

# Equity in assisted suicide

**Claudia Gamondi, Prof, PhD**

Cheffe de service

Service de Soins Palliatifs et de Support

Département de médecine

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## *Some definitions*

**EQUITY**, *noun* [Latin root: *aequus* > equal, even, fair]

“The situation in which everyone is treated fairly according to their needs and no group of people is given special treatment” (Cambridge dictionary)

“Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged)” (Braveman 2014)

*Non-discrimination, fairness, equality, justice, vulnerability ...*

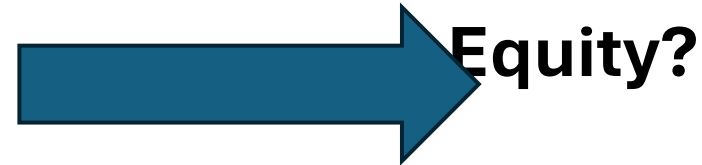


# *Operationalizing equity in assisted suicide*

Regulations, ethical guidelines, criteria:

## Key elements

- Decision-making capacity
- Autonomous wishes
- Severe suffering
- Consideration of alternatives



## *Operationalizing equity in assisted suicide*

### **Access**



- Equal access to information
- Economic barriers
- Geographic barriers

### **Safeguards**



- Freedom from external pressure
- Exploration of alternatives
- Additional support
- Neither underprotection nor overprotection

# *Due diligence considerations in the context of social vulnerability*

## **Evaluation of decision-making capacity**

Language barriers

Structural barriers (e.g., time constraints, geographical distance)

Multidisciplinary and context sensitive approach

Cultural aspects (e.g., regarding values, communication styles)

# *Due diligence considerations in the context of social vulnerability*

## **Evaluation of decision-making capacity**

Language barriers

Structural barriers (e.g., time constraints, geographical distance)

Multidisciplinary and context sensitive approach

Cultural aspects (e.g., regarding values, communication styles)

## **Autonomous wishes**

Freedom from external pressure, e.g.,

Poverty

Social isolation

Unequal access to support offers

Precarity

Experiences of discrimination

## *Due diligence considerations in the context of social vulnerability*

### **Severe suffering**

Attribution of suffering (e.g., factors not related to the disease amplifying suffering)

Meanings of suffering (e.g., notions of dignity, dependency)

Expression of suffering

## *Due diligence considerations in the context of social vulnerability*

### **Severe suffering**

Attribution of suffering (e.g., factors not related to the disease amplifying suffering)

Meanings of suffering (e.g., notions of dignity, dependency)

Expression of suffering

### **Consideration of alternatives**

Real vs theoretic availability

Social support (e.g., networks, community)

Administrative support (e.g., financial, housing, organisation of care)

# Equity is challenged in dementia

- Progressive loss of decision-making capacity creates a narrowing "window of opportunity" for autonomous requests.
- Individuals with greater education, social support, and healthcare access may be more likely to navigate eligibility requirements.
- Fear of future dependency, institutionalization, and loss of identity are among the most frequently reported motivations.
- Assessing voluntariness becomes increasingly complex when cognitive decline coexists with vulnerability and dependence on caregivers.



# Why equity is challenged in psychiatric illness

- Distinguishing a durable autonomous wish to die from symptoms of mental illness is often difficult.
- Access to high-quality psychiatric care is unequal and may influence requests for assisted dying.
- Social isolation, trauma, poverty, and marginalization frequently coexist with psychiatric suffering.
- Capacity assessments show substantial variability among clinicians and jurisdictions.
- Risk of both underprotection (premature approval) and overprotection (blanket exclusion).

# Why equity is challenged in psychiatric illness

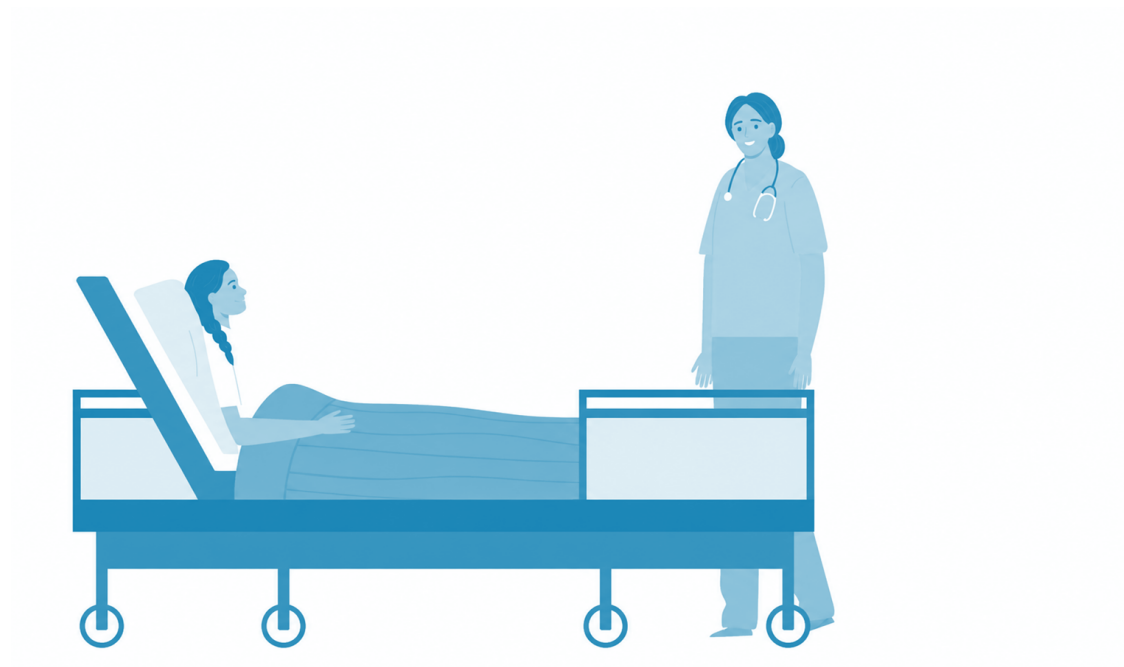
## Netherlands

- Psychiatric euthanasia accounts for approximately 1–2% of euthanasia cases.
- Most applicants are women.
- Many have multiple psychiatric diagnoses and long treatment histories.

## Canada

- MAID-MD (mental disorder as sole underlying condition) remains highly debated because of concerns regarding vulnerability, irremediability, and inequitable access to mental

# Cinical case



**Ms. B., aged 72**, is a woman who migrated to Switzerland more than 30 years ago. She is widowed, lives alone, and has very limited financial resources. Her son lives abroad and contact with him is infrequent. Her social network is limited.

**Ms. B.'s life history** has been marked by considerable socioeconomic precarity. She has a history of substance use disorder and reports having used heroin and other substances for many years. She no longer uses illicit drugs today, but has chronic alcohol misuse, with substantial daily consumption. She lives in a small, run-down studio apartment in a working-class neighbourhood of Lausanne, in an environment marked by social isolation, precarity, and proximity to people who are themselves living in situations of marginalisation. Her apartment is cluttered and poorly maintained, and she mainly goes out to do some shopping or to visit places where she occasionally meets other people in vulnerable situations.

**Her medical history** is also marked by a significant psychiatric background. Since adulthood, Ms. B. has experienced several episodes of psychotic decompensation requiring multiple psychiatric hospitalisations. She has received various diagnoses over the course of her life, including a personality disorder with significant relational difficulties, chronic emotional instability, and recurrent psychotic episodes. Several psychiatric hospitalisations have taken place over the decades, sometimes in contexts of psychosocial crisis, substance use, or interruption of follow-up care. At present, she does not show acute psychotic symptoms and is not hospitalised, but her psychiatric history remains an important element of her clinical background.

**One year ago, she was diagnosed with early-stage Alzheimer's disease.** She remains autonomous in her activities of daily living and is still able to manage her everyday affairs on her own.

**During a consultation**, she explains that she has already initiated steps with the association Exit and wishes to obtain the medical documentation required for the assessment of her request for assisted suicide.

**She states:** “I am still doing relatively well today, but I do not want to live through what my mother went through with her dementia. I would rather be able to decide for myself before I lose my autonomy and my ability to recognise my loved ones.”

**Ms. B. appears** coherent, oriented, and able to explain the reasons for her request. At the time of the assessment, she shows no obvious signs of major depression or active psychotic symptoms. She mainly expresses a significant fear of future dependency, institutionalisation, and loneliness as her illness progresses.

**The assessment also reveals** considerable social fragility, a sense of abandonment, and concern about her material future. She says she is afraid of ending her days alone, without support, in an institution she would not have chosen.

**The possibilities of** psychosocial support, home-based care, treatment for alcohol-related problems, intensified psychiatric follow-up, and strengthening of her social network have not yet been explored in detail.

*You are consulted as a specialised palliative care team to contribute to the assessment of the situation and to the reflection surrounding this request.*



# Mentimeter

# Group work – 15 minutes

Risk of inequity?

Due care?

What factors of inequality or vulnerability do you identify?

Could certain characteristics of Ms. B. influence how her request is perceived or assessed?

# Case variations

## **Would your analysis or actions change**

- if Ms. B. were 55 years old?
- if she lived with her spouse?
- if she had substantial financial resources?
- if she had already written advance directives requesting assisted suicide at the first signs of cognitive decline?



# What is the greatest ethical risk in this case?

- Denying a competent person's request
- Granting the request too early
- Overestimating the impact of dementia
- Underestimating the impact of social vulnerability
- Allowing personal values to influence assessment

# Plenary feedback from group work

# Future challenges

- Euthanasia on advance directives
- Organ donation after assisted death ([Organ donation after assisted suicide](#))
- New technologies in assisted death ([Sarco: The suicide capsule causing a stir in Switzerland](#) )
- Role of palliative care professionals in assisted death (Bigorio paper)

# Thank you for you attention!



## Literature

CNE 2006: Critères de diligence concernant l'assistance au suicide Prise de position N° 13/2006

<https://www.merriam-webster.com/grammar/equality-vs-equity-difference>

<https://dictionary.cambridge.org/dictionary/english/equity>

Braveman P. What are health disparities and health equity? We need to be clear. Public Health Rep. 2014 Jan-Feb;129 Suppl 2(Suppl 2):5-8. doi: 10.1177/00333549141291S203. PMID: 24385658; PMCID: PMC3863701.

ASSM 2018 Management of death and dying

# Insomnia in Palliative Care Patients

## Pharmacological Interventions

Dr. med. Jessica Rueff  
DKF Research Group Palliative Care  
University of Basel

# Mrs. Counting Sheep

- “Please consult this patients for symptom control and ACP. 57 year old female,with metastatic lung cancer. Pain well controlled with opioid analgesia. Seems somewhat depressed in consultation, complains about insomnia.”

# Mrs. Counting Sheep

## Main complaint

- "The pain doesn't keep me awake anymore. It's my thoughts."
- Difficulty falling asleep, multiple nocturnal awakenings
- Daytime fatigue



# Mrs. Counting Sheep

## **Additional assessment**

- Patient feels depressed, anhedonia
- Reduced appetite
- No delirium, no suicidal ideation
- No significant dyspnea or uncontrolled symptoms

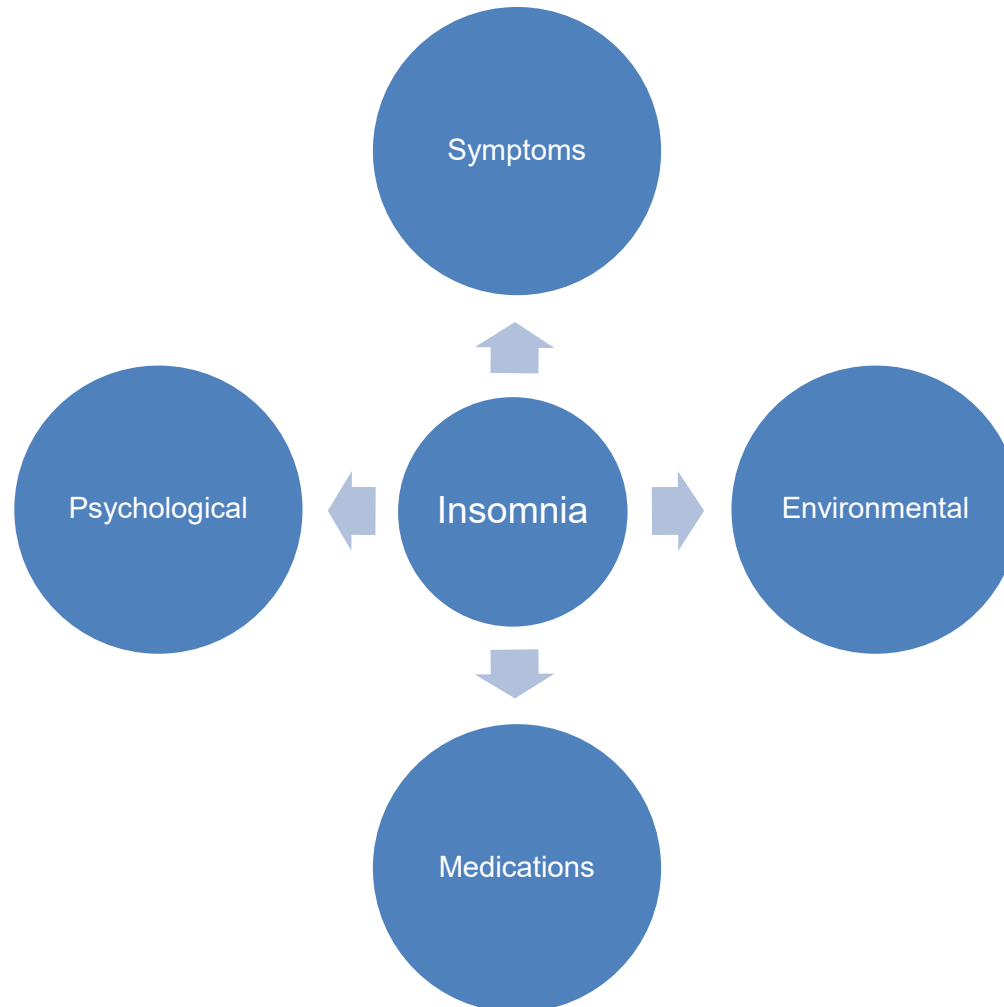


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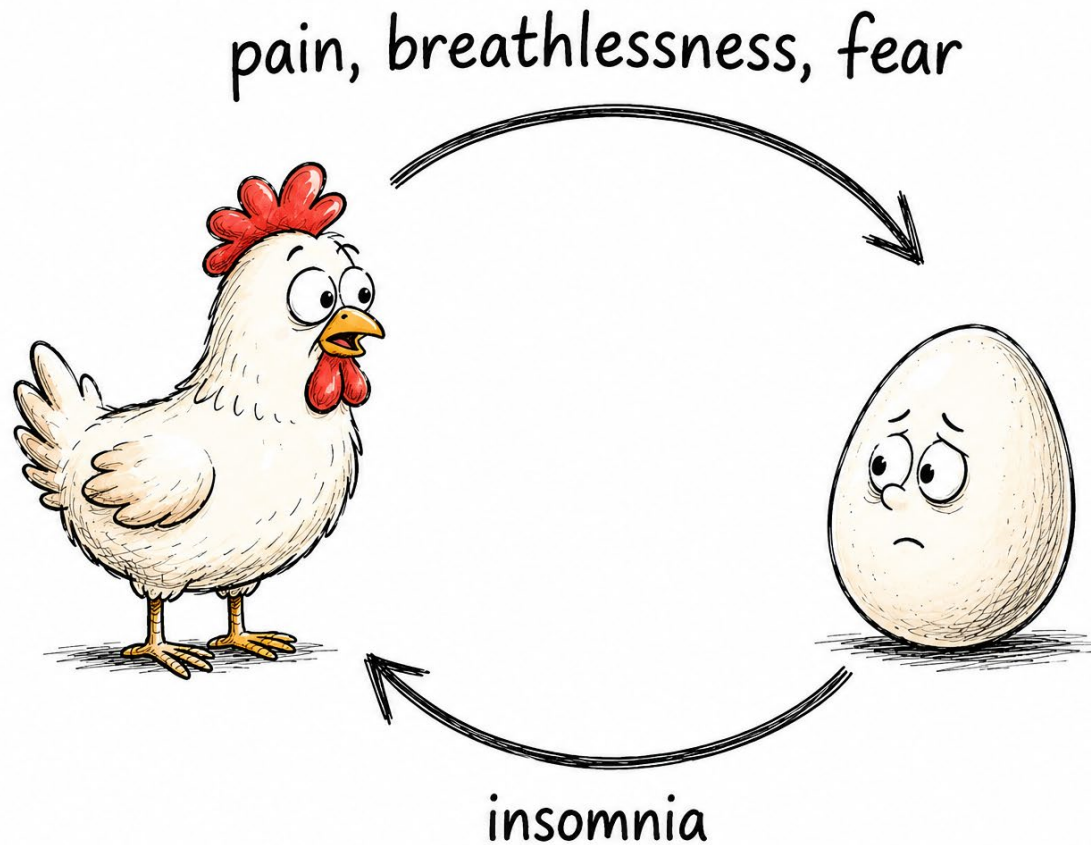
# What is insomnia

- Dissatisfaction with sleep quantity and/or quality
- Difficulty initiating, maintaining sleep or early morning awakening
- Adequate opportunity and setting for sleep
- Palliative Care: prevalence between 2%-100%, median 49%

# Insomnia in PC



# Insomnia in PC



# How do we assess insomnia

- We often don't
- ESAS, NRS, Sleep Diary
- Insomnia Severity Index (ISI)
  - 7 Questions, 0-4 points, starting 15 point clinical insomnia

| <b>Insomnia Problem</b>         | <b>None</b> | <b>Mild</b> | <b>Moderate</b> | <b>Severe</b> | <b>Very Severe</b> |
|---------------------------------|-------------|-------------|-----------------|---------------|--------------------|
| 1. Difficulty falling asleep    | 0           | 1           | 2               | 3             | 4                  |
| 2. Difficulty staying asleep    | 0           | 1           | 2               | 3             | 4                  |
| 3. Problems waking up too early | 0           | 1           | 2               | 3             | 4                  |

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

|                |           |                      |              |                   |
|----------------|-----------|----------------------|--------------|-------------------|
| Very Satisfied | Satisfied | Moderately Satisfied | Dissatisfied | Very Dissatisfied |
| 0              | 1         | 2                    | 3            | 4                 |

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

|                          |          |          |      |                      |
|--------------------------|----------|----------|------|----------------------|
| Not at all<br>Noticeable | A Little | Somewhat | Much | Very Much Noticeable |
| 0                        | 1        | 2        | 3    | 4                    |

6. How WORRIED/DISTRESSED are you about your current sleep problem?

|                       |          |          |      |                   |
|-----------------------|----------|----------|------|-------------------|
| Not at all<br>Worried | A Little | Somewhat | Much | Very Much Worried |
| 0                     | 1        | 2        | 3    | 4                 |

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

|                           |          |          |      |                       |
|---------------------------|----------|----------|------|-----------------------|
| Not at all<br>Interfering | A Little | Somewhat | Much | Very Much Interfering |
| 0                         | 1        | 2        | 3    | 4                     |

# How do we assess insomnia

- Pittsburgh Sleep Quality Index (PSQI)
- (Polysomnography, Actigraphy (wearables))



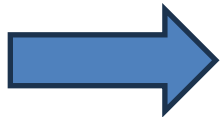
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If the issue persists, please reach out to us at [hello@mentimeter.com](mailto:hello@mentimeter.com)

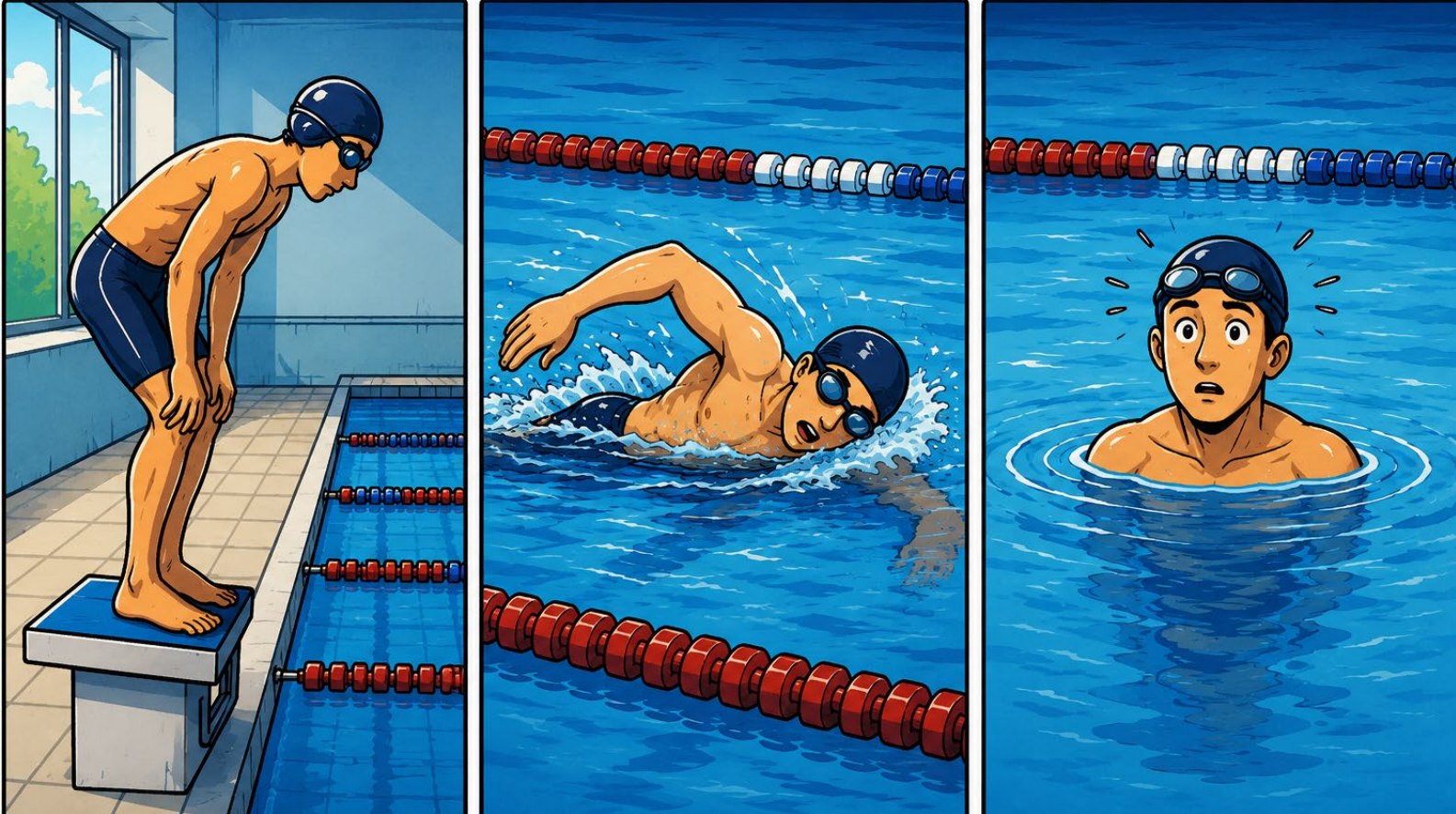
# Non pharmacological interventions

- Treating symptoms
- Identify medication that may disturb sleep
- Day/Night structure, good sleep environment
- CBT-I
  - Mindfulness, ACT, sleep restriction, sleep hygiene  
etc



Is this feasible in our patient population?

# Pharmacological interventions



# Pharmacological interventions

**For isolated sleep-onset insomnia:**

- **Dual orexin receptor antagonists (DORA):**  
Daridorexant 25–50 mg, (lemborexant 5–10 mg, or suvorexant 10–20 mg at bedtime)
- **Melatonin:** 1–5 mg at bedtime
- **Benzodiazepine receptor agonists (Z-drugs):**  
Zolpidem 5–10 mg (immediate-release) or 6.25–12.5 mg (extended-release), Zopiclone 7.5 mg at bedtime



# Pharmacological interventions

## For sleep maintenance insomnia:

- **DORA**
- **Low-dose tricyclic antidepressant:** Trimipramin 8mg?  
25 mg?, Saroten 10-25 mg

# Pharmacological interventions

## Additional agents for insomnia:

- **Sedating antidepressants:**
  - Mirtazapine 7.5–30 mg at bedtime (better tolerated in older or frail patients)
  - Trazodone 25–100 mg at bedtime
  - TCAs
- **Sedating antipsychotics** (monitoring EPMS)
  - Olanzapine 2.5–5 mg at bedtime
  - Quetiapine 12.5–25 mg at bedtime

# Pharmacological interventions

## Additional agents for insomnia:

- **Benzodiazepines:**  
Lorazepam 0.5–1 mg at bedtime
- **Medical cannabis:** Oral form preferred

With caution  
in elderly!

