or misuse should be screened for even in the presence of clearly defined terminal illness, including any lifetime personal or family history of opioid, alcohol, or other substance abuse. If risk factors are present (about 20% of the population), special precautions should be taken to minimize the risk of abuse, including clearly defined and adhered to prescribing contracts and strict limits and expectations about renewals and dose alteration processes. One single prescriber should be responsible for all opioid prescriptions and renewals, and one pharmacy should be used. If clinicians are inexperienced with such prescribing, formal consultation with specialists in palliative care and/or addiction medicine should be considered.

Most seriously ill patients with chronic moderate to severe pain should be initially started on around-the-clock dosing using a short-acting opioid. [Table 125-2](#) shows the equianalgesic dosing, usual starting doses, half-life, and duration for the commonly available opioid agents. Once the total daily dosing has been determined (sum of all scheduled and “as needed” doses), the patient may be switched to a long-acting opioid to cover the baseline requirements. As needed opioids for breakthrough pain should be approximately 10% of the total daily dose every 1 to 2 hours orally or every 30 to 60 minutes subcutaneously or intravenously. If a patient is requiring more than 4 to 6 breakthrough doses per day, he should be in contact with the prescribing clinician for re-evaluation of dosing. Continuous intravenous or subcutaneous infusions of opioids may be needed for rapid control of severe pain. Methadone is useful in palliative care because of its excellent oral bioavailability, lack of active metabolites in renal impairment, low cost, flexible route of administration (PO, IV, SC), and possible effect on both neuropathic and somatic pain. However, it does have a dose-dependent, progressively long half-life and arrhythmogenic potential.

Constipation occurs with all opioids, and it should be anticipated and treated. Other predictable but less common side effects include nausea, myoclonus, urinary retention, pruritis, and delirium. Some of these side effects are time-limited with