



initiation (e.g., nausea), while others can be managed by dose reduction or opioid rotation (e.g., myoclonus, delirium). Major respiratory depression is extremely rare if the opioid is dosed appropriately and proportionate to the severity of symptoms. In the absence of a prior personal or family history of drug and alcohol abuse, addiction is rare in the presence of serious illness, but physical dependence (i.e., withdrawal symptoms upon abrupt cessation) and tolerance (i.e., decrease in drug effect over time) should be expected. Naloxone should be rarely used unless a clear overdose is suspected, or if life-threatening complications occur. Special caution about opioid prescribing is needed in the elderly and debilitated patients, and recommended starting doses should be reduced by approximately 50%. There are additional opioid selection recommendations for patients with renal insufficiency (avoid morphine and codeine; use hydromorphone and oxycodone with caution; methadone and fentanyl (optimal) and hepatic insufficiency (cautiously use fentanyl, hydromorphone, oxycodone, or methadone; avoid or decrease dose of morphine).

Non-pain

There are numerous non-pain physical symptoms that can dominate and overwhelm the clinical picture in any given patient. These include dyspnea, nausea and vomiting, constipation, anorexia-cachexia, fatigue, bleeding, agitation, apathy, myoclonus, pruritis, and specific functional deficits. Each symptom requires a structured approach to the history and physical examination with a full exploration of the potential etiologies and treatment options; informed by the prognosis and preferences of the patient and family. (For practical information geared to basic palliative management of pain and other symptoms, see Quill TE, Holloway RG, Shah MS, et al: *Primer of Palliative Care*, ed 5, Illinois, 2010, American Academy of Hospice and Palliative Medicine.)

Psychological Distress

Depression, anxiety, and delirium are all common in the palliative care setting. They are frequently under-recognized and under-treated. Appropriate diagnosis and treatment can improve quality of life.

Nearly all patients in palliative care and their families experience sadness, preparatory grief, and transient anxiety as illness advances. Grief or normal sadness is often experienced in waves with retained capacity for pleasure. Depression is more enduring, persistent and intense, and may be associated with hopelessness, helplessness, worthlessness, and guilt. Two screening questions assessing depressed mood and anhedonia include: “*Are you depressed?*” and “*Do you have much interest and pleasure in doing things?*” One should be cautious about overusing somatic symptoms to diagnose depression (e.g., fatigue, anorexia, sleep disturbance) because they frequently overlap with physiological changes associated with advanced disease. For depression and anxiety, consider and rule out contributions from physical symptoms (e.g., uncontrolled pain), medical causes (e.g., hypothyroidism, hyperthyroidism), and medications. Effective pharmacological and non-pharmacological treatments exist for both depression and anxiety, though treatment selection depends on symptom intensity, patient prognosis, and treatment benefits

and burdens. Other members of the interdisciplinary team (social worker, chaplain, and psychologist) often play a critical role in assessment and ongoing management.

Delirium, an acquired and fluctuating disorder of consciousness and cognition, occurs commonly in the palliative care setting. The level of psychomotor activity can vary from hyperactive (“agitated” delirium) to hypoactive (“quiet” delirium). Nearly 80% of the delirium in the palliative care setting is the hypoactive variant. As a result, it is often under-diagnosed or misdiagnosed as depression and fatigue. The most common causes of delirium in palliative care include medications (e.g., opioids), metabolic disorders due to progressive organ failure, and infection. Meticulous attention to the history from collateral sources (e.g., nurses, caregiver) and a detailed medication history are essential for an accurate diagnosis. While delirium may reverse if an obvious cause is identified and removed, frequently it represents an important marker of progressive illness so cognitive improvements may be transient and incomplete. In addition to etiology-specific treatment (e.g., change or stop medications, treat infection, oxygen, hydration, biphosphonates), environmental interventions are recommended for all patients (e.g., quiet reassurance, gentle re-orientation, optimize sensory input, minimize night disruptions). Pharmacological management should be used sparingly and cautiously, and may include antipsychotic medications, benzodiazepines, and psychostimulants (for the hypoactive variant).

Spiritual and Existential Pain

Spiritual and existential distress is prevalent in patients and families with serious illness, especially at the end of life. Spirituality is about one’s relationship with and responses to transcendent questions that confront one as a human being (e.g., search for meaning and purpose in life). Religion is a set of texts, practices, and beliefs about the transcendence shared by a community. Spirituality is broader than religion. The spiritual issues of seriously ill and dying patients often center on questions of meaning, value, and relationships. Dying patients want to be assured of their value in the face of actual or perceived threats to their intactness as a human being (e.g., physical and cognitive declines, altered appearances). Spirituality can help people find hope in despair and help restore purpose.

One of the goals of palliative care is to relieve spiritual and existential distress. Patients and families often welcome such discussions. Examples of open-ended questions to facilitate this dialogue include: “*Are you at peace with all of this?*” and “*Is faith (religion, spirituality) important to you?*” Acknowledgement and empathetic listening are the most important responses for most clinicians, as opposed to trying to provide “correct answers.”

Other strategies for fostering hope and meaning include developing caring relationships, setting attainable goals, involving the patient in the decision-making process, affirming the patient’s worth, using lighthearted humor (when appropriate), and reminiscing with life review. It is important, however, to know one’s professional boundaries and refer to chaplains or clergy from the patient’s faith traditions if questions move beyond the realm of general exploration (e.g., “*It sounds like it would be good to explore this with someone with more experience than I have. Would it be okay for me to send our chaplain in to discuss this with you?*”).