**For patients with life expectancy of days to weeks (dying patients), the guideline recommends titrating the dose of existing pharmacotherapy or benzodiazepines**

# Evidence is (not) surprisingly low

## Systematic Review/Cochrane

- Antidepressant for insomnia in adults (Everitt et al.)
- Eszopiclone for insomnia (Wehrle et al.)
- Benzodiazepines and related drug for insomnia in PC patients (Hirst et al. 2013) **Empty review, withdrawn**
- Pharmacological interventions for insomnia in palliative care patients





|                               |                                                                                                                                                                                                                          |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11.18.                        | <b>Konsensbasierte Empfehlung</b>                                                                                                                                                                                        |
| <b>EK</b>                     | Die medikamentöse Therapie von Schlafstörungen <i>soll</i> ursachenspezifisch erfolgen.                                                                                                                                  |
| 11.19.                        | <b>Konsensbasierte Empfehlung</b>                                                                                                                                                                                        |
| <b>EK</b>                     | Bei Verwendung sedierender Medikamente in anderer Indikation <i>sollte</i> deren Wirkung auf den Schlaf bei zusätzlicher Insomnie genutzt werden.                                                                        |
| 11.20.                        | <b>Konsensbasierte Empfehlung</b>                                                                                                                                                                                        |
| <b>EK</b>                     | Der übliche Zeitraum einer Kurzzeitbehandlung (3-4 Wochen) von Insomnien mit Medikamenten <i>kann</i> bei Patienten mit einer nicht-heilbaren Krebserkrankung ausgeweitet werden.                                        |
| 11.21.                        | <b>Evidenzbasierte Empfehlung</b>                                                                                                                                                                                        |
| Empfehlungsgrad<br><b>B</b>   | Zur Behandlung der Insomnien bei Patienten mit einer nicht-heilbaren Krebserkrankung <i>sollten</i> kurzfristig bevorzugt Zopiclon und Zolpidem und mittelfristig bevorzugt sedierende Antidepressiva eingesetzt werden. |
| Level of Evidence<br><b>4</b> | Quellen: -                                                                                                                                                                                                               |

|                                |                                                                                                                                                                                                                                                                 |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11.23.                         | Evidenzbasierte Empfehlung                                                                                                                                                                                                                                      |
| Empfehlungsgrad<br><b>0/B</b>  | a) Zur kurzfristigen medikamentösen Behandlung der Insomnie <i>können</i> sedierende Antidepressiva verwendet werden.<br>b) Zur mittelfristigen medikamentösen Behandlung der Insomnie <i>sollten</i> sedierende Antidepressiva verwendet werden.               |
| Level of Evidence<br><b>1-</b> | Quellen: Cankurtaran et al. 2008 [923], Palesh et al. 2012 [924], Tanimukai et al. 2012 [925], Theobald et al. 2002 [926]                                                                                                                                       |
| 11.24.                         | Evidenzbasierte Empfehlung                                                                                                                                                                                                                                      |
| Empfehlungsgrad<br><b>B</b>    | Benzodiazepine <i>sollten</i> zur Behandlung der Insomnie bevorzugt nur bei ebenfalls bestehenden anderen Indikationen für ihren Einsatz verwendet werden.                                                                                                      |
| Level of Evidence<br><b>4</b>  | Quellen: Hirst et al. 2000 [927], Matsuo et al. 2007 [928], Kaneishi et al. 2015 [929]                                                                                                                                                                          |
| 11.25.                         | Evidenzbasierte Empfehlung                                                                                                                                                                                                                                      |
| Empfehlungsgrad<br><b>0</b>    | Bei Patienten mit einer nicht-heilbaren Krebserkrankung <i>können</i> sedierende Antipsychotika zur Behandlung der Insomnie eingesetzt werden, wenn andere Therapien nicht möglich sind, oder wenn sie für andere Symptome synergistisch genutzt werden können. |

# Evidence is (not) surprisingly low

Scoping Review by Ryan et al. (2025) for advanced cancer patients

- 3 RCTs, 2 prospective and 5 retrospective analysis
- Only 5 studies use validated sleep assessment tools

TABLE 2. INSOMNIA SEVERITY INDEX ON DAY 8: MEAN WITH 95% CI (MULTIPLE IMPUTATION)

|                     | <i>Temazepam</i> |                      | <i>Melatonin</i> |                      | <i>Placebo</i> |                      | <i>Adjusted mean difference (95% CI)</i> | <i>p Value</i> |
|---------------------|------------------|----------------------|------------------|----------------------|----------------|----------------------|------------------------------------------|----------------|
|                     | <i>N</i>         | <i>Mean (95% CI)</i> | <i>N</i>         | <i>Mean (95% CI)</i> | <i>N</i>       | <i>Mean (95% CI)</i> |                                          |                |
| Day 8               | 9                | 11.6 (7.1, 16.1)     | 6                | 10.8 (2.5, 19.1)     | 4              | 20.8 (3.3, 38.2)     |                                          |                |
| Temazepam–placebo   |                  |                      |                  |                      |                |                      | −9.1 (−17.5, −0.7)                       | 0.04           |
| Melatonin–placebo   |                  |                      |                  |                      |                |                      | −9.6 (−18.0, −1.2)                       | 0.03           |
| Melatonin–temazepam |                  |                      |                  |                      |                |                      | −0.5 (−7.3, 6.3)                         | 0.88           |

TABLE 3. MEAN DIFFERENCES (95% CI) IN EORTC QLQ-C15-PAL COMPONENTS AT DAY 8

|                                          | <i>Temazepam–placebo adjusted mean difference (95% CI)</i> | <i>p Value</i> | <i>Melatonin–placebo adjusted mean difference (95% CI)</i> | <i>p Value</i> |
|------------------------------------------|------------------------------------------------------------|----------------|------------------------------------------------------------|----------------|
| Global quality of life: mean with 95% CI | −3.4 (−24.0, 17.1)                                         | 0.717          | −8.5 (−29.3, 12.4)                                         | 0.39           |
| Physical functioning                     | −17.8 (−50.6, 15.0)                                        | 0.257          | −10.4 (−43.7, 23.0)                                        | 0.51           |
| Emotional functioning                    | 2.8 (−29.5, 35.1)                                          | 0.853          | −9.7 (−42.0, 22.6)                                         | 0.52           |
| Fatigue                                  | 1.1 (−36.7, 38.9)                                          | 0.949          | −7.4 (−46.2, 31.3)                                         | 0.68           |
| Nausea/vomiting                          | −9.3 (−49.6, 31.1)                                         | 0.621          | 6.2 (−34.6, 46.9)                                          | 0.75           |
| Pain                                     | 12.6 (−32.5, 57.7)                                         | 0.547          | −6.4 (−51.2, 38.5)                                         | 0.76           |
| Breathlessness                           | 6.9 (−35.6, 49.3)                                          | 0.730          | 11.2 (−32.7, 55.1)                                         | 0.59           |
| Insomnia                                 | −37.1 (−85.3, 11.1)                                        | 0.118          | −42.0 (−91.8, 7.7)                                         | 0.09           |
| Appetite loss                            | −14.4 (−62.5, 33.7)                                        | 0.523          | −8.8 (−58.7, 41.1)                                         | 0.71           |
| Constipation                             | −9.0 (−58.8, 40.9)                                         | 0.695          | 6.9 (−41.4, 55.3)                                          | 0.76           |

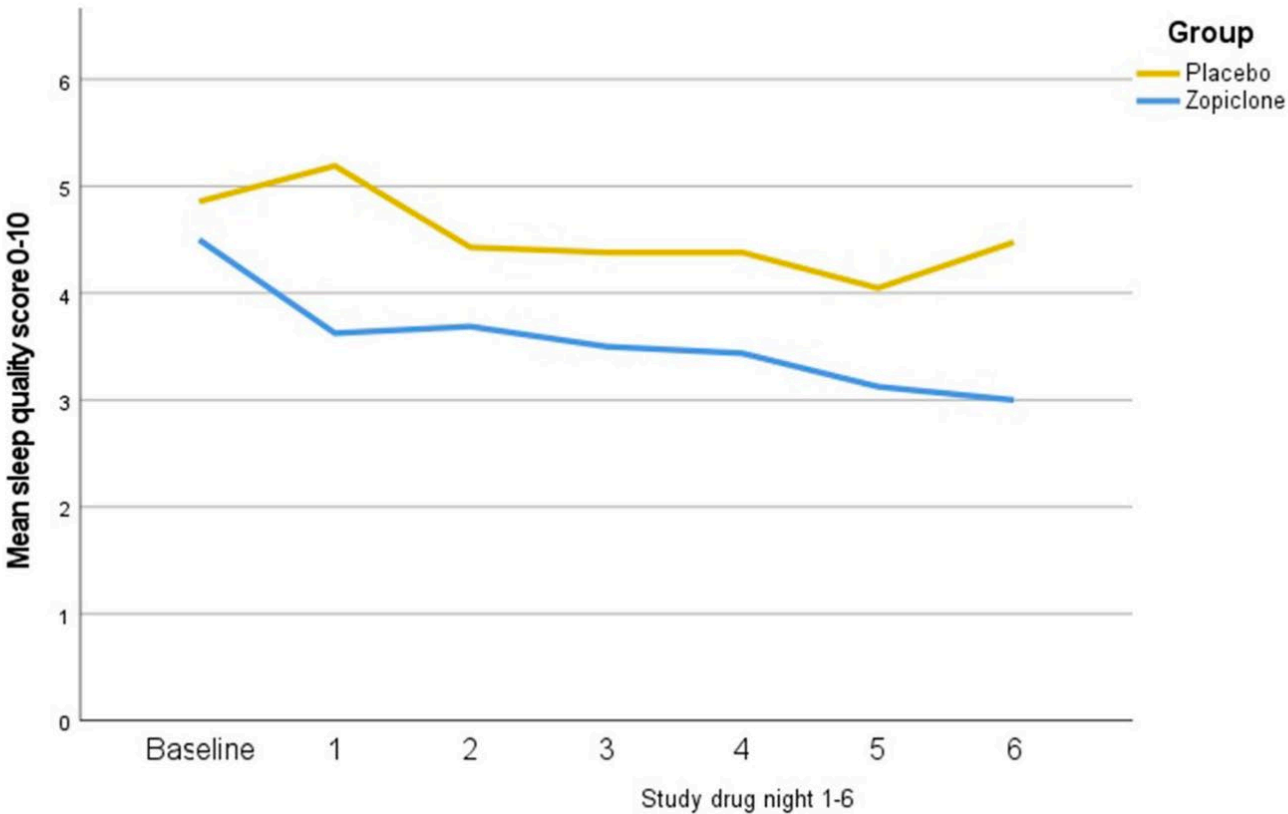
EORTC QLQ-C15-PAL, European Organization for Research and Treatment of Cancer Care Quality of Life Questionnaire for Palliative Care Patients; CI, confidence interval.

**Table 3** Main results: primary outcome: patient-reported sleep quality (NRS 0–10). Secondary outcomes: patient-reported sleep onset latency (SOL) and total sleep time (TST)

| Outcome                              | Zopiclone <i>n</i> = 18 |            | Placebo <i>n</i> = 21 |            | <i>P</i> <sup>1</sup> |
|--------------------------------------|-------------------------|------------|-----------------------|------------|-----------------------|
|                                      | Mean                    | 95% CI     | Mean                  | 95% CI     |                       |
| Sleep quality, 0–10 NRS <sup>2</sup> | 2.9                     | 2.3 to 3.8 | 4.5                   | 3.6 to 5.4 | 0.021                 |
| SOL, minutes <sup>3</sup>            | 29                      | 13 to 51   | 62                    | 40 to 87   | 0.045                 |
| TST, minutes <sup>4</sup>            | 449                     | 403 to 496 | 411                   | 380 to 440 | 0.167                 |

<sup>1</sup>*P*-value from the *t*-test comparing differences in sleep quality night 6. <sup>2</sup>Patient-reported sleep quality NRS 0–10, 0=best sleep, 10=worst possible sleep, <sup>3</sup>sleep onset latency. <sup>4</sup>Total sleep time

**Fig. 2** Profile of mean patient-reported sleep quality scores over time by treatment group



# Case Report Daridorexant

Mrs. D., born 1942

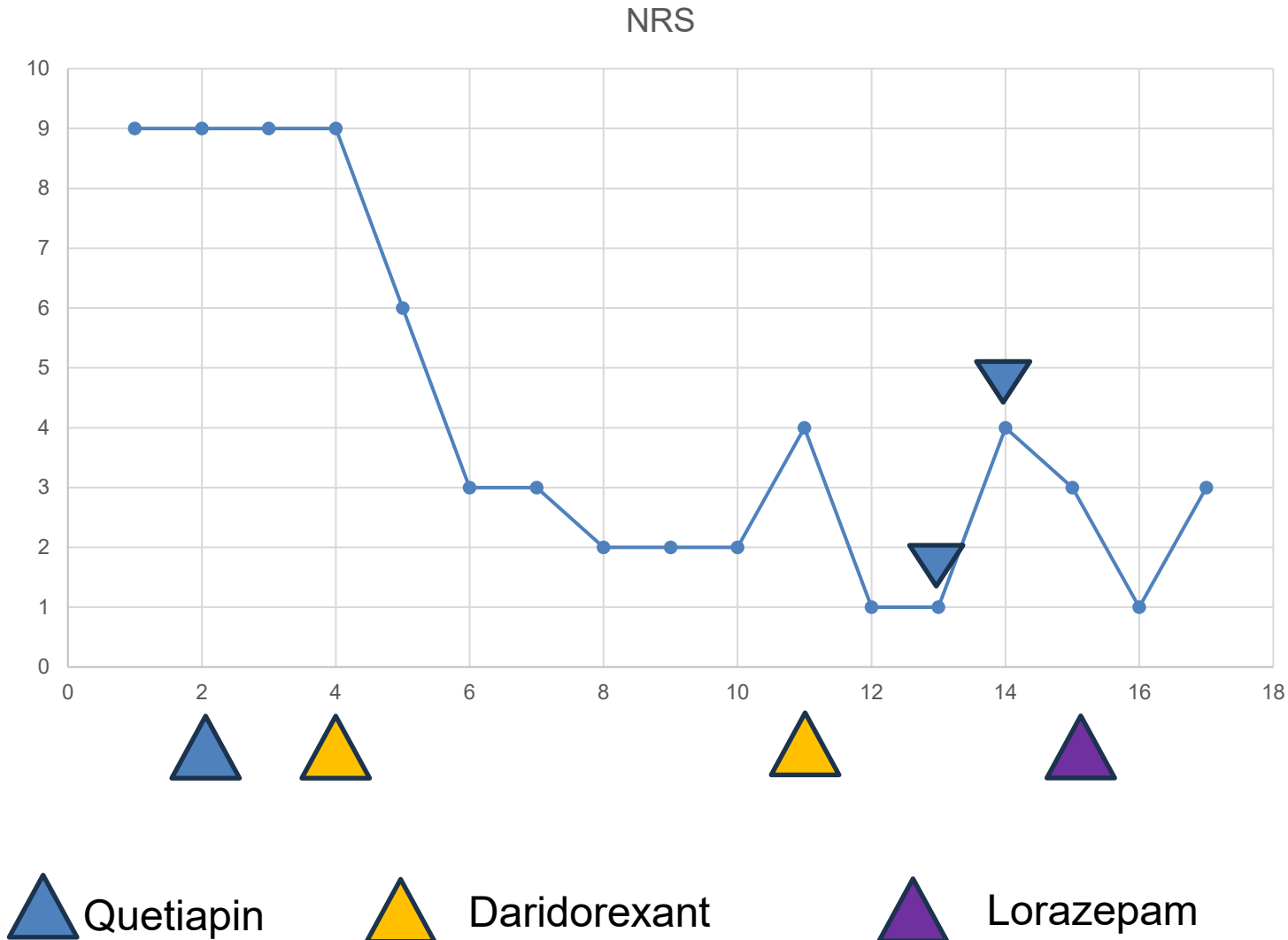
- 04/2014 bulbar-onset ALS
- Idiopathic Parkinsonsyndrom, ED 2018
  - Treated with Madopar
- Presents to the PC unit after acute deterioration of mobility

# Case Report Daridorexant

- S: Pain shoulder, knees, dysphagia, orthopnoe, sleep onset insomnia
- E: Planning of ongoing care
- N: MPCT, ALS nurse, RehaB, spitex, ergo/physio
- S: Married to husband, 2 sons (australia, uster)
- “Acute” ECOG 4, communication with tablet, patient seemed oriented



# Case Report Daridorexant



| Drug class                      | Efficacy for insomnia                                                               | Safety in PC                                                                          | Evidence in PC                                                                        |
|---------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <b>Benzodiazepines</b>          |    |    |    |
| <b>Z-drugs</b>                  |    |    |    |
| <b>DORAs</b>                    |    |    |    |
| <b>Sedating antidepressants</b> |    |    |    |
| <b>Antipsychotics</b>           |   |   |   |
| <b>Melatonin</b>                |  |  |  |

# Goodnight! Questions?



# Palli-GeMed: a home-based palliative emergency response team in Geneva

**Summer School in Palliative Medicine**

Murten | 24.06.2026

**Simon Singovski**

Chief resident

Palliative Medicine

Geneva University Hospitals

# Declaration

- No conflict of interest to declare

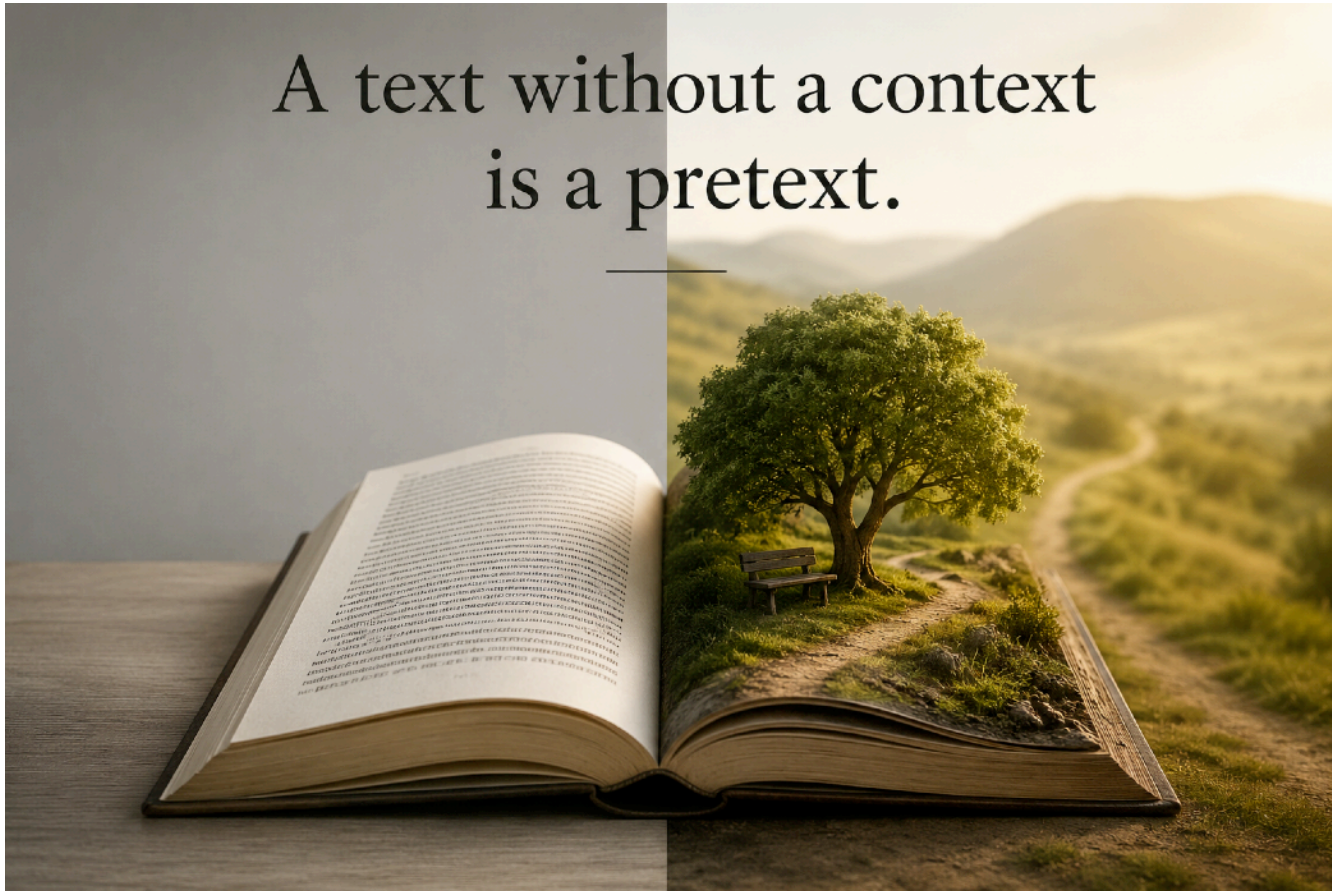
# Aim of this presentation

Introduce **Palli-GeMed**: the first home-based palliative emergency response team in Switzerland



# The context

A text without a context  
is a pretext.



Commonly attributed to various authors (exact origin uncertain)

# Death at Home: preferences and benefits

## 1. Preferred by the majority of the Population

- Switzerland: 72% (Federal Council report “*End of Life*”, 18 September 2020)
- Worldwide: estimates vary widely, ranging from 11% to 89% (Pinto S. *Journal of Pain and Symptom Management*, 2024)

## 2. Benefits for patients (Pinto S., 2024)

- Choice of environment and surrounding people, greater autonomy and dignity

## 3. Benefits for family members / loved ones (Pinto S., 2024)

- Death perceived as more peaceful
- Greater recognition and involvement by the healthcare team

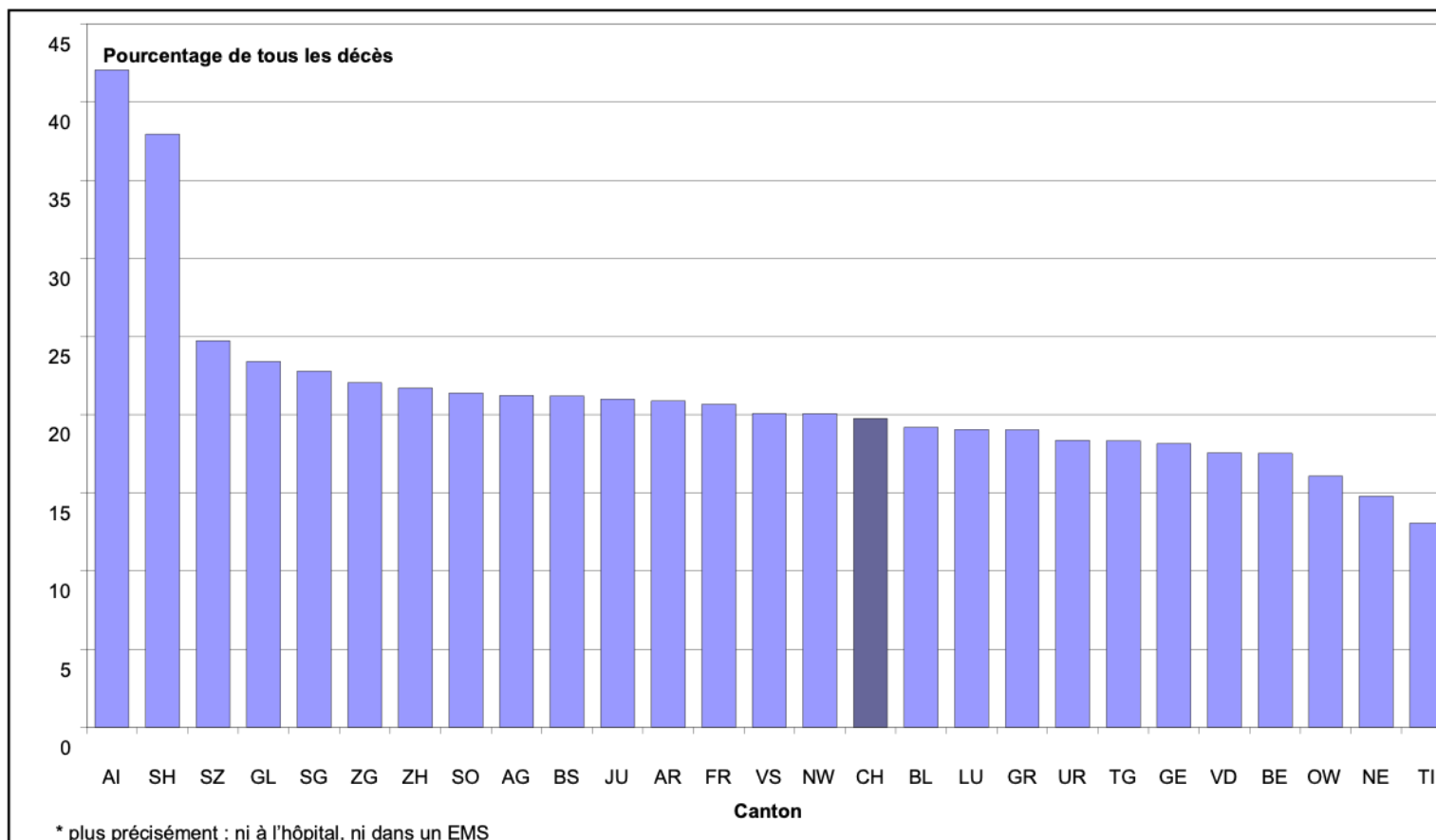
## 4. Economic benefits

- Reduction in healthcare costs during the last two months of life (Gonzalez-Jaramillo V. *Palliative & Supportive Care*, 2021)



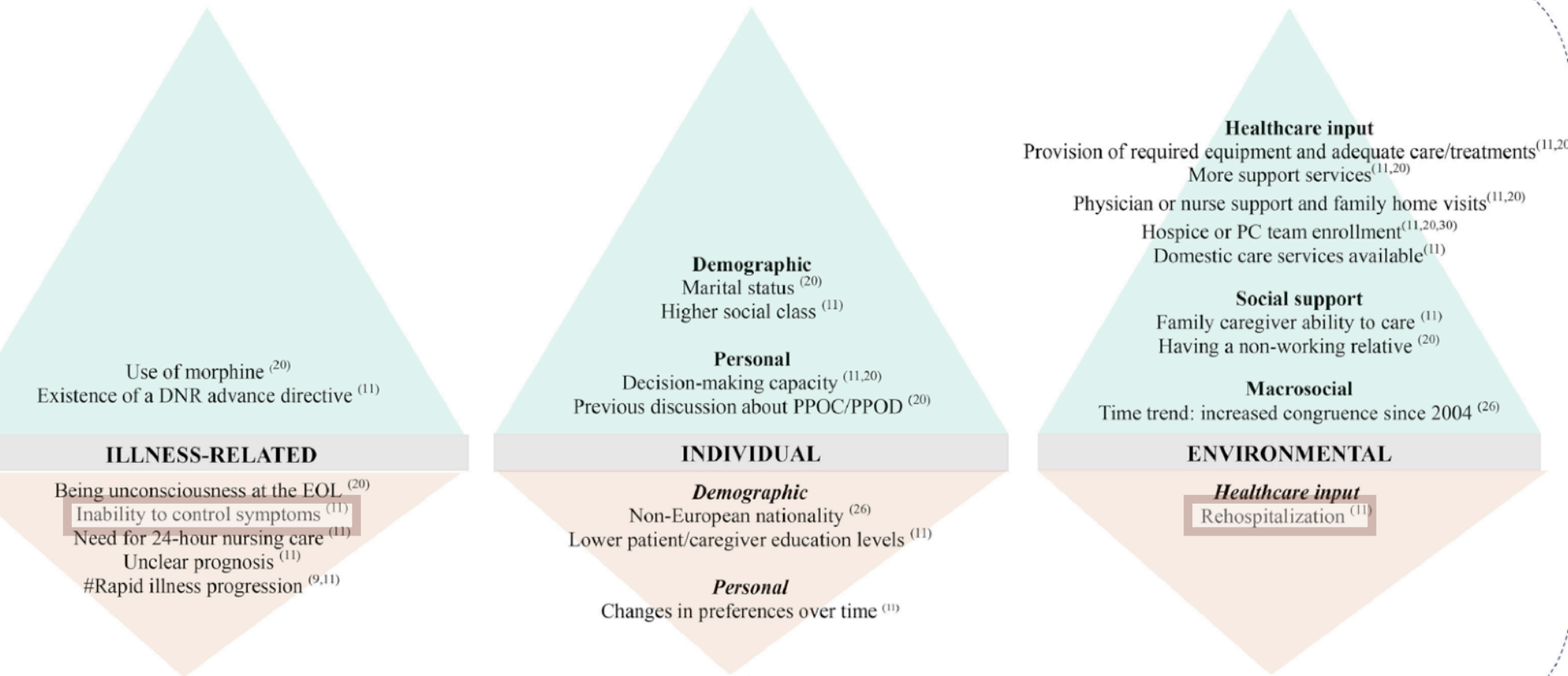
# Death at Home in Switzerland

Proportion des personnes décédées à domicile\*, 2009



Données : OFS, plusieurs sources de données

# Death at Home: associated factors



- Pinto S, 2024

# Palliative Emergencies: a collaborative care model

1. Collaboration between prehospital emergency services and palliative care teams:
  - **Montgomery et al., 2017** (Calgary, Canada): 55% home deaths among patients with palliative emergencies.
  - **Dent et al., 2024** (London, UK): 84% of nursing home residents remained in place without transfer to hospital.
  
2. Specialized palliative care intervention:
  - **Webber et al., 2020** (London, Ontario, Canada): reduction in emergency department visits (from 63% to 21%) and hospital admissions (from 62% to 25%). 79% of patients died at home or in a nursing home.
  - **Hsu et al., 2021** (Taipei, Taiwan): 30.7% reduction in emergency department visits.
  - **Valenti et al., 2023** (Bologna, Italy): 59% reduction in transfers to the emergency department and 68% reduction in in-hospital deaths.
  - **Deniau et al., 2023** (Paris, France): 93% of patients remained at home.
  
3. Palliative Care Hotline: many studies, non conclusive

# The journey

“Traveler,  
there is no path.  
The path is made  
by walking.”

—  
*Antonio Machado*

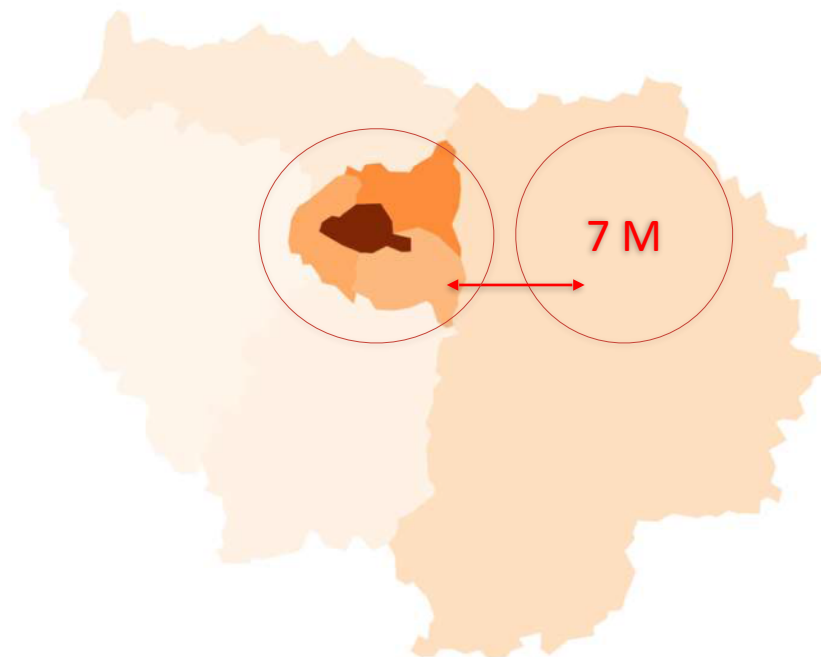
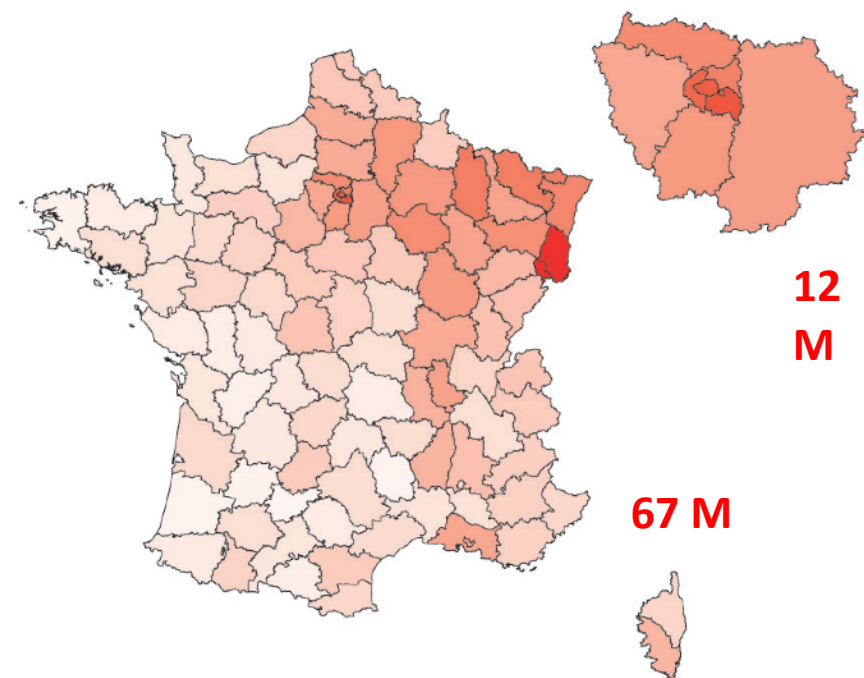




# Pallidom



Un territoire complet 75 + 92 + 93 + 94



# Palli-GEMED

Urgences Palliatives à domicile



- 24/7 physician only consultation
- Available to all patients in Geneva region



- Acute medical issue in a palliative care setting
- Usual physicians unavailable



- Same-day consultation report
- Bridging follow-up until continuity of care is restored

# Palli-GEMED

Urgences Palliatives à domicile



Supervision and interventions by two **senior physicians** (100%), Palliative Medicine, Geneva University Hospitals



Interventions by two **resident physicians** (100%), General Medicine Department, Geneva University Hospitals



**Ressources from HUG:** other resident physicians, Palliative Medicine on-call physician  
**Ressources from GeMed:** attending physicians



# Private - Public collaboration

|                          | HUG                                                                                                                                             | GeMed                                                                                                                          |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Staffing                 | <ul style="list-style-type: none"> <li>• Palliative Medicine specialists</li> <li>• Learning resident physicians</li> <li>• No nurse</li> </ul> | <ul style="list-style-type: none"> <li>• Out-of-hours staff (resident and attending physicians)</li> <li>• No nurse</li> </ul> |
| Triage                   | <ul style="list-style-type: none"> <li>• Supervision by Palliative Medicine specialists</li> </ul>                                              | <ul style="list-style-type: none"> <li>• 24/7 telephone availability</li> <li>• Internal processes</li> </ul>                  |
| Drugs, Material          | <ul style="list-style-type: none"> <li>• None</li> </ul>                                                                                        | <ul style="list-style-type: none"> <li>• Pharmacy, opioids</li> <li>• Car</li> </ul>                                           |
| Electronic Health Record | <ul style="list-style-type: none"> <li>• DPI</li> </ul>                                                                                         | <ul style="list-style-type: none"> <li>• Mediway</li> </ul>                                                                    |



# Medias

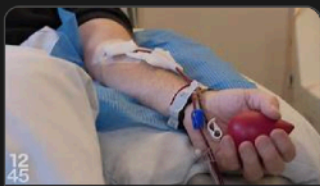
## Actualités



### Tribune de Genève

Genève: nouveau service d'urgences palliatives à domicile

la semaine dernière



### rts

Les HUG lancent un service d'urgence palliative à domicile pour améliorer la qualité de vie des patients

la semaine dernière



### 20 Minutes Switzerland...

Genève: création d'un service d'urgences palliatives à domicile

la semaine dernière

GENÈVE

**LE COURRIER**  
L'essentiel, autrement

## Des urgences palliatives à domicile

En novembre 2024, les HUG et GenèveMédecins ont lancé «Palli-GeMed», dont l'équipe effectue des interventions urgentes directement chez les patient·es en



## Les HUG lancent un service d'urgences palliatives à domicile: interview de Simon Singovski

Interview de Simon Singovski, chef de clinique à la Consultation de soins palliatifs à domicile.

La Matinale

Le 8 janvier 2025

# The results



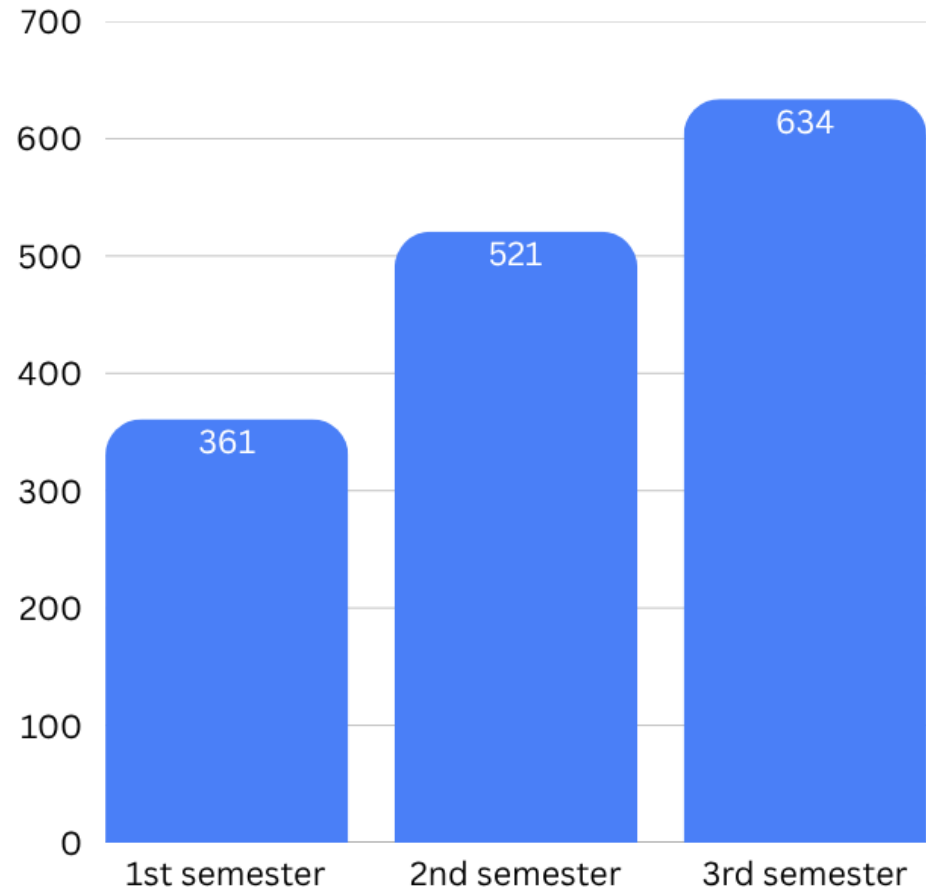
“Nature does  
not hurry,  
yet everything  
is accomplished.”

—  
Lao Tzu

# Consultations

Consultations:

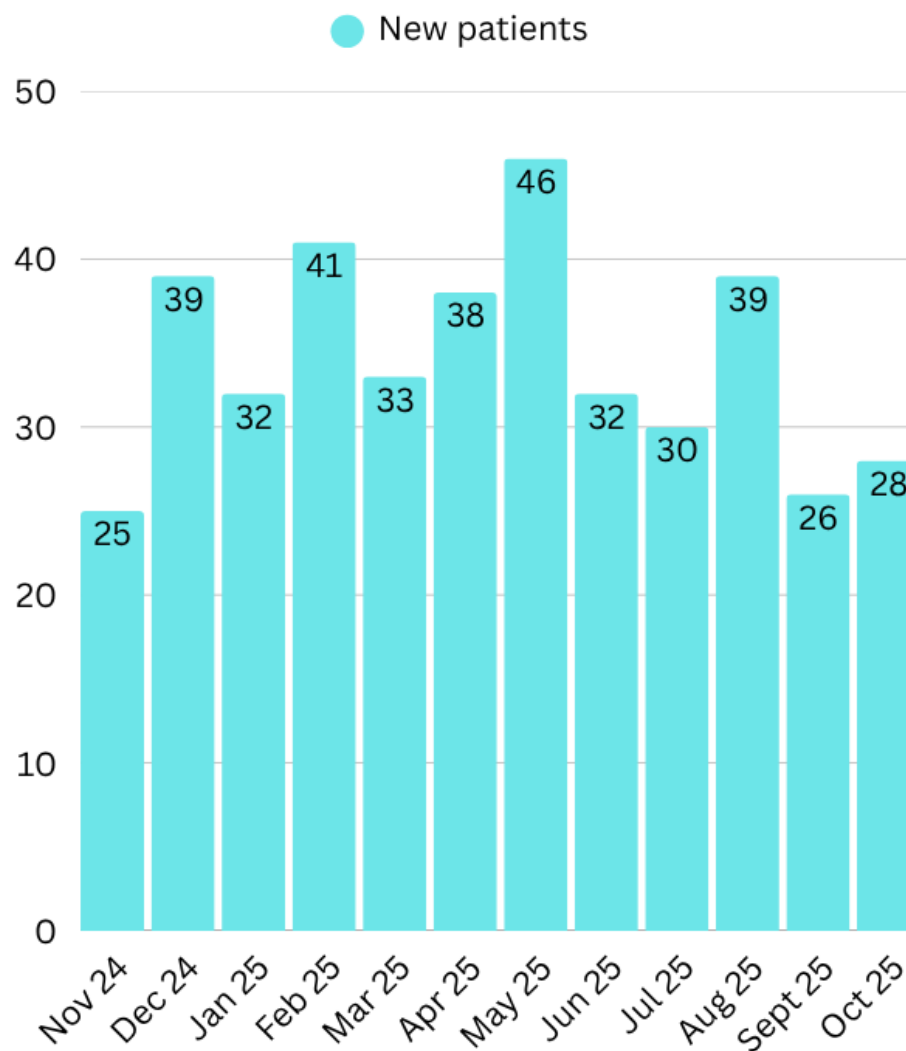
- Total 1st year: 882
- Total 18 months: 1516
- 2.6/day
- Projection: 1300-1400/year



# Patients

During the first year

- Total of 409 patients
- 2.16 consultation/patient



# Patients

Mean age: 82 ans (40 - 106)

F 58% / M 42%

Know by PC team: 33%



## Critical condition

- Respiratory failure: 34%
- Circulatory failure circulatoire: 13%
- Loss of consciousness/inability to speak: 21%

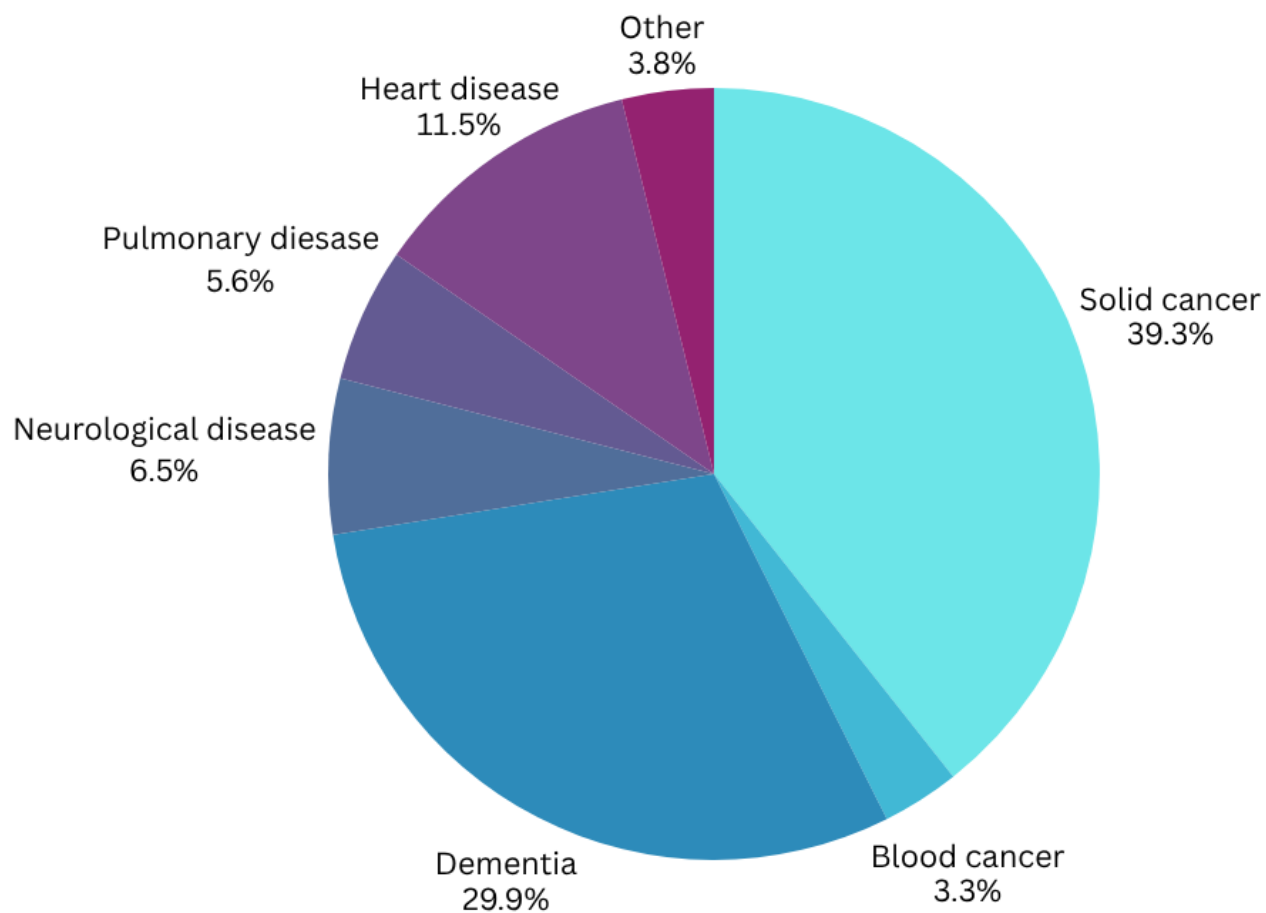


## Place of residence:

- Home: 241 (65%)
- Nursing home: 125 (35%)

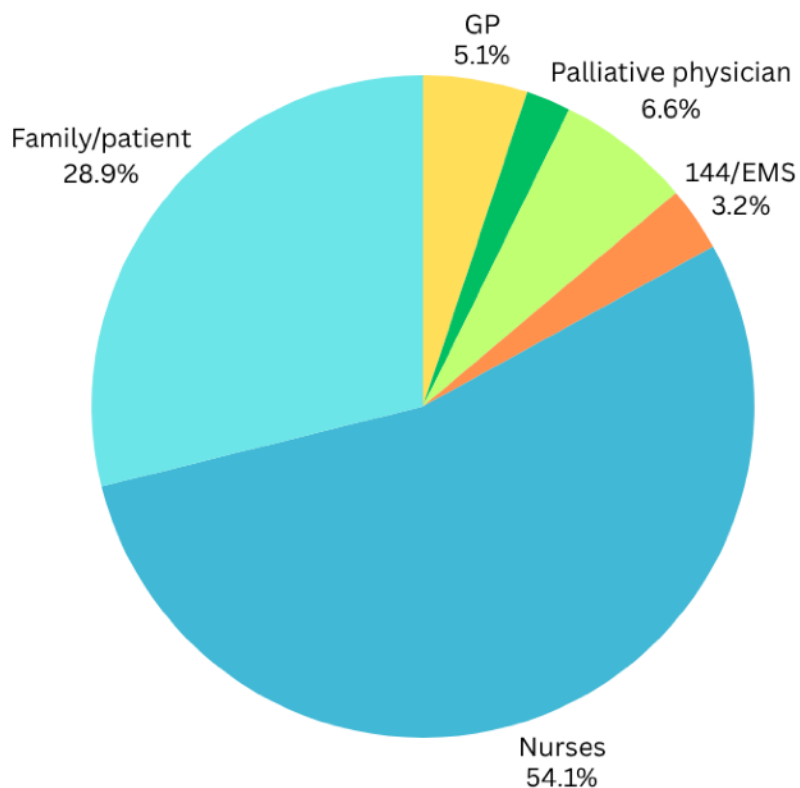


# Primary disease

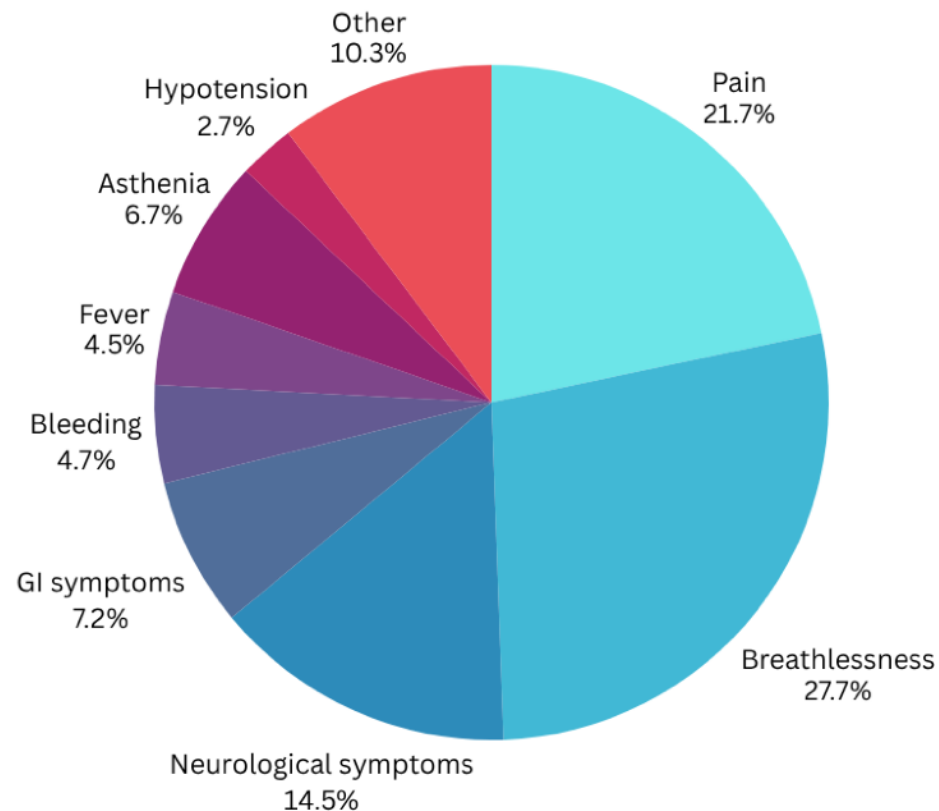


# Patients

**Origin of call**



**Main symptom**





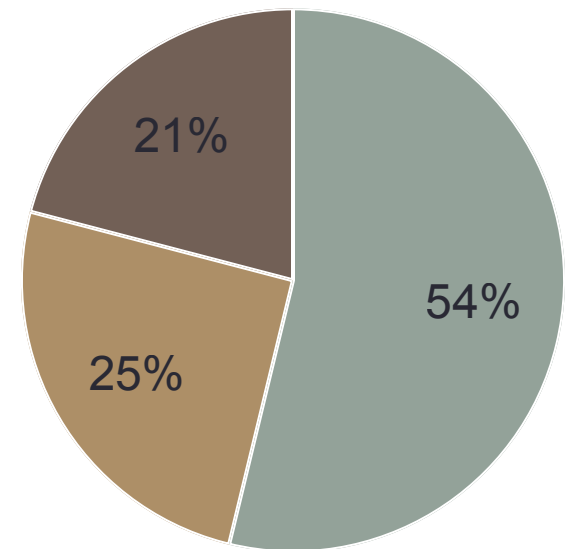
# Timing

## Description:

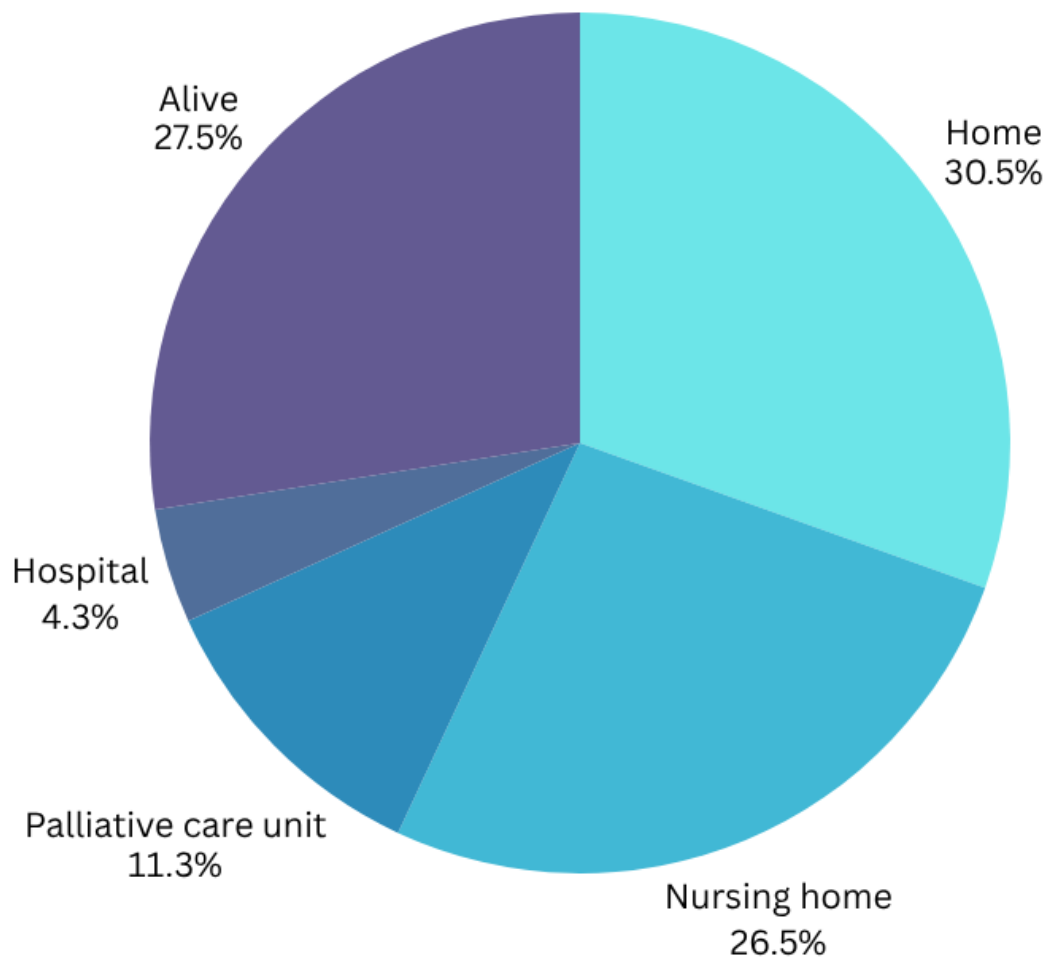
- Mean consultation duration: 63 minutes (5 - 227)
- Mean response time: 108 minutes (0 - 593)
- Follow-up duration: 4.3 days (1-37)

● Day    ● Weekend    ● Night

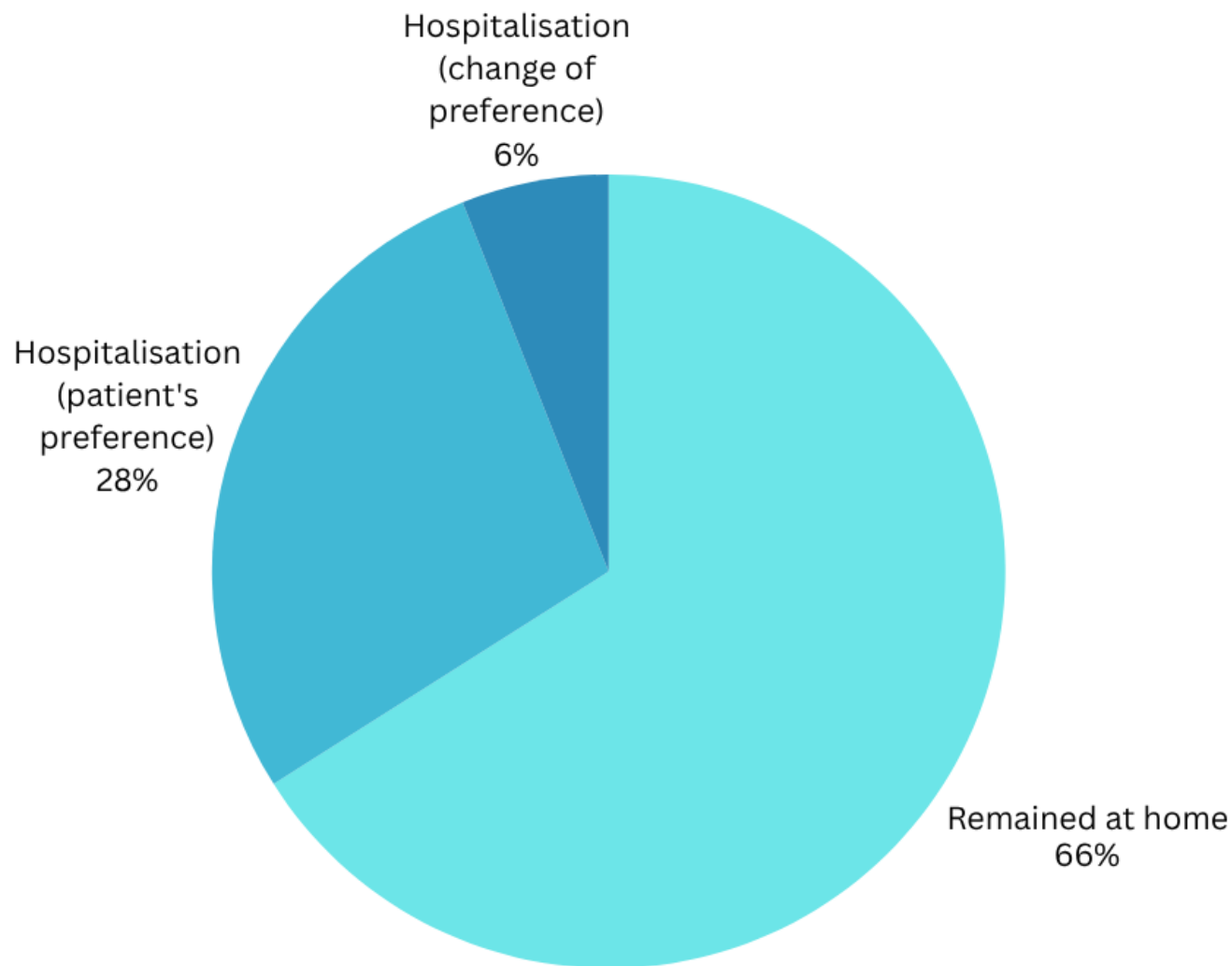
Consultation period



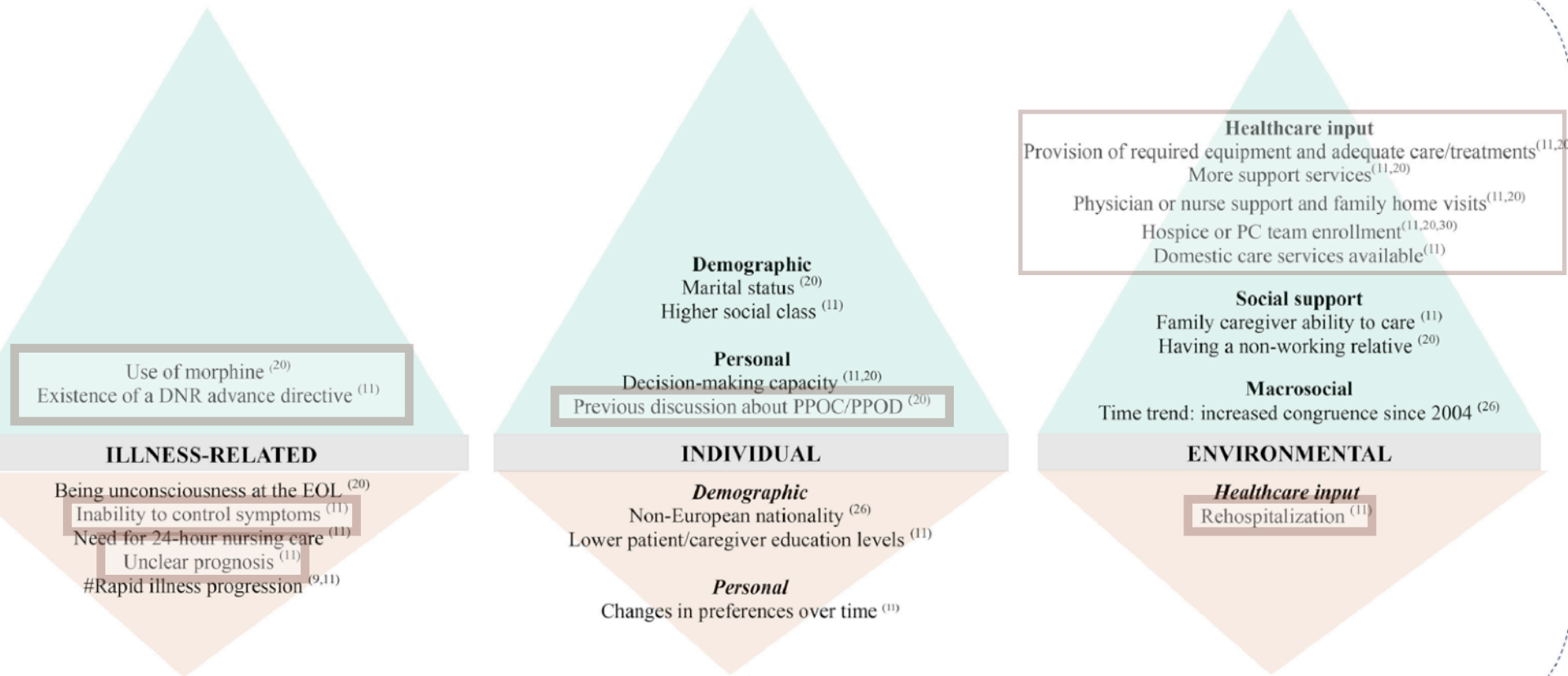
## Place of death



## Care trajectory



# Death at Home: associated factors



- Pinto S, 2024

# Conclusions

- Home death is **preferred** by most people in Switzerland, but this preference is not yet adequately supported by the healthcare system.
- Achieving this goal requires **proactive planning** and **coordinated responses** from the multidisciplinary healthcare network.
- **Palliative emergencies** are a key barrier to home death and must be managed rapidly and effectively.
- **Palli-GeMed** is a novel palliative emergency service developed to help patients remain at home at the end of life.

# Thank you

**Prof. Sophie Pautex**

**Philippe Vandeplas**

**Petra Vayne-Bossert**

**Fanny Arango**

**Clément Leclaire**



# Thank you

**Simon Singovski**

Chief resident  
Palliative Medicine  
Geneva University Hospitals

[simon.singovski@hug.ch](mailto:simon.singovski@hug.ch)



# Clinical hypnosis in palliative care

Summer School in Palliative Medicine

June 2026

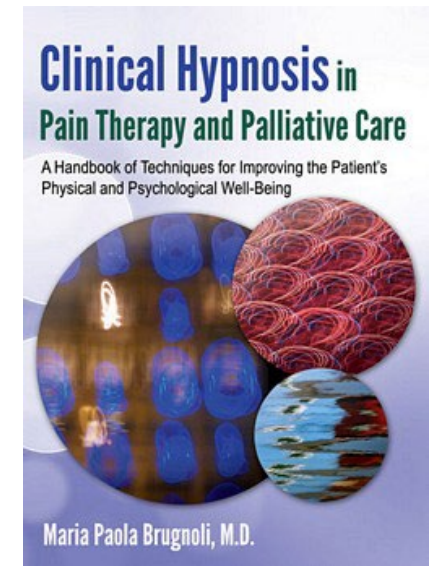
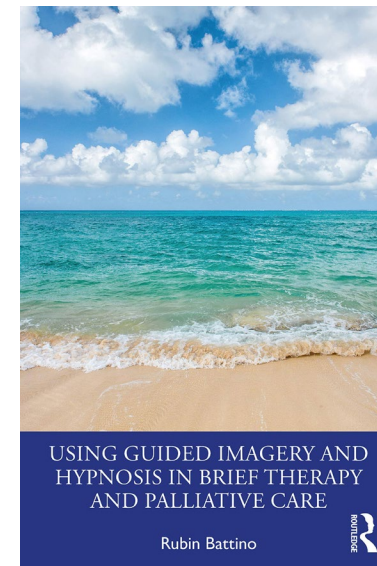
Dr. Florence Sartorio



# Literature

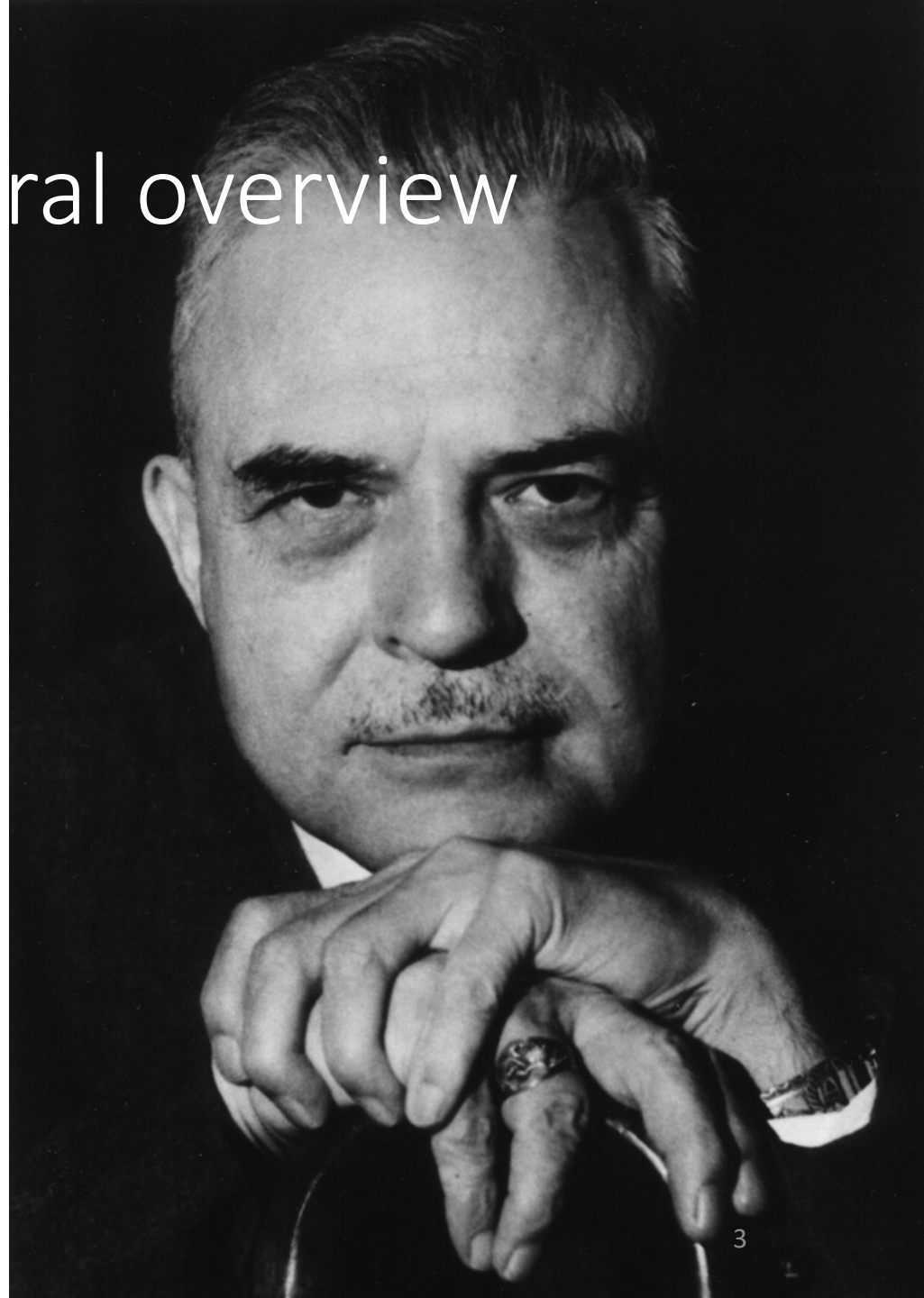
| Keywords on Pubmed                                         | Number of articles |
|------------------------------------------------------------|--------------------|
| Hypnosis                                                   | 16 611             |
| Clinical hypnosis                                          | 360                |
| Complementary medicine / alternative medicine + palliative | 428                |
| Hypnosis + palliative                                      | 141                |
| Clinical hypnosis + palliative                             | 15                 |

Clinical hypnosis  
/  
Medical hypnosis  
/  
Therapeutic hypnosis



# Therapeutic hypnosis – general overview

- **Not:** stage hypnosis, nothing religious
- Hypnologist or hypnotherapist?
- **Ericksonian** hypnosis (American psychiatrist, 1901–1980)
  - **Anti-paternalist**
  - “**Low** position”, the therapist is at the service of the patient
- A tool based on problem → **solution**
  - **Conversational** hypnosis
  - **Procedural** hypnosis
  - **Dedicated** sessions with therapeutic objectives
- A different approach
  - Between **cognitive therapy** and **spiritual healing**
  - Based on a strong therapeutic **relationship**
  - Focused on **internal resources** (opposing: medication / advices)
  - The patient is an **active** participant
  - **Creative** approach



# Definitions

## Hypnosis

- Milton Erickson : “A particular state of consciousness that favors **unconscious** functioning over **conscious** functioning.”
- “A state of psychological functioning in which a person experiences an **expanded** field of awareness.”<sup>11</sup>
- A natural and recognized state<sup>7,11</sup> based on dissociation
  - NOT indicated: psychiatric illness with **psychosis** (acute psychosis or neuroleptic)



# Definitions

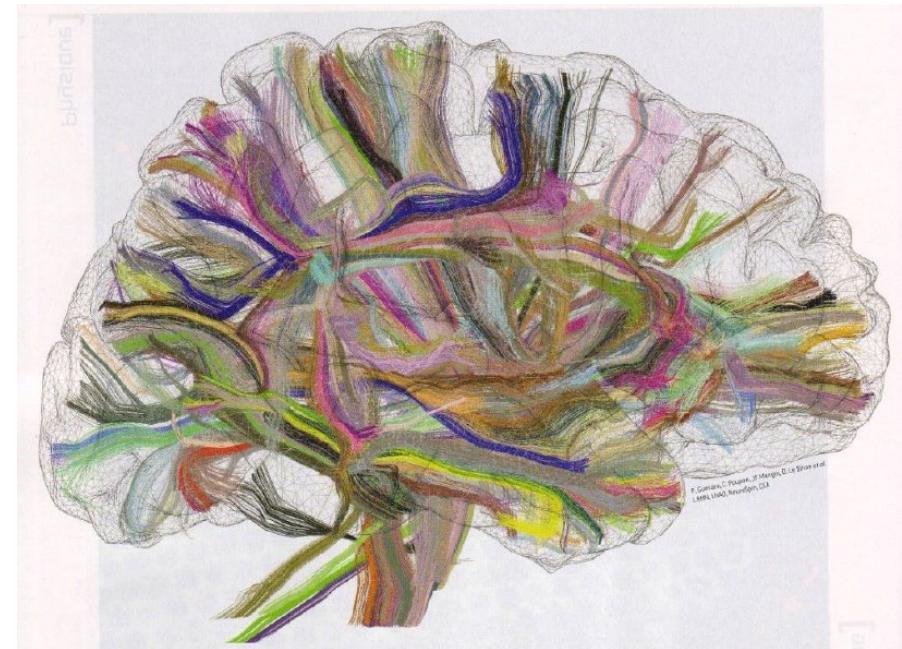
## Therapeutic hypnosis

- “A state of psychological functioning in which a person, **in relationship with a practitioner**, experiences an expanded field of consciousness, for a **therapeutic** purpose.”<sup>11</sup>
- Changes occur in subjective experience, with modifications in:
  - Perception
  - Sensation
  - Emotion
  - Thought
  - Behavior<sup>17</sup>



# Neurophysiological basis Functional MRI

- Hypnosis shows high levels of **connectivity** and **specific** neural connections (“connectome”)<sup>14</sup>

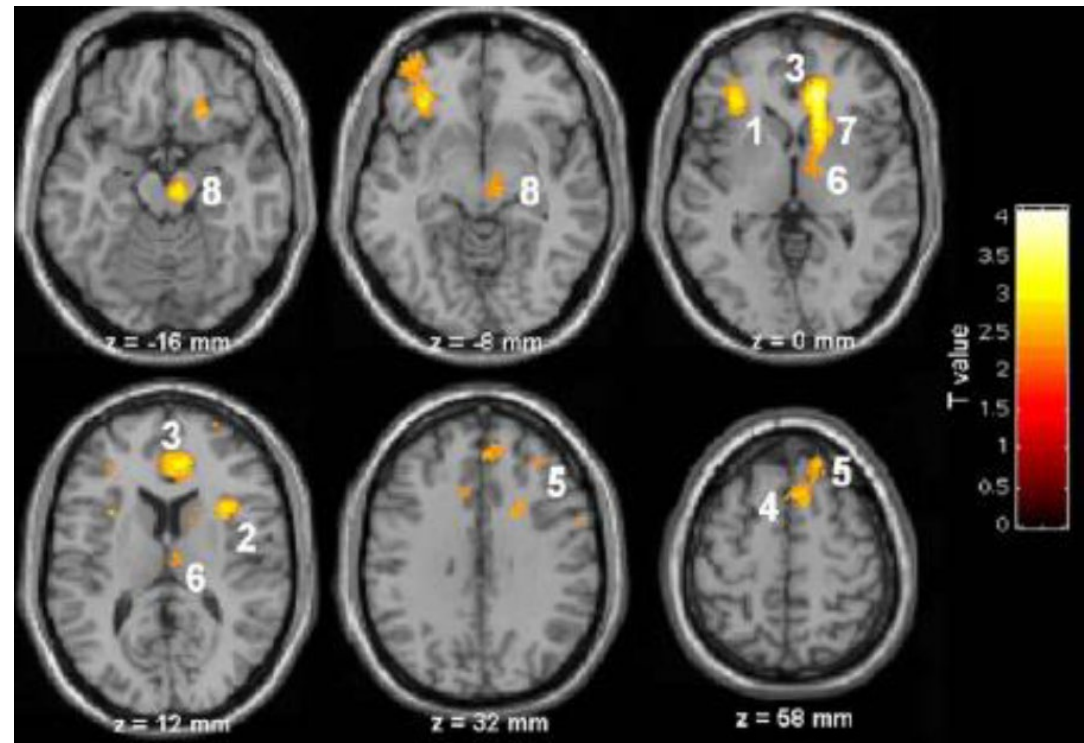




# Neurophysiological basis

## Functional MRI

- Functional MRI shows that hypnosis **modifies** the connectivity of different brain centers involved in **nociception**<sup>13,15</sup>



# Neurophysiological basis

## Functional MRI

- Brain areas connected during hypnosis Bruno Suarez, 2005 and 2009

- Anterior cingulate cortex :

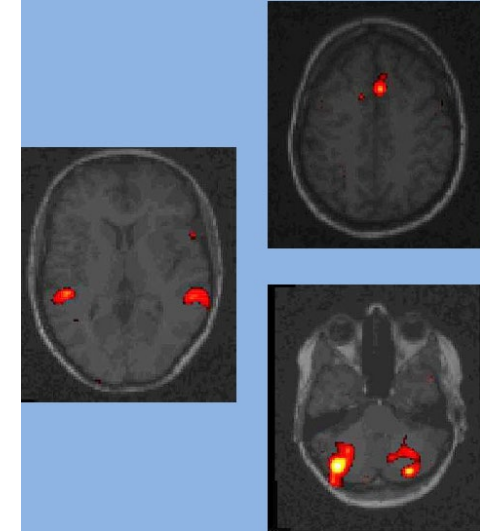
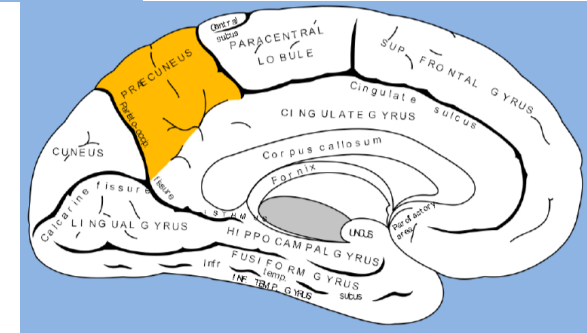
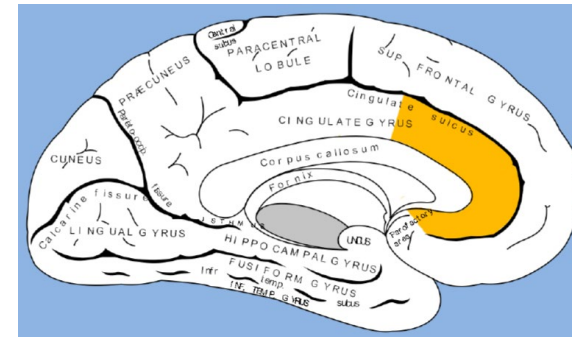
- Desire and motivation to act
- Emotional component of pain

- Precuneus :

- Sense of agency (feeling of being the author of one's actions)
- Self-awareness

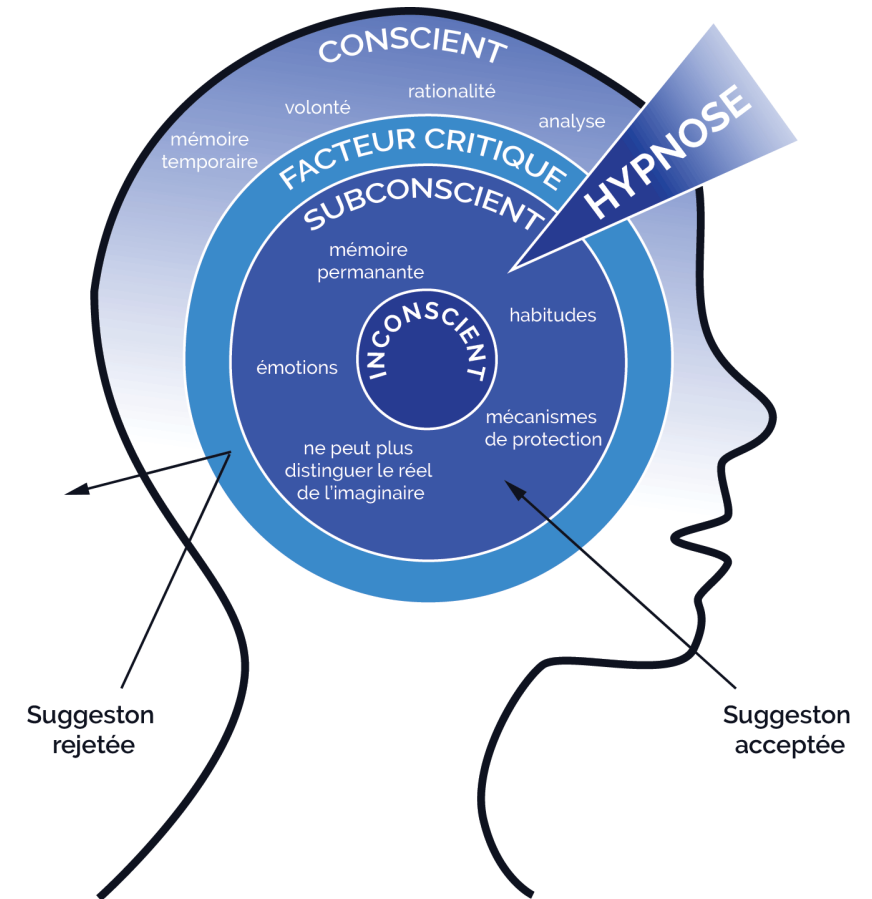
- Cerebellum :

- 80% higher-level cognitive functions (e.g., memory recall)
- 20% motor coordination
- Connected with the prefrontal cortex and sensory areas



# Hypnotic trance

- The patient keeps **control**
- Allows **searching for solutions** beyond rational reasoning
- Helps **reconnect** with the **body** and **emotions**





# Applications in palliative care

- “Ideal” population<sup>16</sup> :
  - Terminal illness, facing death → trauma → **dissociation**
  - Motivated to improve quality of life and regain control
  - Ready to “try anything”
- Still needs further study<sup>1</sup>
- Also beneficial for relatives<sup>1,16</sup>
- Adjunct treatment<sup>8</sup>



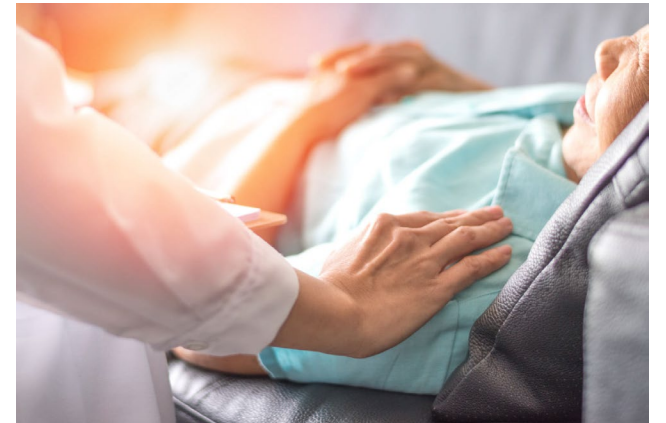
# Applications in palliative care

- Early palliative care
  - Work on symptoms (early or refractory):  
physical / psychological / spiritual<sup>3,16</sup>
    - Pain<sup>8,10,16,19,20</sup>
    - Anxiety<sup>2,10,16,19,20</sup> (COPD<sup>9</sup>, including objective markers)
    - Nausea<sup>8,16,19</sup>
    - Fatigue<sup>8</sup>, sleep disorders<sup>8</sup>, hot flashes<sup>8</sup>, respiratory symptoms<sup>19</sup>
    - Psychosomatic symptoms<sup>2</sup>
  - Long-term effects possible (up to 2 years)<sup>10,17</sup>
  - In oncology (post-chemotherapy nausea<sup>16</sup>)
  - Also facilitates future trance induction



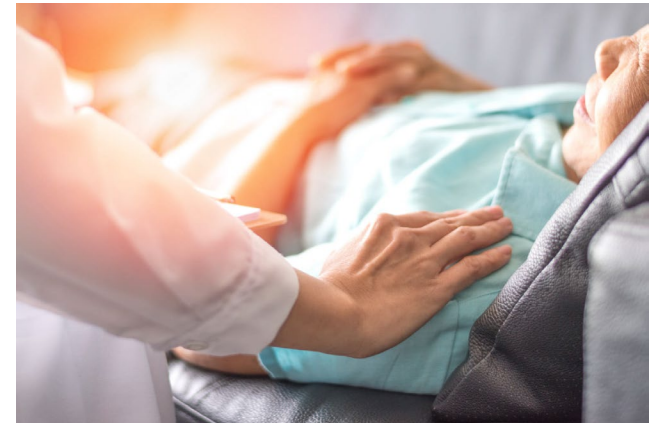
# Applications in palliative care

- Terminal palliative care<sup>5</sup>
  - Relaxation
  - Recalling (good) memories
  - Escape and moments of respite
  - Achieving personal goals
  - Preparation for death<sup>16</sup>



# Applications in palliative care

- At any time !
  - During invasive procedures<sup>6,16</sup>
    - Self-hypnosis<sup>8,20</sup>
  - Reduce pharmacological treatments (opioids<sup>10</sup>)
  - Fear of death & existential distress<sup>4,12,18</sup>
- Hypnosis helps :
  - Living in the present moment<sup>16</sup>
  - Maintaining and strengthening hope<sup>17</sup>
- Hypnosis improves :
  - Patient coping capacity<sup>17</sup>
  - Listening and attention from caregivers<sup>20</sup>

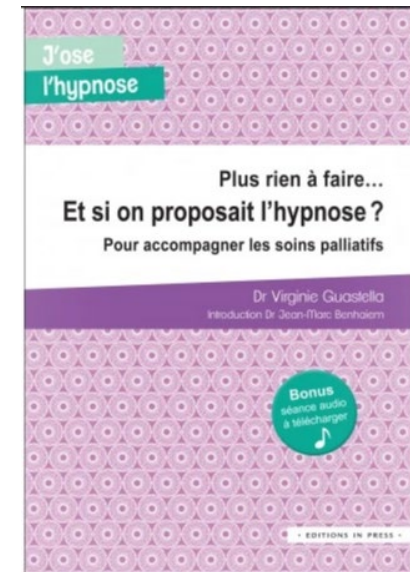


# Clinical Case – Mrs. M.

- 45 years old, multi-metastatic melanoma (especially brain metastases → cognitive impairment), probable end-of-life
- Comorbidities: Obesity
- Past history: Childhood sexual abuse
- Clinical issues: Urinary incontinence, Pseudo-urinary retention, Syndrome of inappropriate antidiuretic hormone secretion, Severe gait disturbance  
→ Urinary catheter placement for comfort and dignity
- Without premedication. Patient's feedback: "It went well... yeah it was good..."
- No externally observed signs of discomfort or anxiety

# What hypnosis brings to my practice

- A **practical** tool that stimulates my creativity
- A **relational** tool where I am at the service of my patient
- A tool that reduces my feeling of **helplessness**
- When we think “There’s nothing more to be done...  
...what if we suggested hypnosis?”



**Thanks for listening!**  
**Any questions?**



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«Best of Palliative Care»?

Anything interesting in the literature since last summer school ?

Bereinigt um diverses urheberrechtlich geschützte Bildmaterial.

Bitte beachten: Nur zur persönlichen Verwendung

Prof. Dr. Jan Gärtner  
Palliative Care Center Bethesda Spital  
Department Clinical Research, University Hospital Basel  
Faculty of Medicine, University of Basel

## High-flow nasal oxygen for the relief of persistent dyspnea in adult patients with cancer: A systematic review and meta-analysis

Lisa Hentsch<sup>1,2</sup> , Ivan Guerreiro<sup>3</sup> , Valentina Gonzalez Jaramillo<sup>4</sup>,  
Simon Singovski<sup>1,2</sup>, Isabelle Santana<sup>5,6</sup> , Sara Cocetta<sup>7</sup> and  
Tanja Fusi-Schmidhauser<sup>2,4,8,9</sup> 

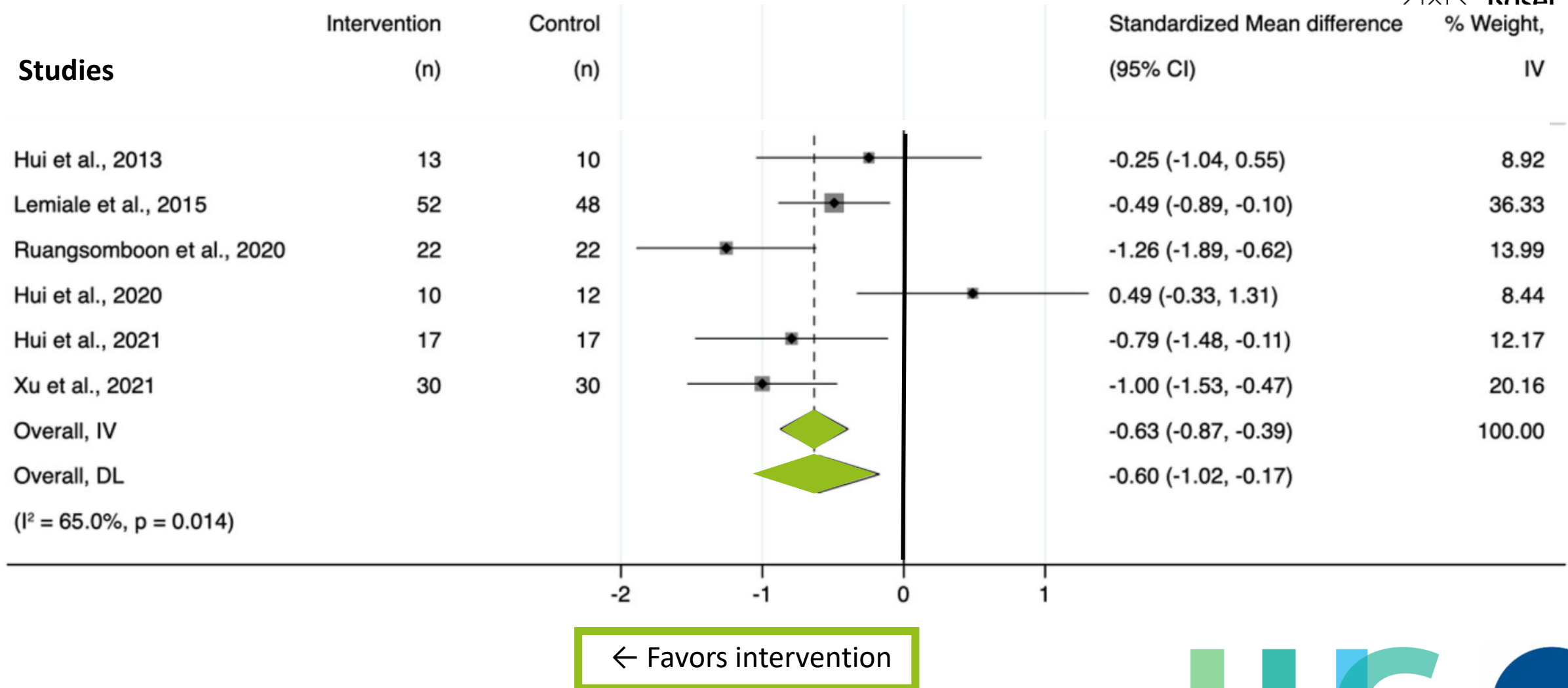
## High-flow O<sub>2</sub> Cross-Over-RCT

Dyspnoea reduction after 10 Minutes [NRS]:

| HFOx         | HFAir        | LFOx        | LFAir       |
|--------------|--------------|-------------|-------------|
| Mean (SD)    | Mean (SD)    | Mean (SD)   | Mean (SD)   |
| -1.8         | -1.8         | -0.5        | -0.6        |
| [-2.8, -0.7] | [-3.0, -0.5] | [-1.0, 0.1] | [-1.3, 0.2] |

# High flow, cancer patients **Meta-Analysis**

Lisa, Tanja, Isabelle, Ivan, Sara, Simon, Sophie, Valentina....



- Sub-group analysis showed that the benefit was confined to hypoxemic patients with no significant improvement in non-hypoxemic individuals.

- Sub-group analysis showed that the benefit was confined to hypoxemic patients with no significant improvement in non-hypoxemic individuals.

## Implication for practice

- High-flow nasal oxygen could be considered as a supportive intervention to reduce dyspnea in hospitalized people with cancer.

**Should we use high-flow in cancer patients ?**



## Our team after Journal club:

- Yes**, in patients who will stay and die in our unit anyway *and are insufficiently controlled by opioids etc*
- Yes**, in patients where the cause of breathlessness is **probably reversible** *i.e. immune-related pneumonitis*

**Should we use high-flow in cancer patients ?**



## High flow with air **vs fan** for 30 minutes in non-hypoxic CANCER patients

### **High flow:**

air flow rate 25 l/min, temperature 37°C, and humidity to level 3

### **Floor fan:**

60 cm away from the patient's face and the airflow adjusted according to the patient's wishes.

**High flow with air vs fan**

## High flow with air vs fan *for 30 minutes in non-hypoxic CANCER patients*

### High flow with air:

air flow rate 25 l/min, temperature 37°C, and humidity to level 3

### Floor fan:

60 cm away from the patient's face and the airflow adjusted according to the patient's wishes.

30 patients

No significant difference in the median NRS scores for dyspnea

Median NRS decreased:      high flow: 5.0 to 3.5       $P = 0.001$

fan:      5.0 to 2.5       $P = 0.012$

*difference statistically not significant*

Dyspnea decreased by at least one point on NRS in 61% vs 64% of the patients

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*difference statistically not significant*

Dyspnea decreased by at least one point on NRS in 61% vs 64% of the patients

|                                                             | HFNT with air | Fan       |
|-------------------------------------------------------------|---------------|-----------|
| Therapy relieved my dyspnea, n (%)                          | 16 (57.1)     | 15 (53.6) |
| Therapy was beneficial for me, n (%)                        | 18 (64.3)     | 12 (42.9) |
| I adapted well to the therapy, n (%)                        | 22 (78.6)     | 19 (67.9) |
| Therapy was unpleasant, n (%)                               | 10 (35.7)     | 10 (35.7) |
| I would like to use the therapy again for my dyspnea, n (%) | 15 (53.6)     | 13 (46.4) |

## High flow with air vs fan *for 30 minutes in non-hypoxic CANCER patients*

Study underpowered

Yet, what do you think.....

**Last note:**

**I love high-flow, but not for dyspnea ! WHY?**

Last note:

I love high-flow, but not for dyspnea ! WHY?

**Secretions and crusts (, „Borken)“**



Naldemidine *Rizmoic*®

μ-Opioidreceptor-Antagonist *PAMORA*

Opioid- induced – constipation *OIC*

**Anyone having experience ?**

Naldemidine *Rizmoic*®

μ-Opioidreceptor-Antagonist *PAMORA*

Opioid- induced – constipation *OIC*

**No conflict of interest !**

Naldemidine *Rizmoic*®

μ-Opioidreceptor-Antagonist *PAMORA*

Opioid- induced – constipation *OIC*

> [Cochrane Database Syst Rev. 2025 Aug 29;8\(8\):CD016207. doi: 10.1002/14651858.CD016207.](#)

## Pharmacological antiemetic prophylaxis and treatment for opioid-induced nausea and vomiting (OINV) in patients treated for cancer pain and cancer-related breathlessness

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# Novel antiemetic effect of naldemedine in patients initiating opioids for cancer pain: a secondary analysis of a randomized clinical trial

Takahiro Higashibata<sup>\*,†,1, ID</sup>, Takaomi Kessoku<sup>†,2,3,4</sup>, Shinya Kajiura<sup>5</sup>, Mami Hirakawa<sup>6</sup>, Shunsuke Oyamada<sup>7</sup>, Keisuke Ariyoshi<sup>8</sup>, Takeshi Yamada<sup>9</sup>, Yoshiyuki Yamamoto<sup>10</sup>, Toshikazu Moriwaki<sup>11</sup>, Hiroka Nagaoka<sup>12</sup>, Yasuyuki Takashima<sup>9</sup>, Kosuke Doki<sup>13</sup>, Bryan J. Mathis<sup>14</sup>, Kosuke Tanaka<sup>2,3,4</sup>, Akiko Fuyuki<sup>2,15</sup>, Atsushi Nakajima<sup>2</sup>, Yo Ishihara<sup>4</sup>, Ryuji Hayashi<sup>5</sup>, Takayuki Ando<sup>16</sup>, Yuko Kobayashi<sup>17</sup>, Naoki Izawa<sup>18</sup>, Yoshiki Horie<sup>18</sup>, Tatsuya Morita<sup>19,20</sup>, Jun Hamano<sup>1, ID</sup>

Higashibata T et al. Novel antiemetic effect of nademedine (...) The Oncologist 2026



**Primary Aim:** Preventive effects of naldemedine on opioid-induced constipation OIC (!!!)

**Methods:** Multicenter, double-blind, randomized, placebo-controlled trial  
Preplanned secondary analysis



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**Intervention:** Naldemedine 0.2 mg vs placebo once daily  
14 days.

**Prim. endpoint:** Complete response (CR) rate:  
no vomiting and no use of rescue antiemetics  
within first 3 days of opioid initiation

**Sec. endpoint;** Nausea and vomiting score *EORTC QLQ-C15-PAL*





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103 patients 48 vs 47

|                         |             |       |             |
|-------------------------|-------------|-------|-------------|
| Complete response (CR): | Naldemedine | 81.3% | $P < 0.001$ |
|                         | Placebo     | 38.3% |             |



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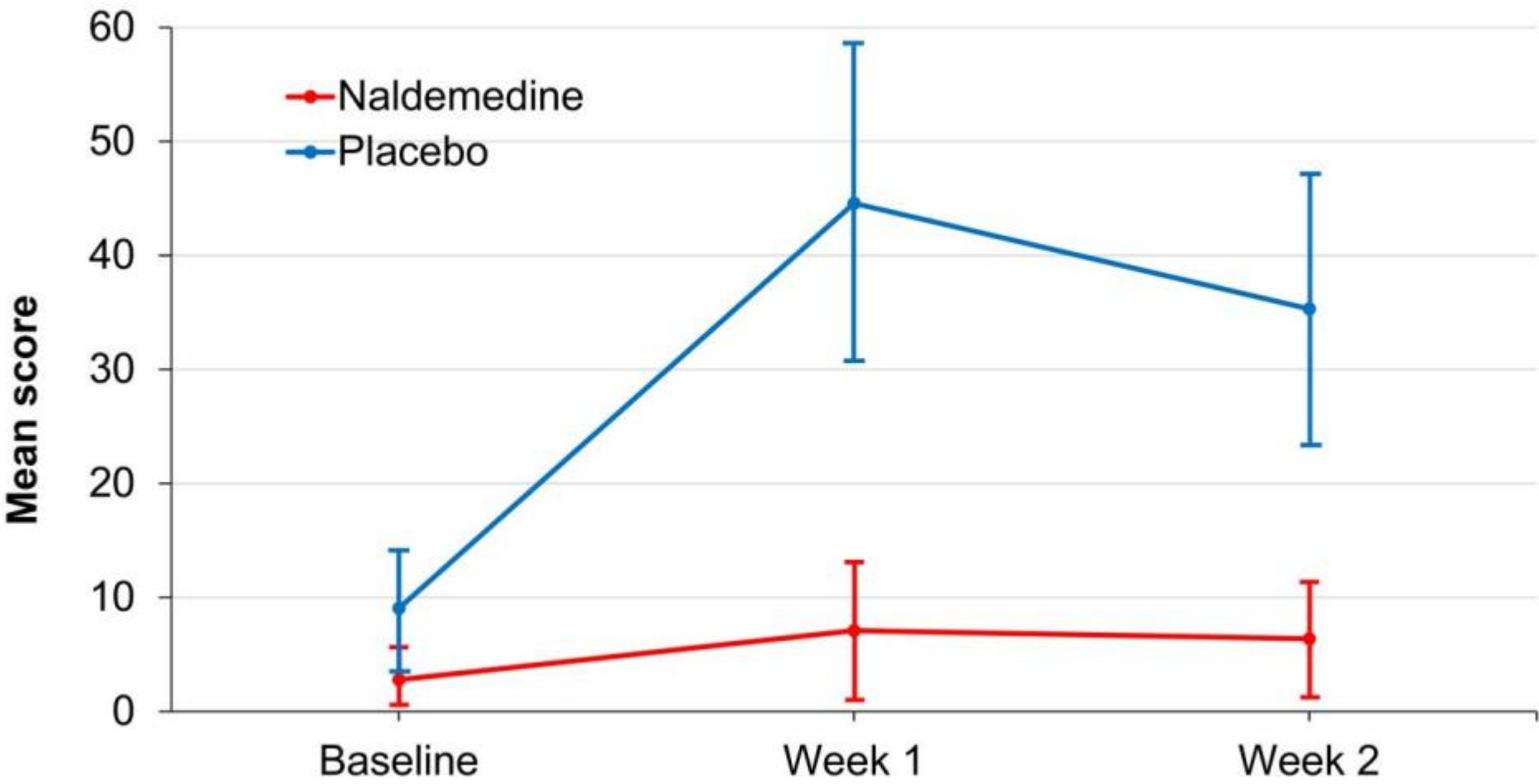
Previous study\*:

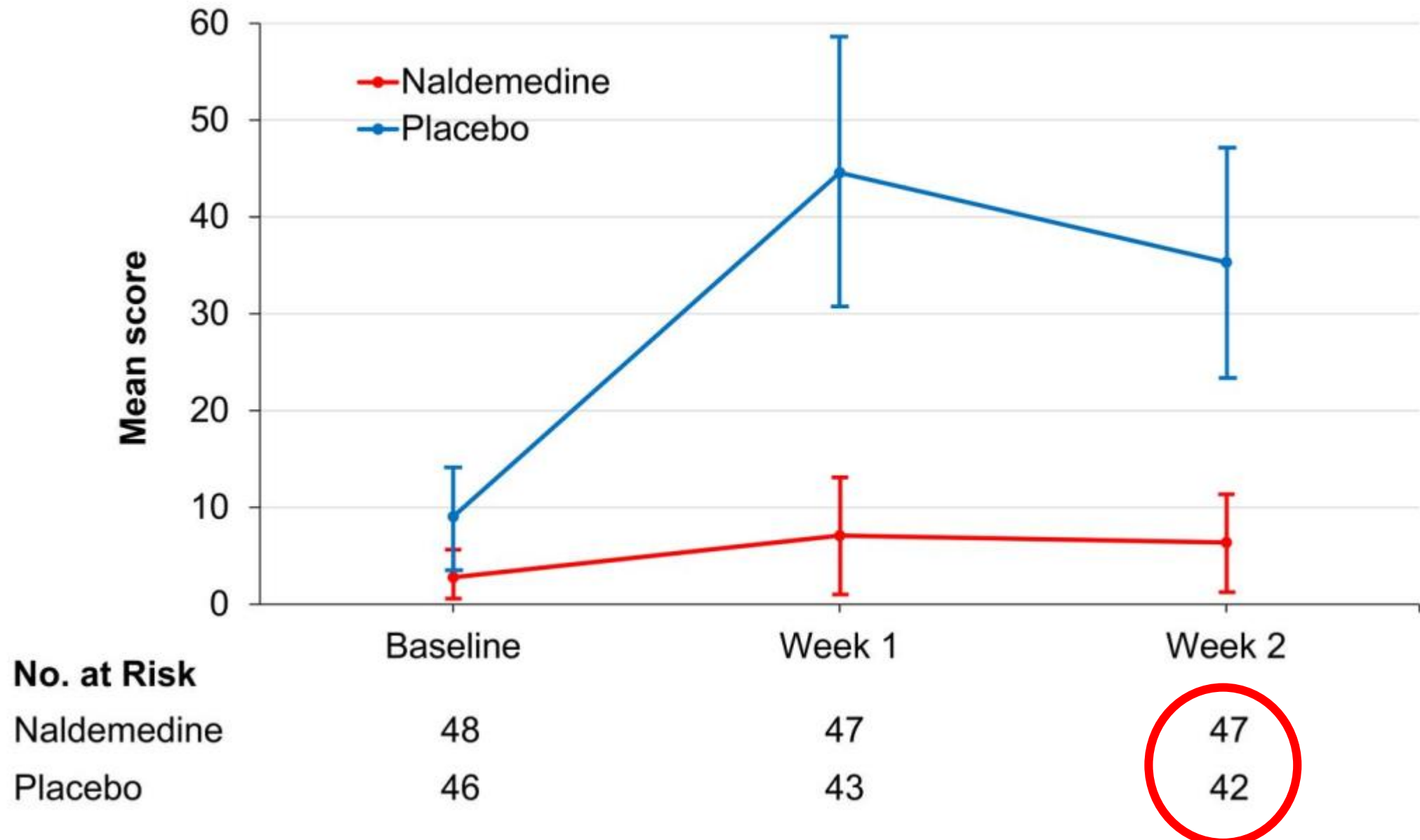
CR *prochlorperazine* vs placebo: 69.5% vs 63.3%

\**Tsukuura* H. et al. Efficacy of prophylactic treatment for oxycodone-induced nausea (...) *Oncologist*. 2018

*Higashibata* T et al. Novel antiemetic effect of nademedine (...) *The Oncologist* 2026D



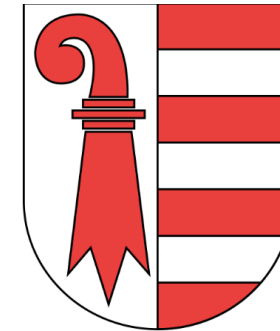




# Erstmals in Europa: Drohne wirft Arzneimittel für Patienten ab

Obwohl viele Drohnenprojekte im Gesundheitsbereich flopten, startet in Deutschland ein neuer Versuch: Eine Medikamenten-Drohne soll vor allem bei der Palliativ-Versorgung helfen.

rap, 20. Februar 2026 um 01:15



# **Dexmedetomidine *Dexdor*<sup>®</sup>**

## **The new midazolam?**

Dexmedetomidine *Dexdor*<sup>®</sup>

The new midazolam?

**No conflict of interest !**



Dexmedetomidine *Dexdor*®  
The new midazolam?

➤ [J Clin Med.](#) 2025 Jun 18;14(12):4348. doi: 10.3390/jcm14124348.

## Comparison of Propofol and Dexmedetomidine Infused Overnight to Treat Hyperactive and Mixed ICU Delirium: A Prospective Randomised Controlled Clinical Trial

Stefan Zimmermann <sup>1</sup>, Alexa Hollinger <sup>1 2</sup>, Rita Achermann <sup>1</sup>, Stefanie von Felten <sup>3 4</sup>,  
Raoul Sutter <sup>1 2</sup>, Stephan Rüegg <sup>2 5</sup>, Salim Abdelhamid <sup>1</sup>, Simon Glatz <sup>1</sup>, Luzius A Steiner <sup>2 6</sup>,  
Martin Siegemund <sup>1 2</sup>

2025

Randomized Controlled Trial ➤ [J Pain Symptom Manage.](#) 2025 Nov;70(5):459-469.

doi: 10.1016/j.jpainsymman.2025.07.027. Epub 2025 Aug 25.

## Dexmedetomidine Versus Midazolam for End-of- Life Sedation: The DREAMS Non-Blinded Randomized Clinical Trial

Benjamin Thomas <sup>1</sup>, Gregory Barclay <sup>2</sup>, Kylie Mansfield <sup>3</sup>, Judy Mullan <sup>3</sup>, Wing-Shan Angela Lo <sup>4</sup>

2025

Mr. A. 84 yrs      Pancreatic Cancer stage IV, best supportive care, ECOG 3, 60kg

At night:      Anxiety, restlessness, aberrant behavior (strange, continuous phonecalls with entire family)

Trazodone, Quetiapine, Mirtazapine:    Not improved

Delirium:

sudden onset ✓

fluctuating symptoms ✓

day/night interference ✓

attention deficit ✓

disorientation ✓

disorders of thought content ✓ *inhaltliche Denkstörungen*

**Haloperidol / Risperidone ?**

ICU guidelines do NOT recommend treatment of delirium, i.e. with neuroleptics *no surprise...*

In agitation, sedating drugs such as benzodiazepines and propofol **trigger** delirium and PTSD *PTBS*

Dexmedetomidine (DEX): «arousable sedation», comparable to restorative sleep and recover from day night cycle

DEX prevents delirium in elderly patients on ICU<sup>2</sup>

Midazolam: More delirium than after propofol sedation on ICU

*ProDex study*

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Midazolam: More delirium than after propofol sedation on ICU



**Memo Palliative Care: DEX is analgesic, anti-emetic, not suppressing respiration**

Dexmedetomidine *Dexdor*®

The new midazolam?

N= 38 patients

**Median duration of delirium: Dex: 34 hours**

**Propofol 66 hours** HR 1.92 (95 CI 0.89-1.15, p: 0.097)

*ProDex study*

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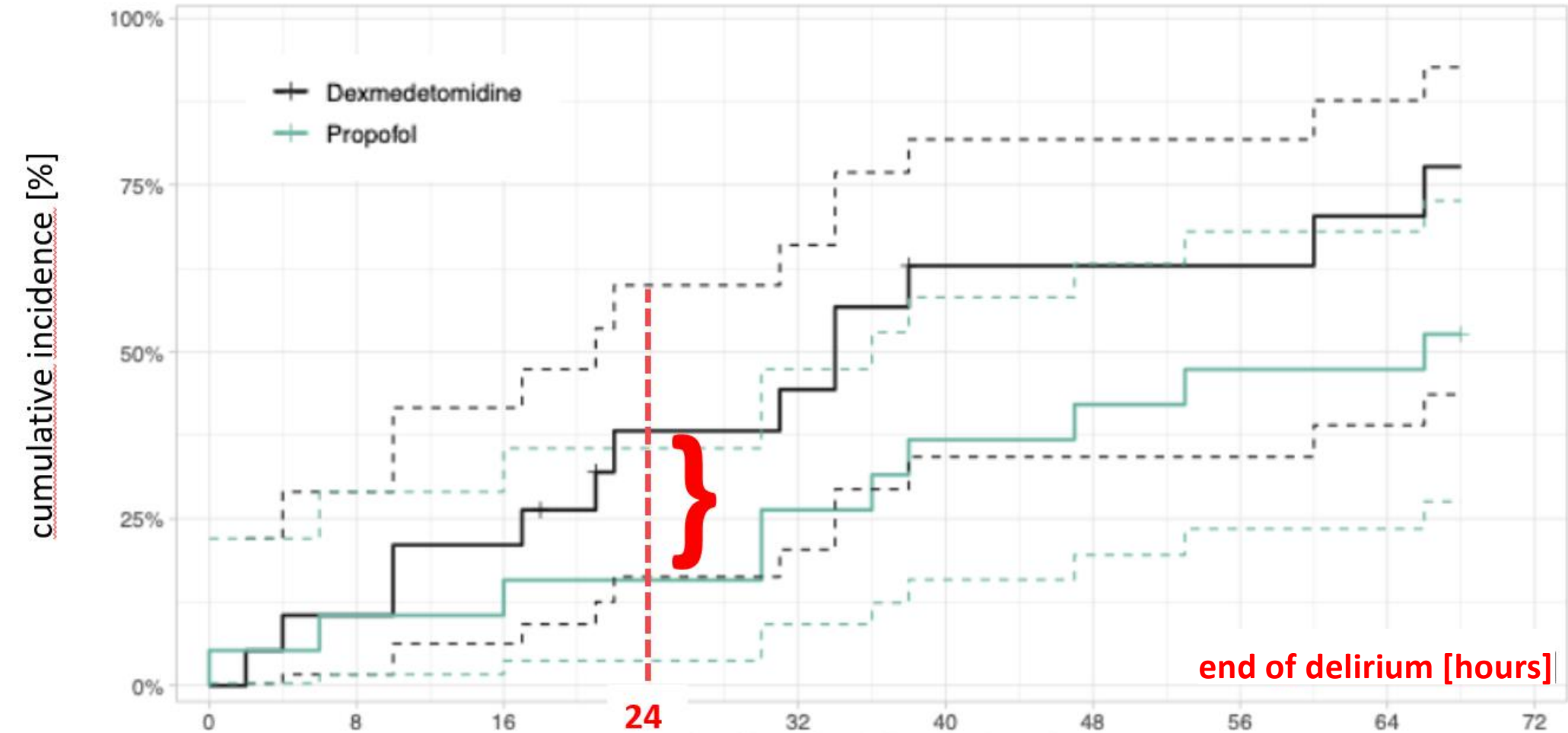
**Delirium: twice as long under midazolam ?**

*ProDex study*

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The new midazolam?

ProDex study

After 24 hours....



**Table 2.** Secondary outcomes.

|                                          | Dexmedetomidine Group<br><i>n</i> = 15 | Propofol Group<br><i>n</i> = 19 |
|------------------------------------------|----------------------------------------|---------------------------------|
| Death at day 28                          | 1 (7)                                  | 5 (26)                          |
| Patients needed ventilation              | 7 (47)                                 | 15 (79)                         |
| Rescue medication, nr of administrations | 11                                     | 71                              |
| Depth of sedation [RASS]                 | 1.0 [0.0–1.5]                          | 1.0 [0.5–2.0]                   |
| ICU length of stay [hours]               | 43 [35–133]                            | 128 (72–330)                    |
| Length of hospital stay [days]           | 10 [6–17]                              | 22 [15–37]                      |



ProDex study

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The new midazolam?

# Dexmedetomidine

## Palliative Care...

**Authors:**

- Benzodiazepines are first-line agents for terminal delirium and end-of-life distress in
- Antipsychotics and barbiturates for refractory cases
- Benzodiazepines can worsen delirium and cause agitation

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- Benzodiazepines are first-line agents for terminal delirium and end-of-life distress
- Antipsychotics and barbiturates for refractory cases
- Benzodiazepines can worsen delirium and cause agitation
- A trial-validated approach of midazolam is not currently available.

**Authors continued:**

- DEX promotes natural sleep
- DEX provides rousable sedation *\*actually not proven- see research question...*
- DEX allows interactivity and cooperation with staff and families
- DEX may reduce delirium, related to decreasing central catecholamines in the locus coeruleus
- DEX has analgesic and anxiolytic potential

### **Research hypothesis**

-DEX is superior to midazolam for rousability

### **Patients**

Adults, cared by Specialist Palliative Care team

End-of-life as determined by senior medical officer *life expectancy <7day*

Refractory physical, psychological, or existential symptoms

### **Exclusion criteria:**

Severe cardiac failure *EF <20%*



### Intervention and Comparator

|                               |       |                |                |
|-------------------------------|-------|----------------|----------------|
| <u>subcutaneous</u> infusion: | DEX:  | 0.5 mcg/kg/h   | 80kg: 40mcg/h  |
|                               | MIDA: | 0.25 mg/kg/day | 80kg: 20mg/day |

|                     |       |            |                     |
|---------------------|-------|------------|---------------------|
| Breakthrough doses: | DEX:  | 0.5 mcg/kg | allowed every 2 hrs |
|                     | MIDA: | 2.5-5 mg   | allowed every 2 hrs |

|       |              |
|-------|--------------|
| Goal: | RASS-PALL <1 |
|-------|--------------|

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|       |              |
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**No dose titration !**

**No loading dose !**

### Intervention and Comparator

|                               |       |                |                       |
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**Doses not modified for renal-, but for hepatic function**

## Intervention and Comparator

Doses not modified for renal-, but for hepatic function

Measure: MELD-Na Bilirubin, INR, Kreatinin, Na<sup>2+</sup>

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## Outcomes

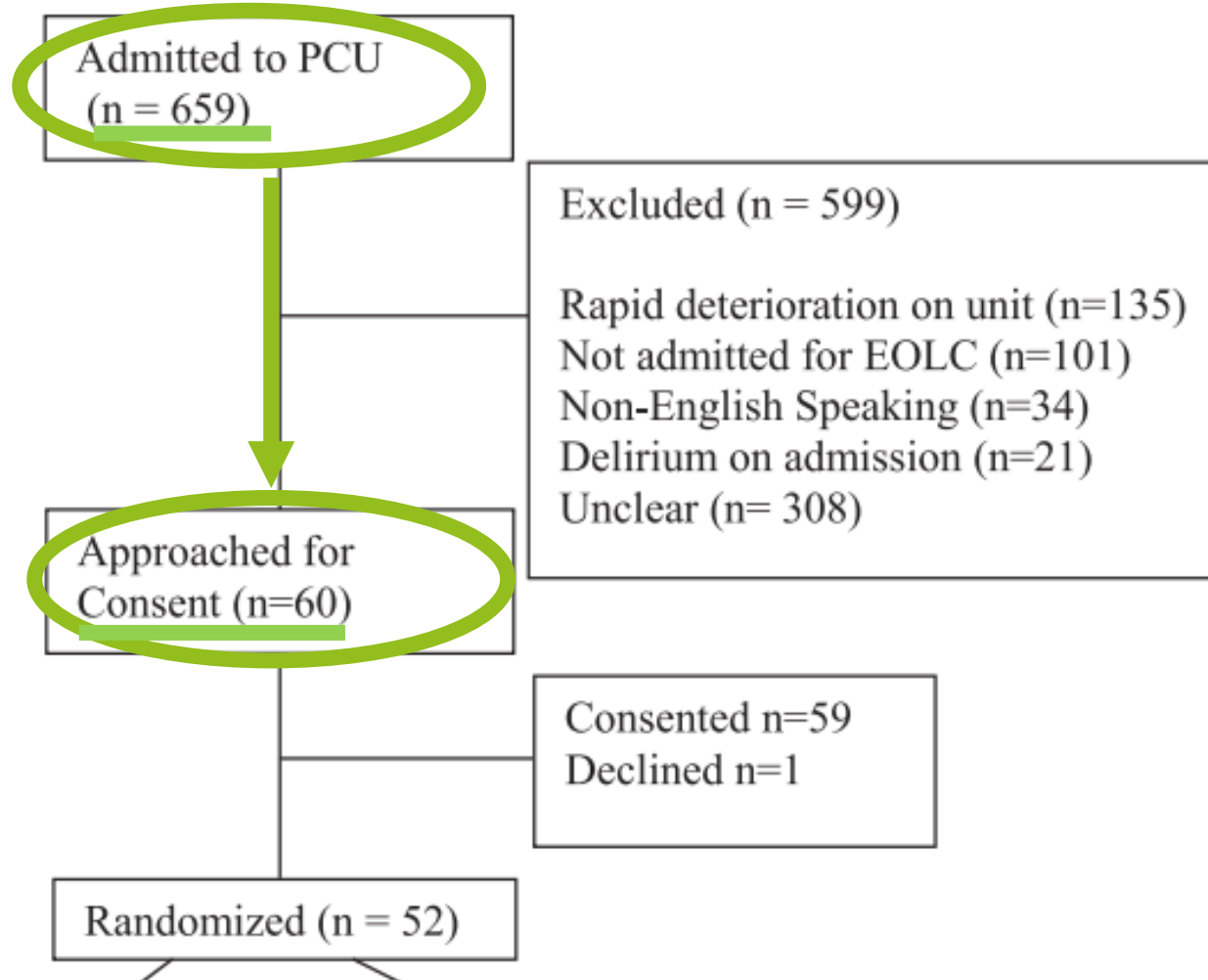
Primary: RASS-PALL *Richmond-Agitation-Scale*

MCID: RASS-PALL +/- 1

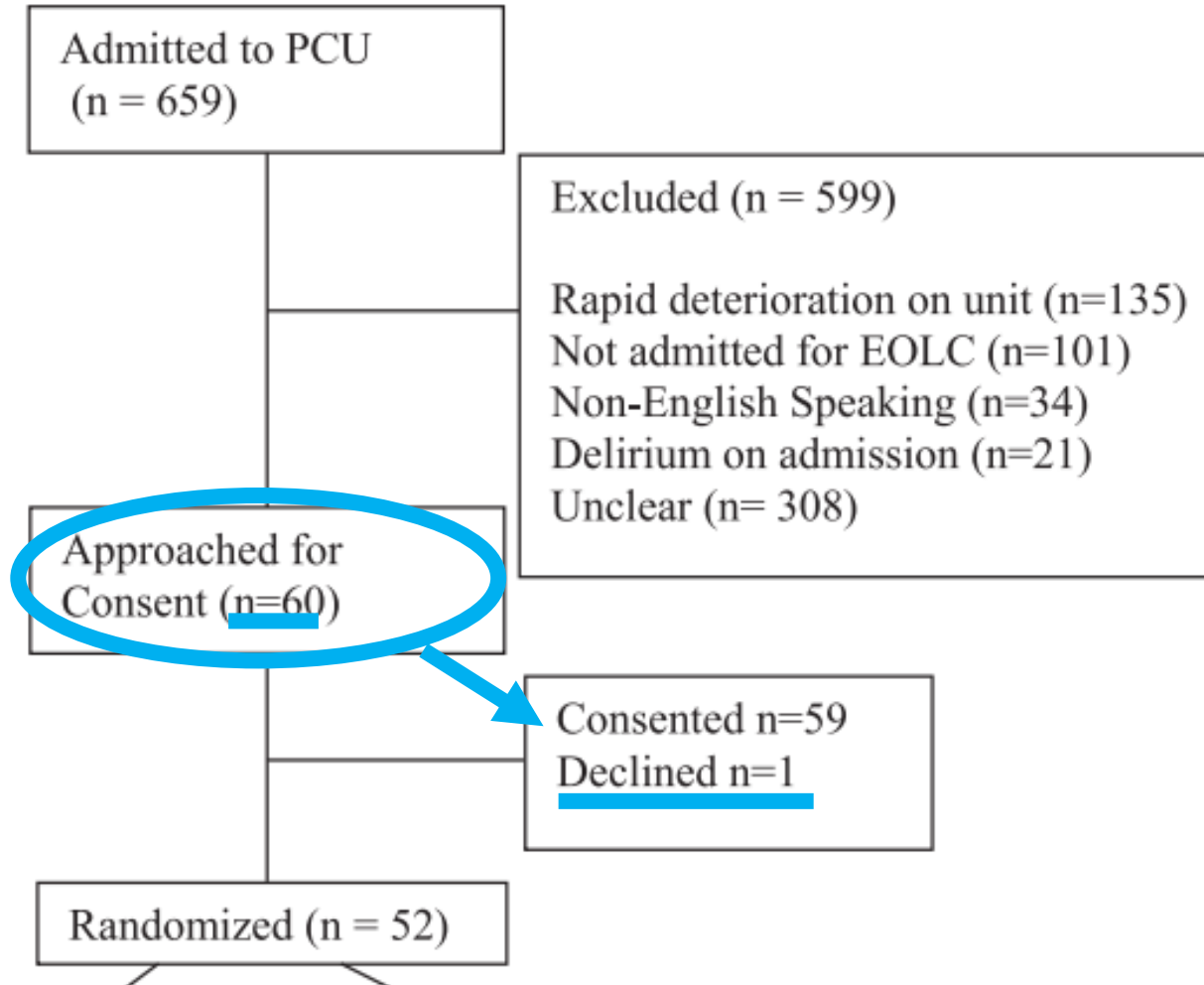
Secondary: MDAS *Memorial delirium assessment score*  
and more...



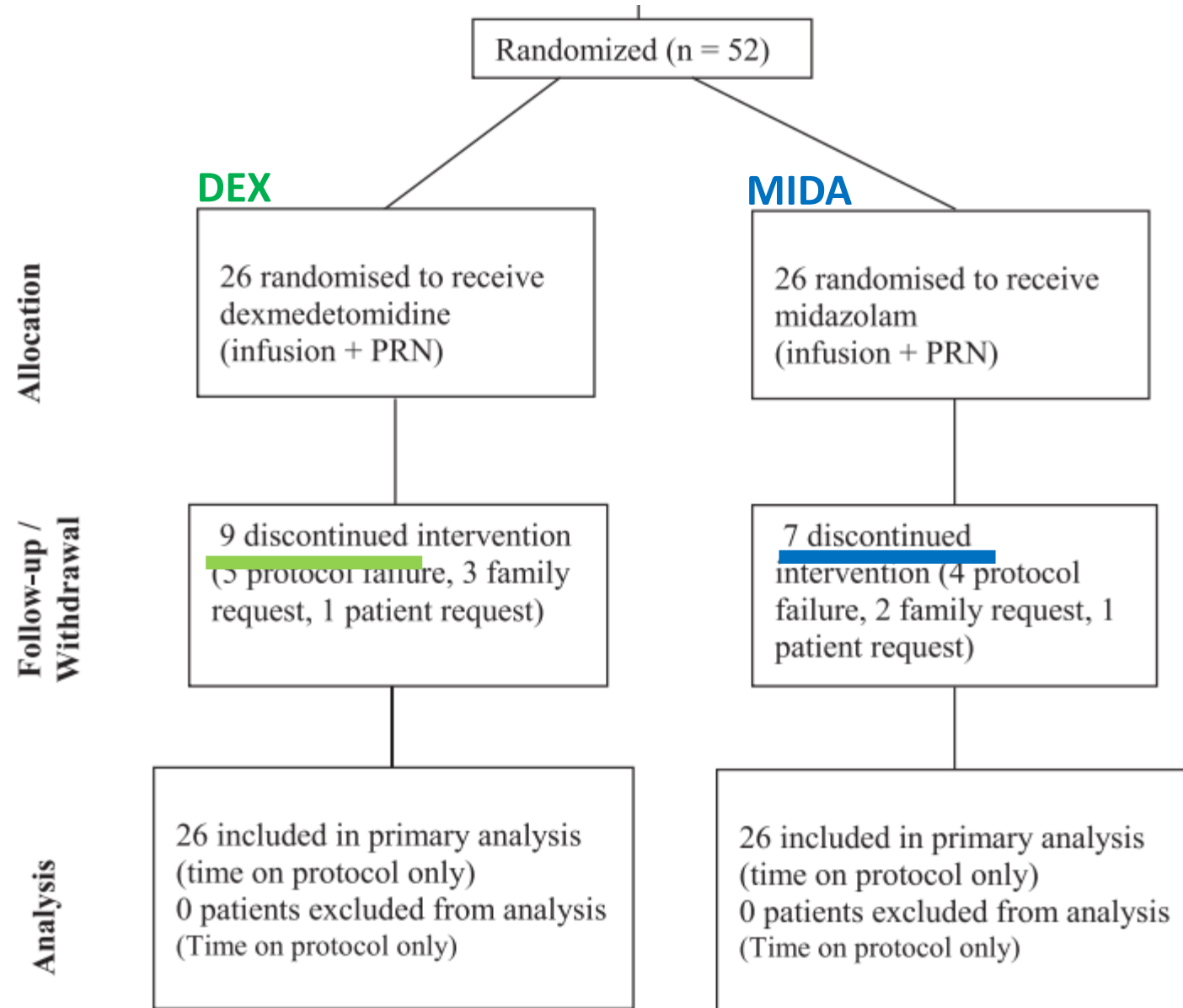
**Result**



**Result**



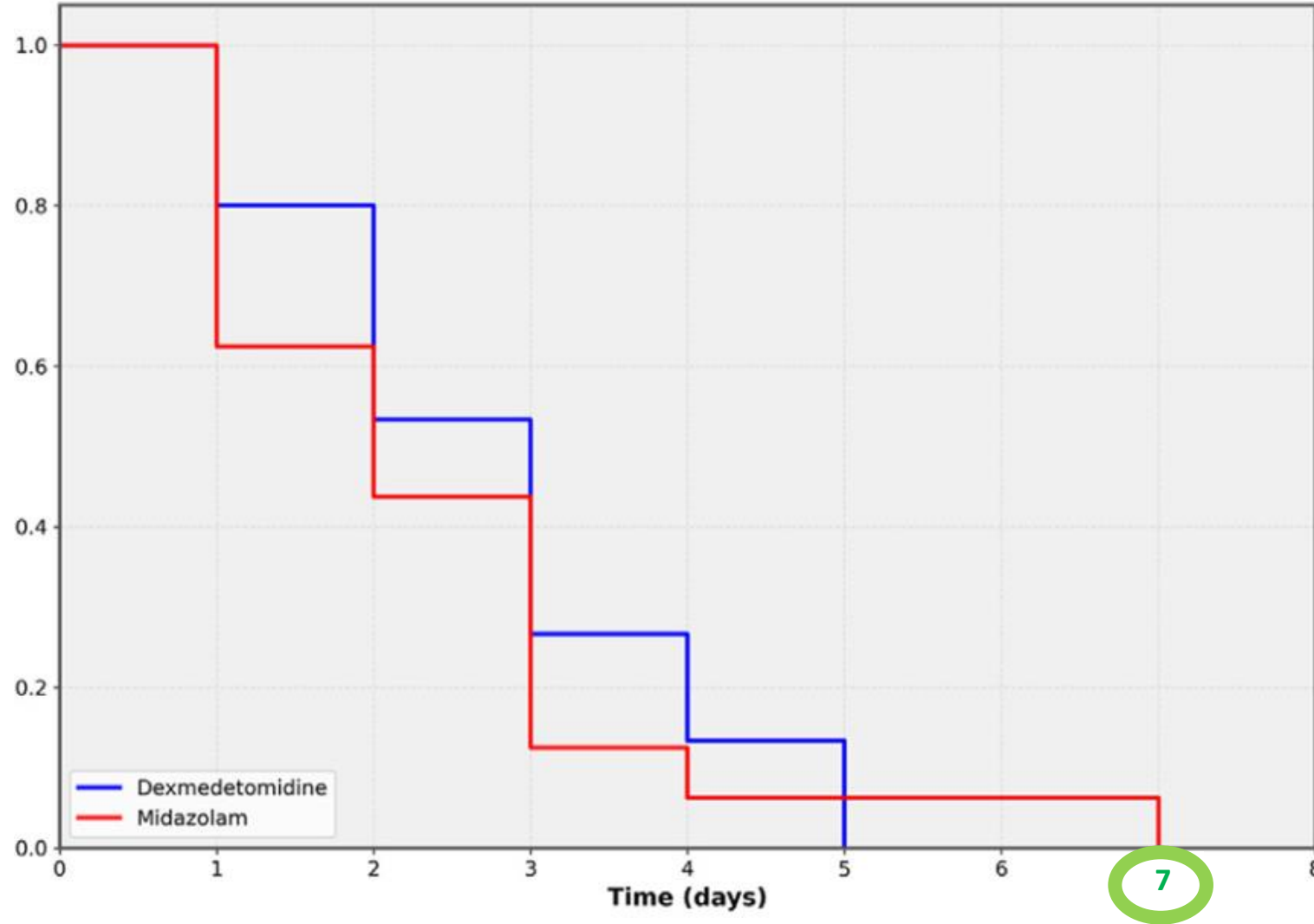
## Results



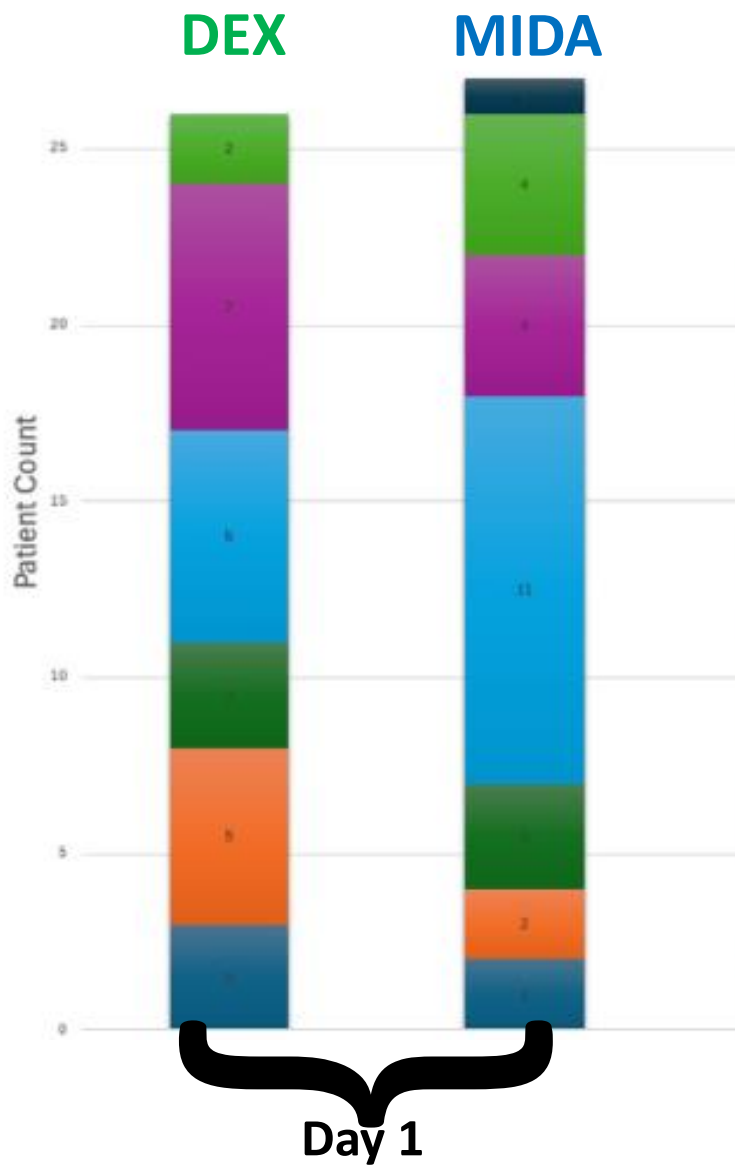


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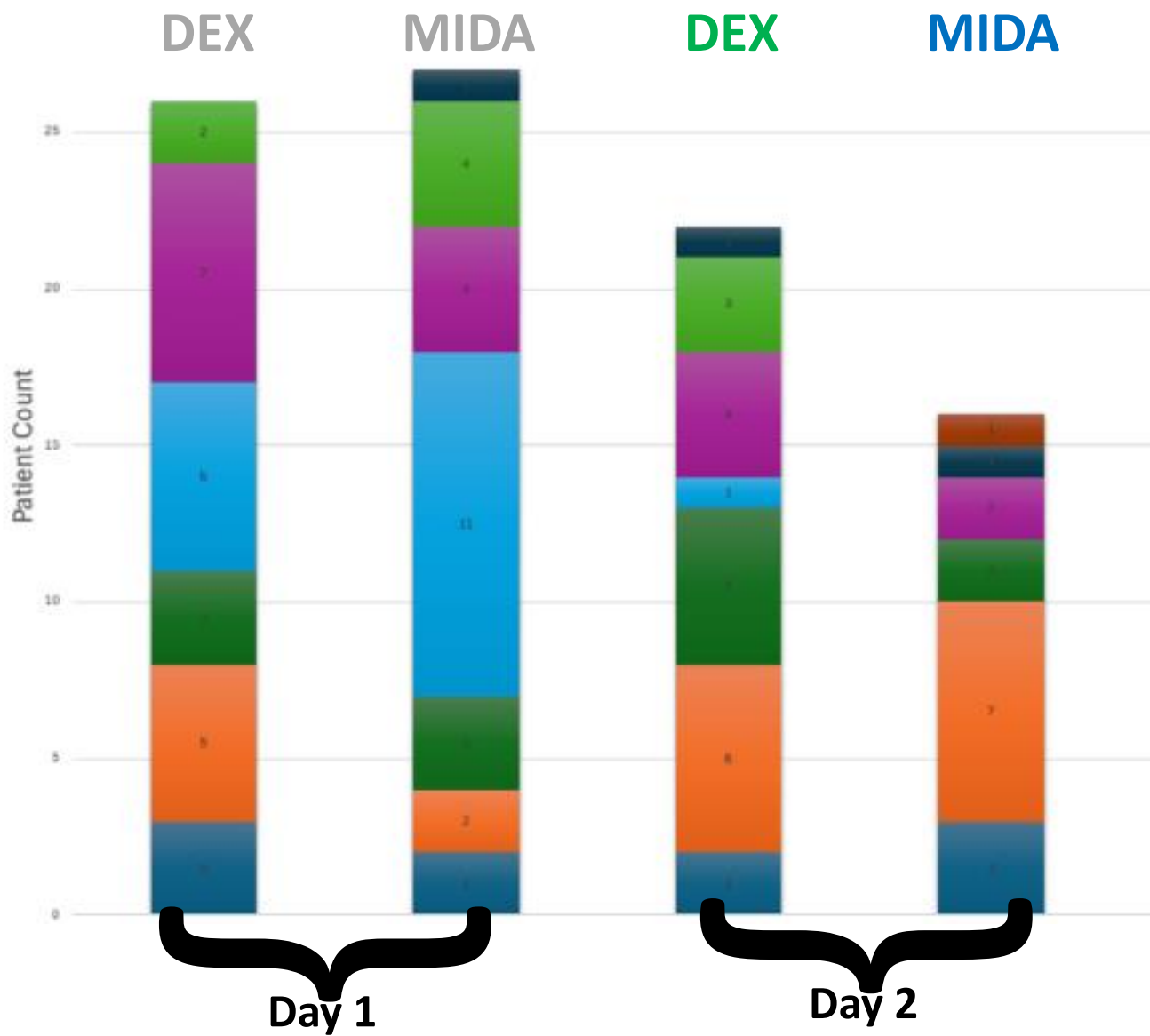
Survival



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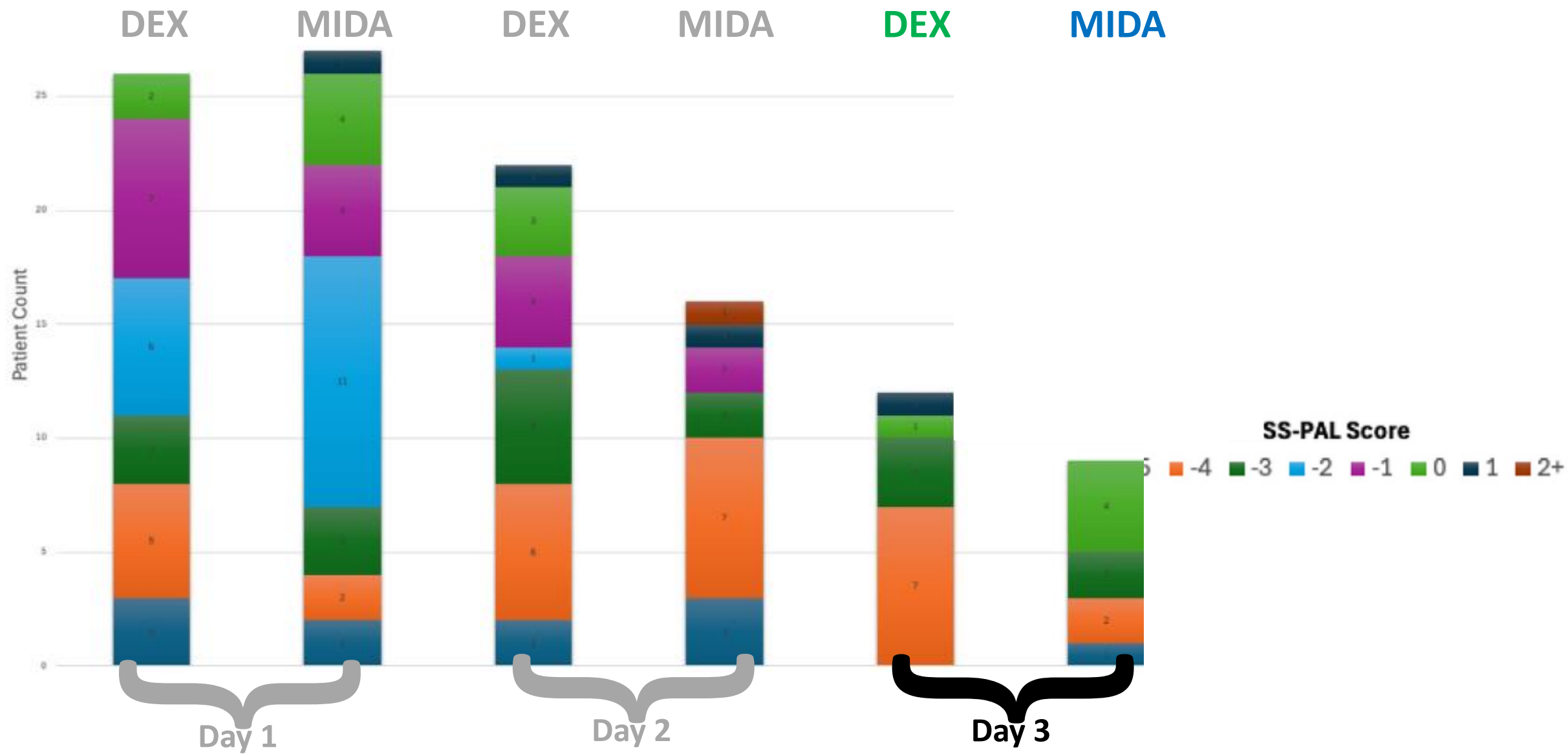
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The new midazolam?



RASS-PAL Score

■ -5 ■ -4 ■ -3 ■ -2 ■ -1 ■ 0 ■ 1 ■ 2+

Dexmedetomidine *Dexdor*<sup>®</sup>  
The new midazolam?

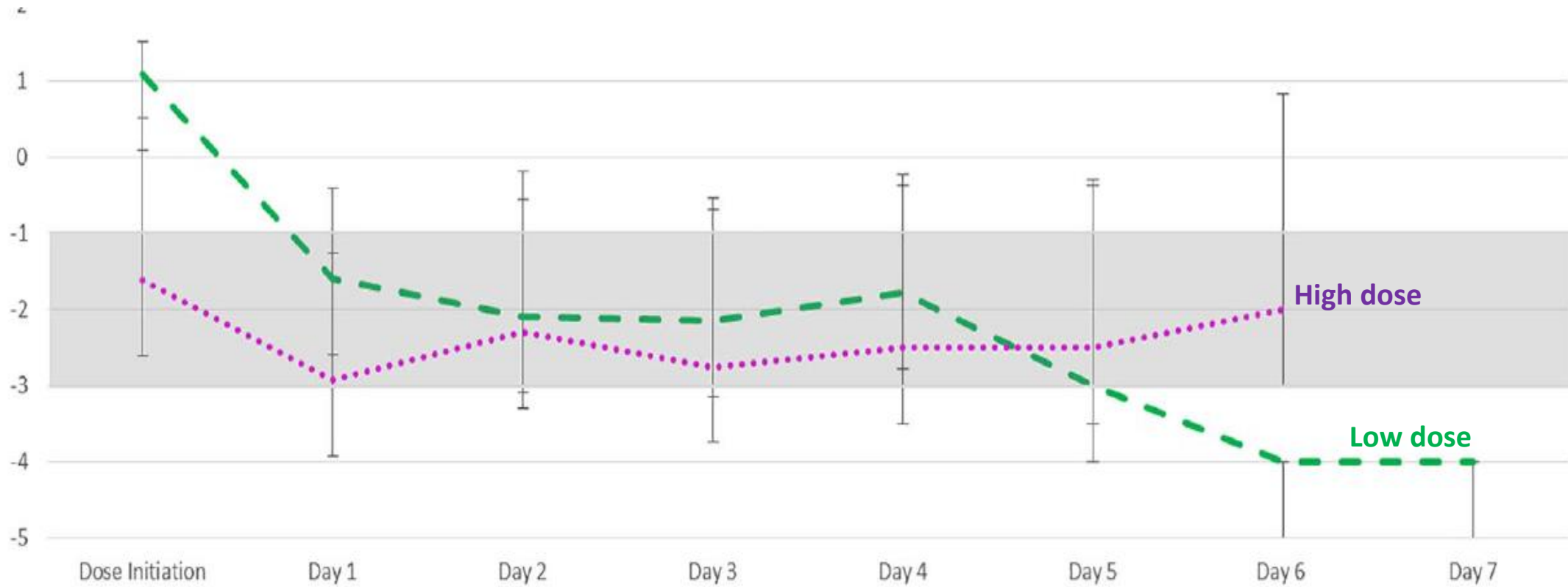


|                                             | Day 0            |                   | Day 1            |                  | Day 2             |                 | Day 3             |            |
|---------------------------------------------|------------------|-------------------|------------------|------------------|-------------------|-----------------|-------------------|------------|
|                                             | DXM              | MDZ               | DXM              | MDZ              | DXM               | MDZ             | DXM               | MDZ        |
| Patients on protocol <sup>a</sup> (n, %)    | 26 (100%)        | 26 (100%)         | 23 (88%)         | 15 (58%)         | 12 (46%)          | 10 (38%)        | 6 (23%)           | 4 (15%)    |
| Patients off protocol (n, %)                | -                | -                 | 0                | 5 (19%)          | 7 (27%)           | 7 (27%)         | 9 (35%)           | 8 (31%)    |
| Patients died (n, %)                        | -                | -                 | 3 (12%)          | 6 (23%)          | 7 (27%)           | 9 (35%)         | 11 (42%)          | 14 (54%)   |
| Withdrawals from protocol                   |                  |                   |                  |                  |                   |                 |                   |            |
| Protocol failure                            | -                | -                 | 0                | 2                | 2                 | 1               | 3                 | 1          |
| Family request                              | -                | -                 | 0                | 2                | 3                 | 0               | 0                 | 0          |
| Patient request                             | -                | -                 | 0                | 1                | 1                 | 0               | 0                 | 0          |
| RASS-PAL (mean)                             | -0.04            | -0.42             | -2.33            | -1.9             | -2.44             | -2.86           | -2.95             | -2.53      |
| Significance                                | <i>P</i> = 0.393 |                   | <i>P</i> = 0.389 |                  | <i>P</i> = 0.4945 |                 | <i>P</i> = 0.6153 |            |
| RASS-PAL 1+ (n, %)                          | 10 (38.46%)      | 10 (38.46%)       |                  | 1 (3.7%)         | 1 (4.55%)         | 2 (12.50%)      | 1 (8.33%)         |            |
| RASS-PAL 0 (n, %)                           | 5 (19.23%)       | 5 (19.23%)        | 2 (7.69%)        | 4 (14.81%)       | 3 (13.64%)        | -               | 1 (8.33%)         | 4 (44.44%) |
| RASS -1 to -3 (n, %)                        | 11 (42.31%)      | 9 (34.62%)        | 16 (61.54%)      | 18 (66.67%)      | 10 (45.45%)       | 4 (25.00%)      | 3 (25.00%)        | 2 (22.22%) |
| RASS below -3 (n, %)                        | -                | 2 (7.69%)         | 8 (30.77%)       | 4 (14.81%)       | 8 (36.36%)        | 10 (62.50%)     | 7 (58.33%)        | 3 (33.33%) |
| MDAS (mean)                                 | 12.42            | 12.73             | 6.52             | 8.7              | 7.31              | 7.09            | 6.13              | 8.5        |
| Significance (between arms)                 | <i>P</i> = 0.844 |                   | <i>P</i> = 0.049 |                  | <i>P</i> = 0.828  |                 | <i>P</i> = 0.220  |            |
| Significance from Day 0                     | -                | <i>P</i> = 0.0004 | <i>P</i> = 0.002 | <i>P</i> = 0.006 | <i>P</i> = 0.0002 | <i>P</i> = 0.02 | <i>P</i> = 0.06   |            |
| MDAS < 7 (absent) (n, %)                    | 6 (23%)          | 2 (8%)            | 8 (35%)          | 5 (28%)          | 5 (33%)           | 4 (36%)         | 3 (38%)           | -          |
| MDAS 7-12 (mild) (n, %)                     | 6 (23%)          | 10 (38%)          | 15 (65%)         | 13 (72%)         | 10 (67%)          | 7 (64%)         | 5 (62%)           | 4 (100%)   |
| MDAS > 13 (mod-sev) (n, %)                  | 14 (54%)         | 14 (58%)          | -                | -                | -                 | -               | -                 | -          |
| PCA (mean)                                  |                  |                   | 2.58             | 2.54             | 2.71              | 2.33            | 0.92              | 2.19       |
| Opioid Infusions (% increase from baseline) | -                | -                 | 18%              | 37%              | 38%               | 42%             | 55%               | 83%        |
| Significance                                | -                | -                 | <i>P</i> = 0.15  |                  | <i>P</i> = 0.94   |                 | <i>P</i> = 0.51   |            |

## Results

- RASS-PAL: No significant difference arms
- DEX: superior early delirium severity scores day 1 *MDAS 6.5 vs. 8.8,  $P = 0.05$ , but did not persist*
- Protocol withdrawal earlier with midazolam: 5 vs. 0 patients on day 1  $P = 0.025$
- Less opioid dose increase under DEX: 55% vs 83% with MIDA
- PCA mild in both arms  $PCA < 3$
- DEX: Significant improvement in PCA from day 2 to 3 *decrease from 2.71 (day 2) to 0.91 (day 3)  $P = 0.03$*
- MIDA: PCA unchanged after day 2

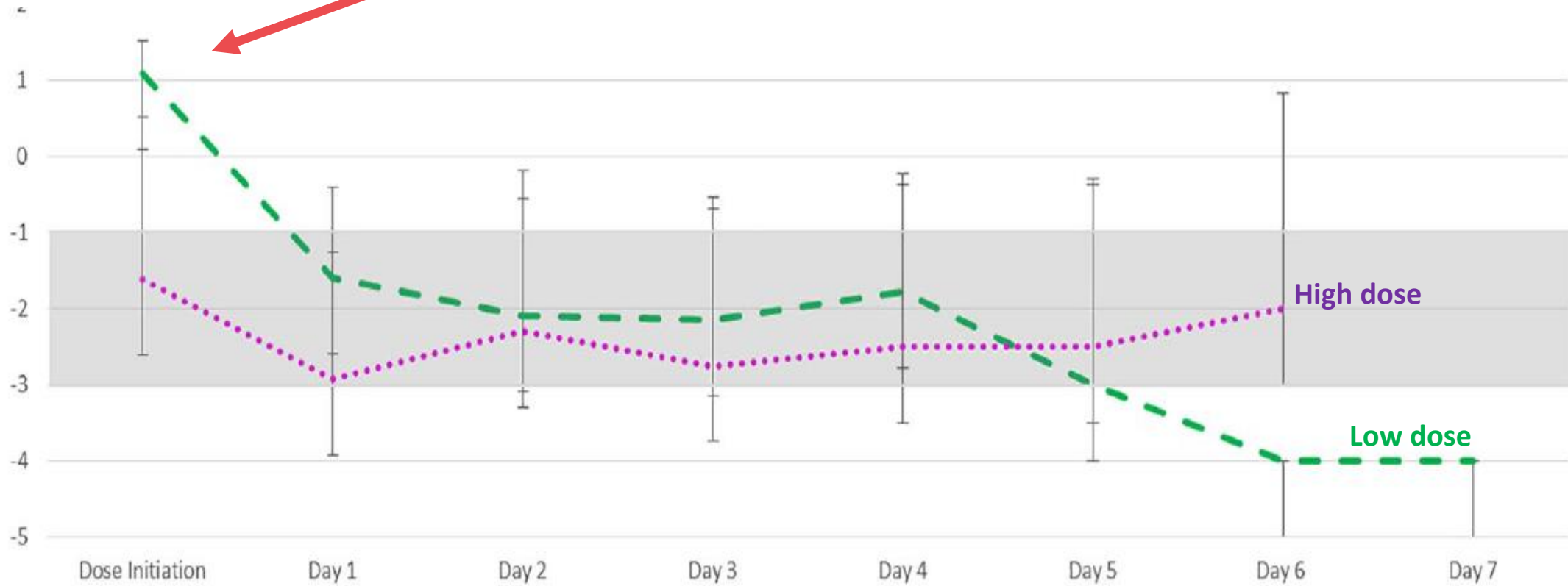
## RASS-PALL



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## RASS-PALL





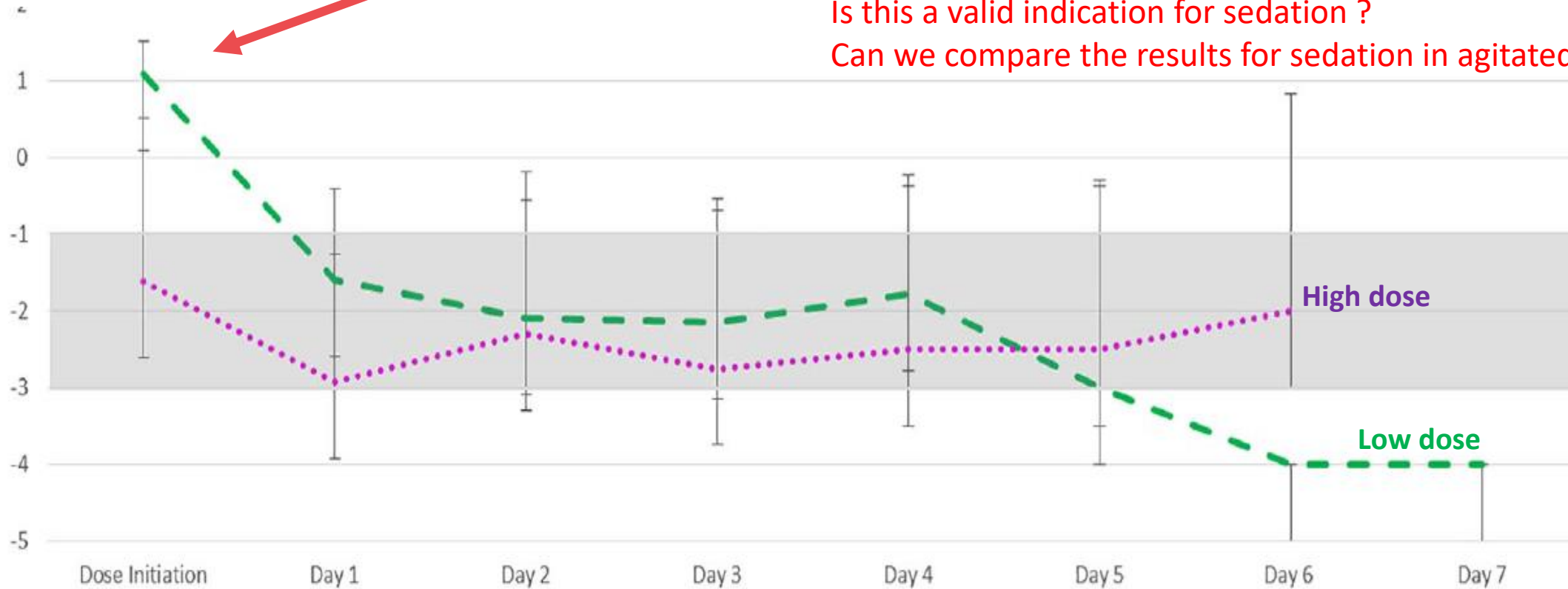


## RASS-PALL



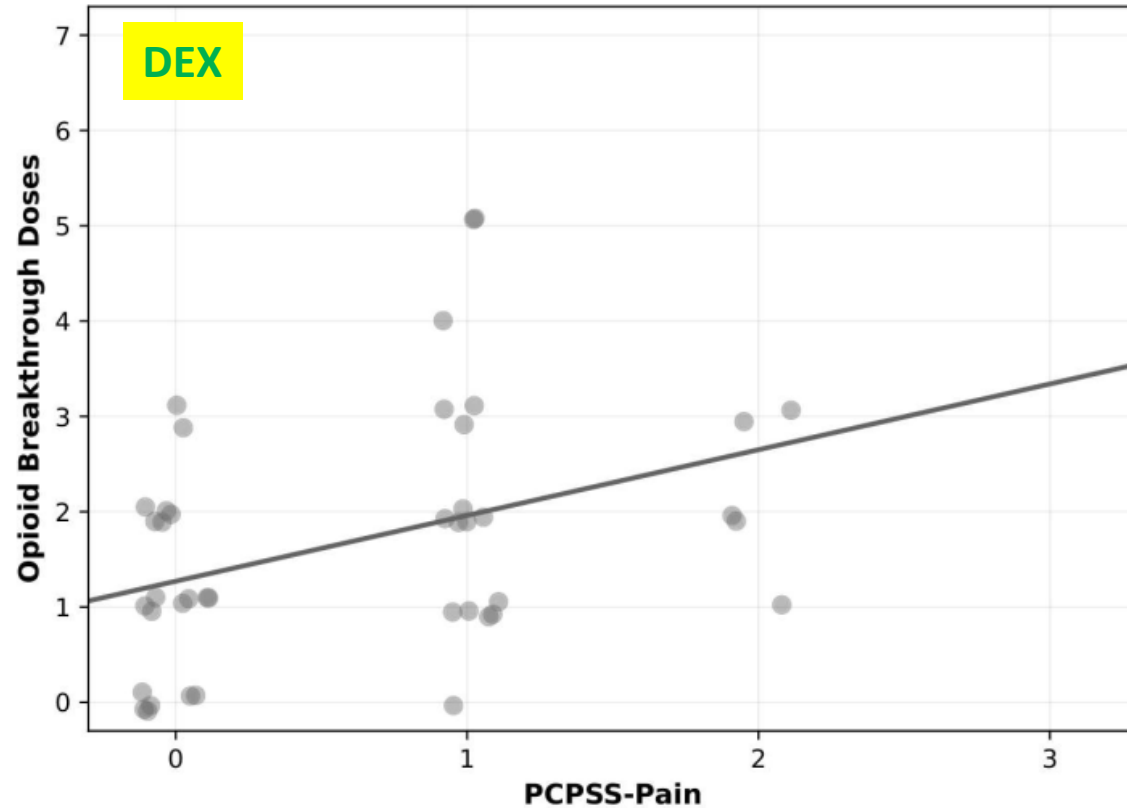
### RASS-PALL 1:

*“Occasional-non purposeful movement, but not aggressive or vigorous”*  
Is this a valid indication for sedation ?  
Can we compare the results for sedation in agitated delirium?



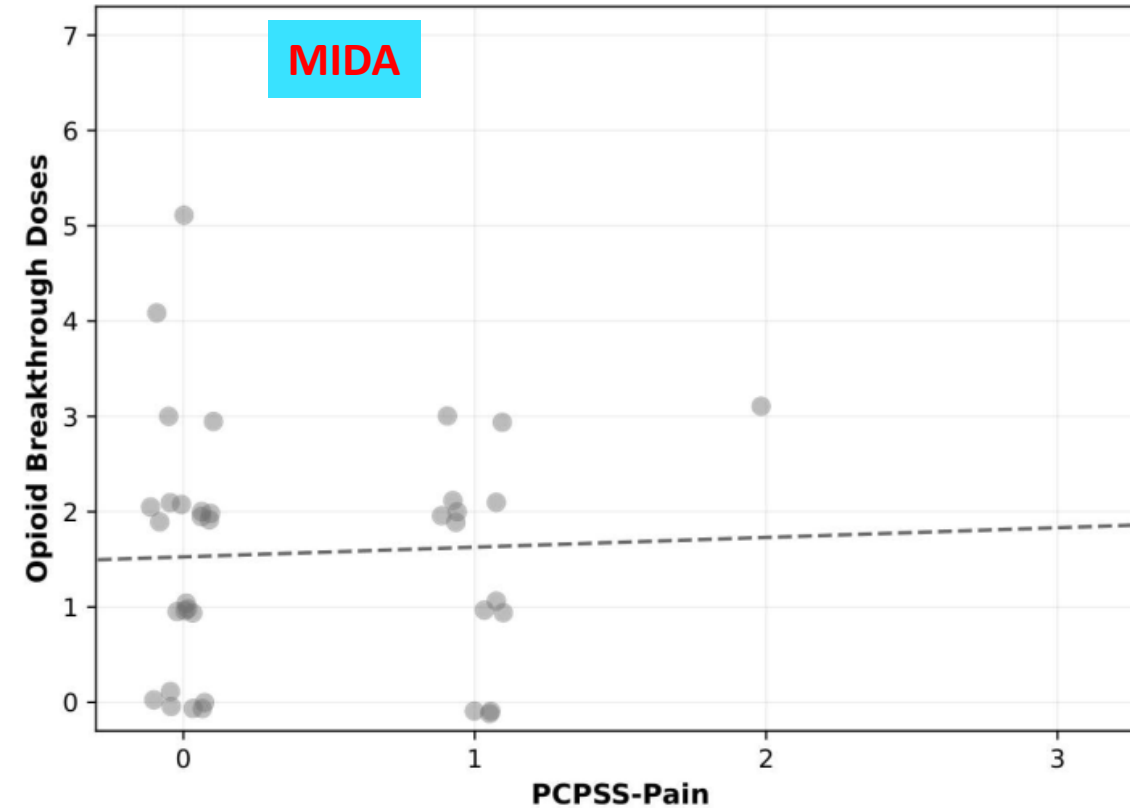
**A DXM: Pain → Opioid Breakthrough**

$r = 0.46, p = 0.001$  (n = 47)



**B MDZ: Pain → Opioid Breakthrough**

$r = 0.068, p = 0.7$  (n = 39)



## Final thoughts



### Off-label use

- DEX use outside the ICU setting is off-label use: Follow usual documentation procedure
- DEX should (only?) be considered if standard options failed or are likely to cause harm or to be inefficient

## Final thoughts



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- DEX should (only?) be considered if standard options failed or are **likely to cause harm** or to be inefficient

Delirium... dizziness under midazolam...?

## Final thoughts



### Potential indications in palliative care

- Hyperactive delirium or agitation
- Severe, opioid-refractory pain
- Severe, opioid- and benzodiazepine refractory dyspnea
- Dyskinesia, nausea, insomnia, shivering
- Sedation

## Final thoughts



### Routes of administration and admixtures

- i.v., s.c., via nasal/buccal route, nebulized
- Admixtures with commonly used drugs is possible. *Proven vor morphine, hydromorphone, haloperidol, hyoscine*

## Final thoughts



### Dosing

- Highly individual, respecting e.g., patient's characteristics *i.e. comorbidities and indications*
- Loading dose over 10 min i.v. is possible, but safety unclear *some clinicians refrain from this*
- Sedation and hyperactive delirium warrant higher doses than pain
- Maintenance doses may range from 0.2–1.0  $\mu\text{g}/\text{kg}/\text{h}$ , but much higher doses have been reported
- If in doubt, start at a rather low maintenance dose *e.g., 0.3  $\mu\text{g}/\text{kg}/\text{h}$*

## Final thoughts



### Safety issues

- Refrain from DEX in severe cardiac comorbidities
- CAVEAT: QT-abnormalities, AV-blocks, reduced LVEF, valvular abnormalities
- ECG monitoring before and 4 h after DEX initiation should be weighed against the estimated life expectancy and the goals of care
- Dose reductions in case of liver dysfunction



## Final thoughts



### Safety issues

- Refrain from DEX in severe cardiac comorbidities
- CAVEAT: QT-abnormalities, AV-blocks, reduced LVEF, valvular abnormalities
- ECG monitoring before and 4 h after DEX initiation should be weighed against the estimated life expectancy and the goals of care
- Dose reductions in case of liver dysfunction
- **In severe symptoms and agitation:**

**Dexmedetomidine often does not suffice as mono-therapy even @ 3mcg/kg/hr and more...**

**To come?**  
**Ketamir-2: Oral ketamine analog**

NMDA Antagonist

Oral: High bioavailability

Better pain relieve than: Pregabalin and or gabapentin

- 1 Mira Pharmaceuticals Inc., Miami, FL, United States.
- 2 Pharmaseed Ltd., Ness Ziona, Israel.

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**To come?**

**Ketamir-2: Oral ketamine analog**

Neuropathic pain and allodynia rodent models:

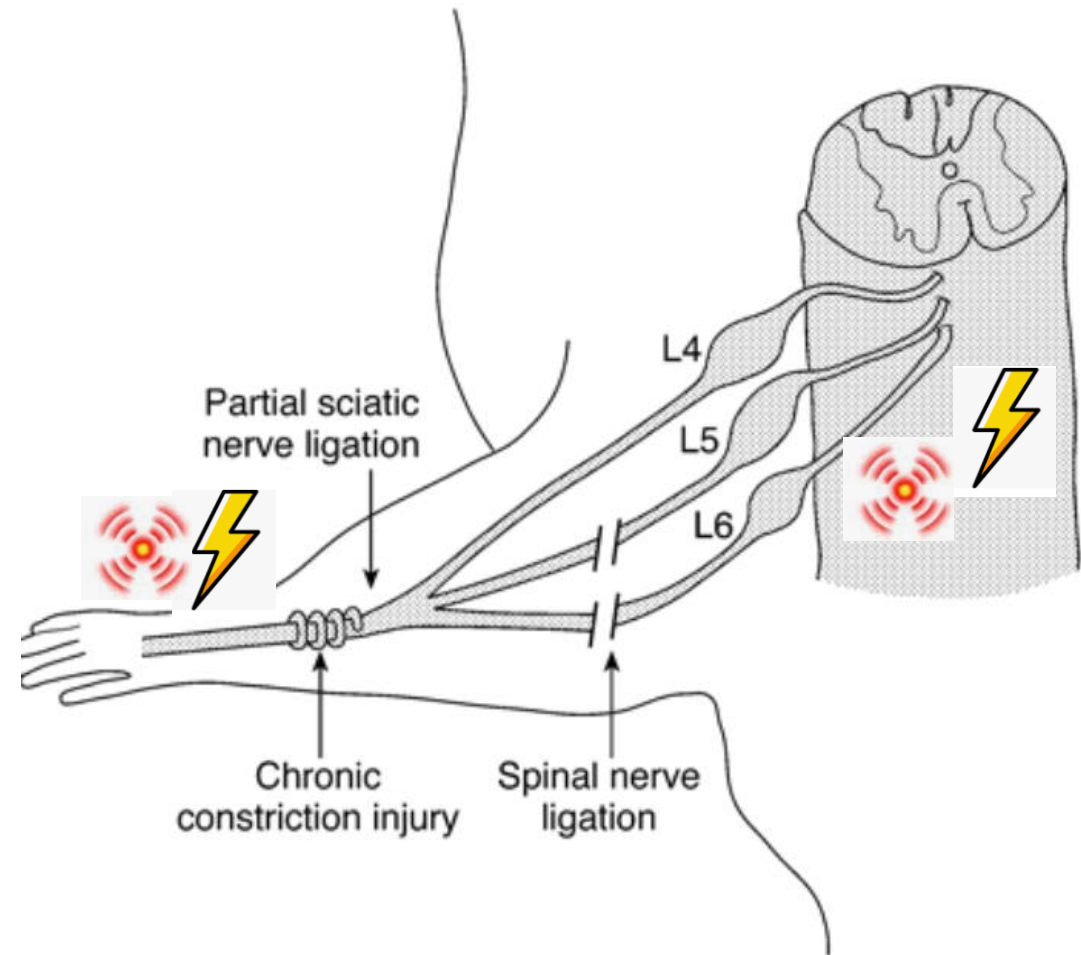
- a) Chung ligation of sciatic nerve
- b) Paclitacel induced neuropathy

To come?

## Ketamir-2: Oral ketamine analog

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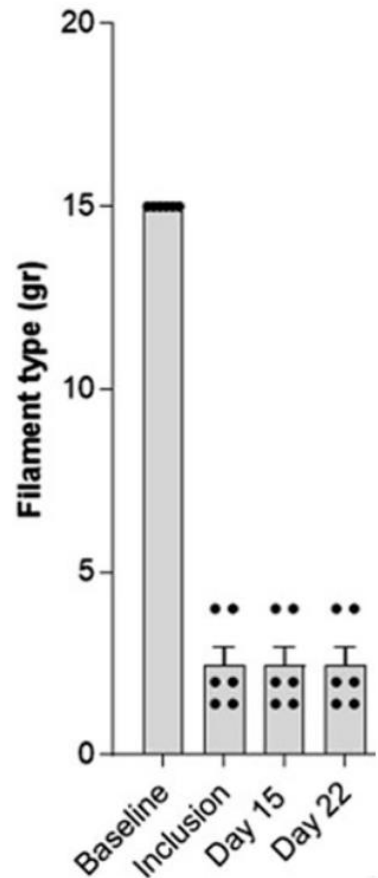
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# To come?

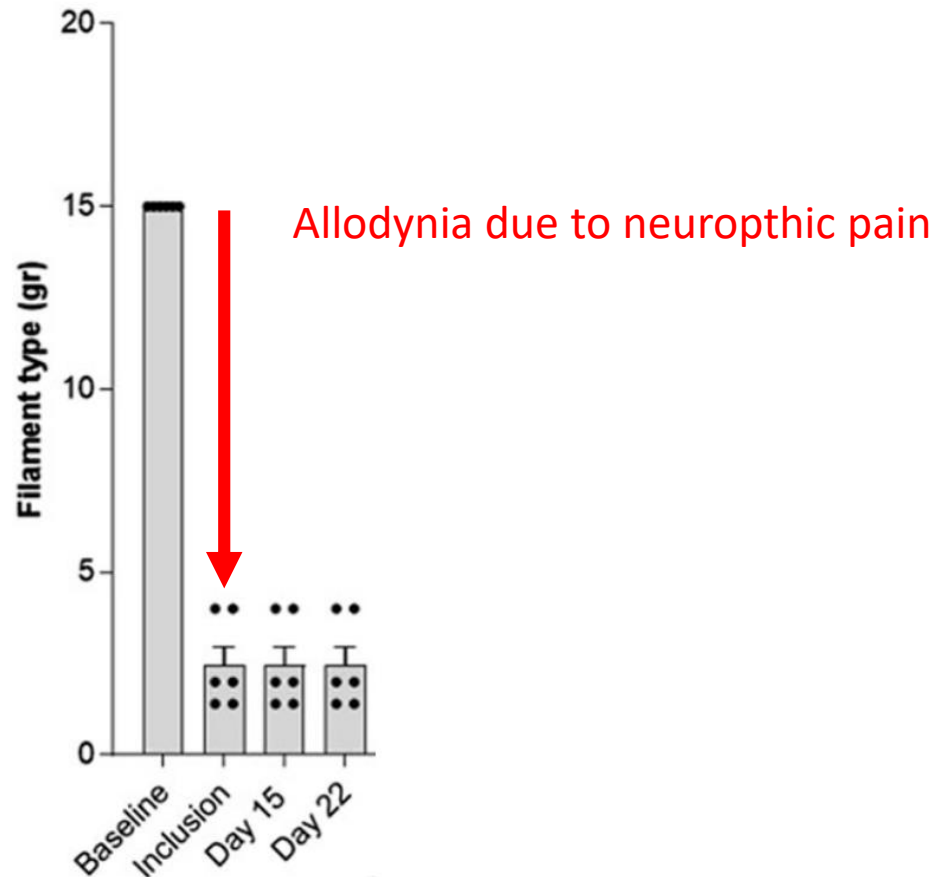
## Ketamir-2: Oral ketamine analog

### Von Frey hair test



## To come? Ketamir-2: Oral ketamine analog

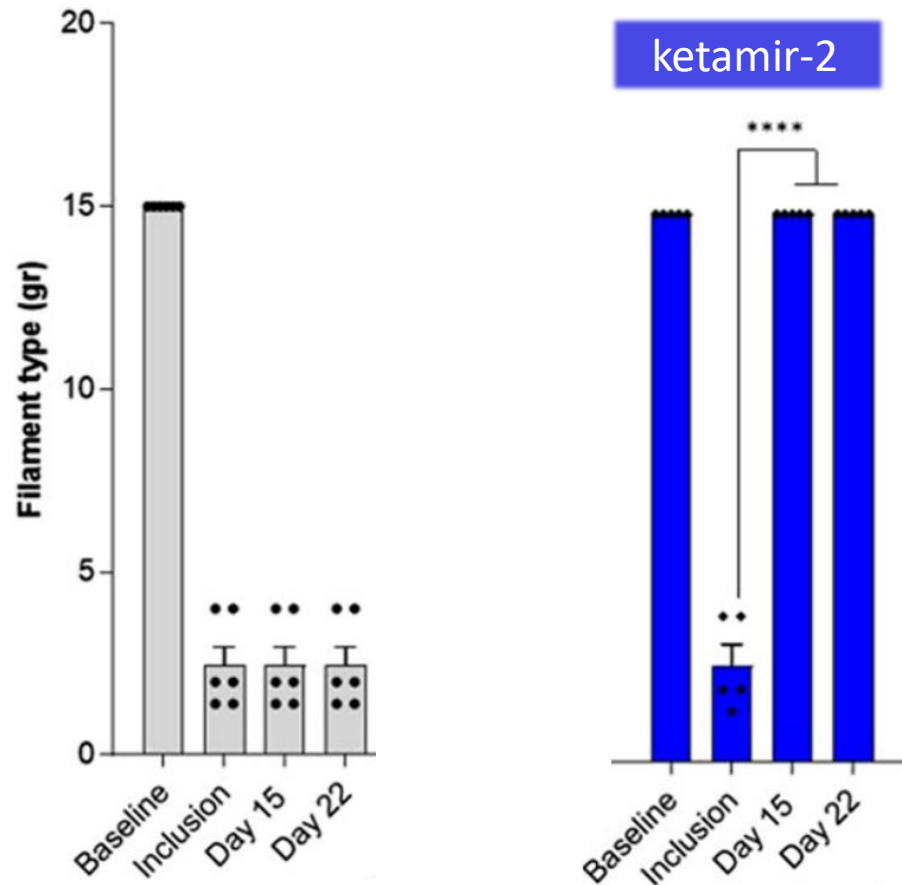
### Von Frey hair test





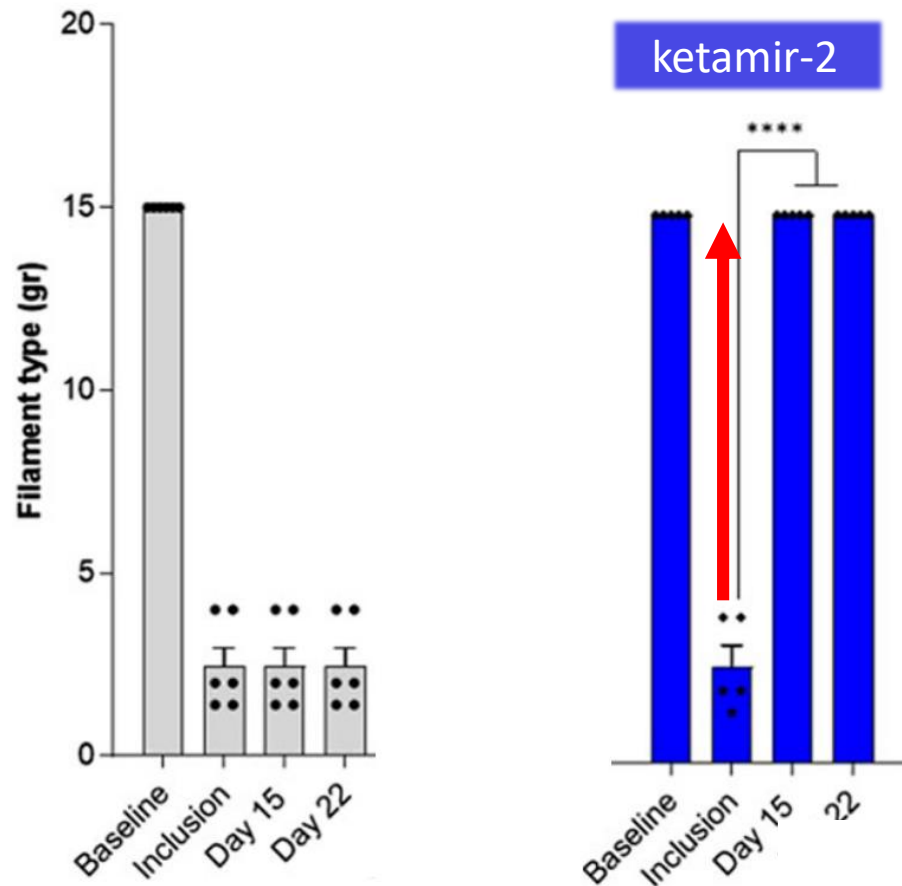
## To come? Ketamir-2: Oral ketamine analog

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## To come? Ketamir-2: Oral ketamine analog

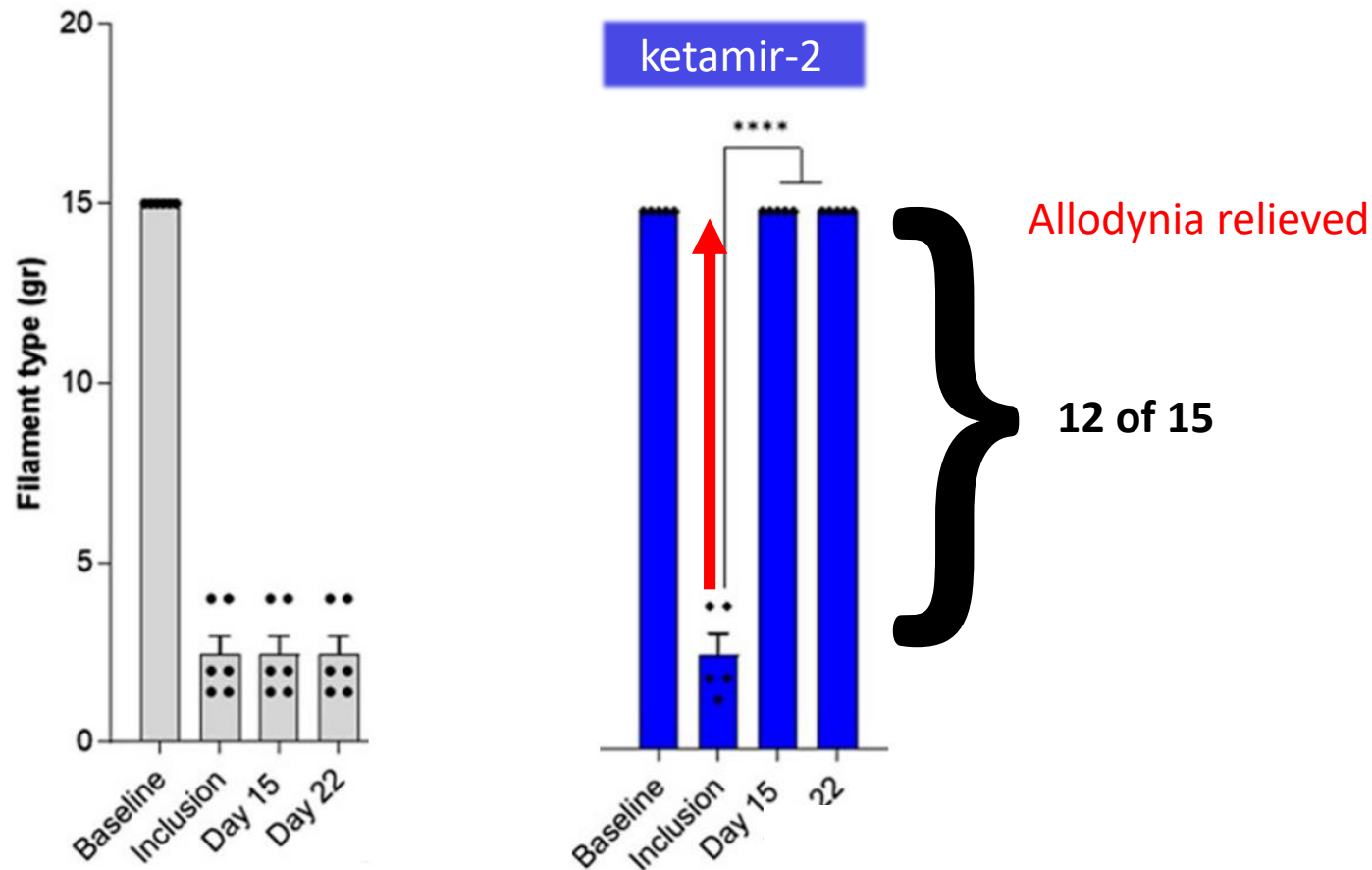
### Von Frey hair test



Allodynia relieved

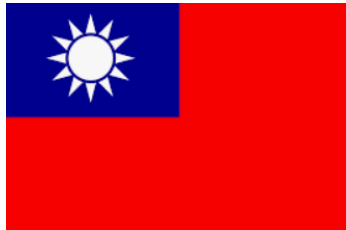
## To come? Ketamir-2: Oral ketamine analog

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## Sedation: A look at practice abroad USA/Taiwan

4-arm RCT



## Sedation: A look at practice abroad USA/Taiwan

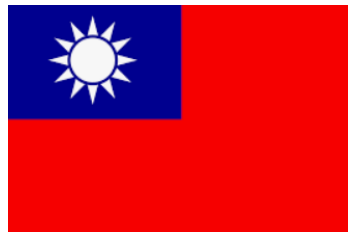
### 4-arm RCT

#### INTERVENTION

**111** Patients randomized

#### **27** Haloperidol

Intravenous haloperidol, 2 mg, every 4 h  
and every 1 h, as needed



# Sedation: A look at practice abroad USA/Taiwan

## 4-arm RCT

### INTERVENTION

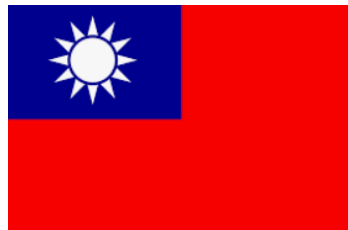
**111** Patients randomized

#### **27** Haloperidol

Intravenous haloperidol, 2 mg, every 4 h  
and every 1 h, as needed

#### **29** Lorazepam

Intravenous lorazepam, 1 mg, every 4 h  
and every 1 h, as needed



# Sedation: A look at practice abroad USA/Taiwan

## 4-arm RCT

### INTERVENTION

**111** Patients randomized

#### **27 Haloperidol**

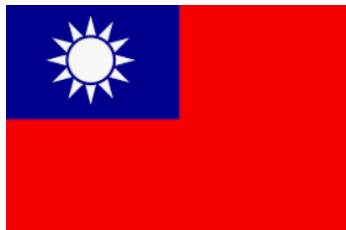
Intravenous haloperidol, 2 mg, every 4 h  
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Intravenous lorazepam, 1 mg, every 4 h  
and every 1 h, as needed

#### **28 Combined haloperidol and lorazepam**

Both intravenous haloperidol, 2 mg,  
+ intravenous lorazepam, 1 mg, every 4 h



# Sedation: A look at practice abroad USA/Taiwan

## 4-arm RCT

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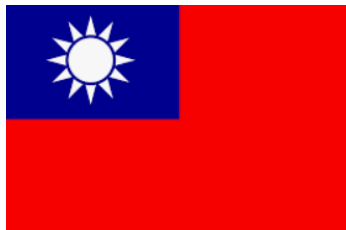
Intravenous lorazepam, 1 mg, every 4 h  
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#### **28 Combined haloperidol and lorazepam**

Both intravenous haloperidol, 2 mg,  
+ intravenous lorazepam, 1 mg, every 4 h

#### **27 Placebo**

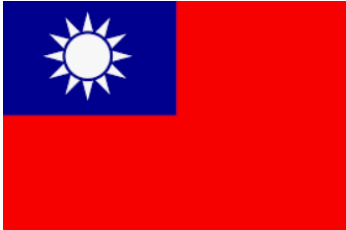
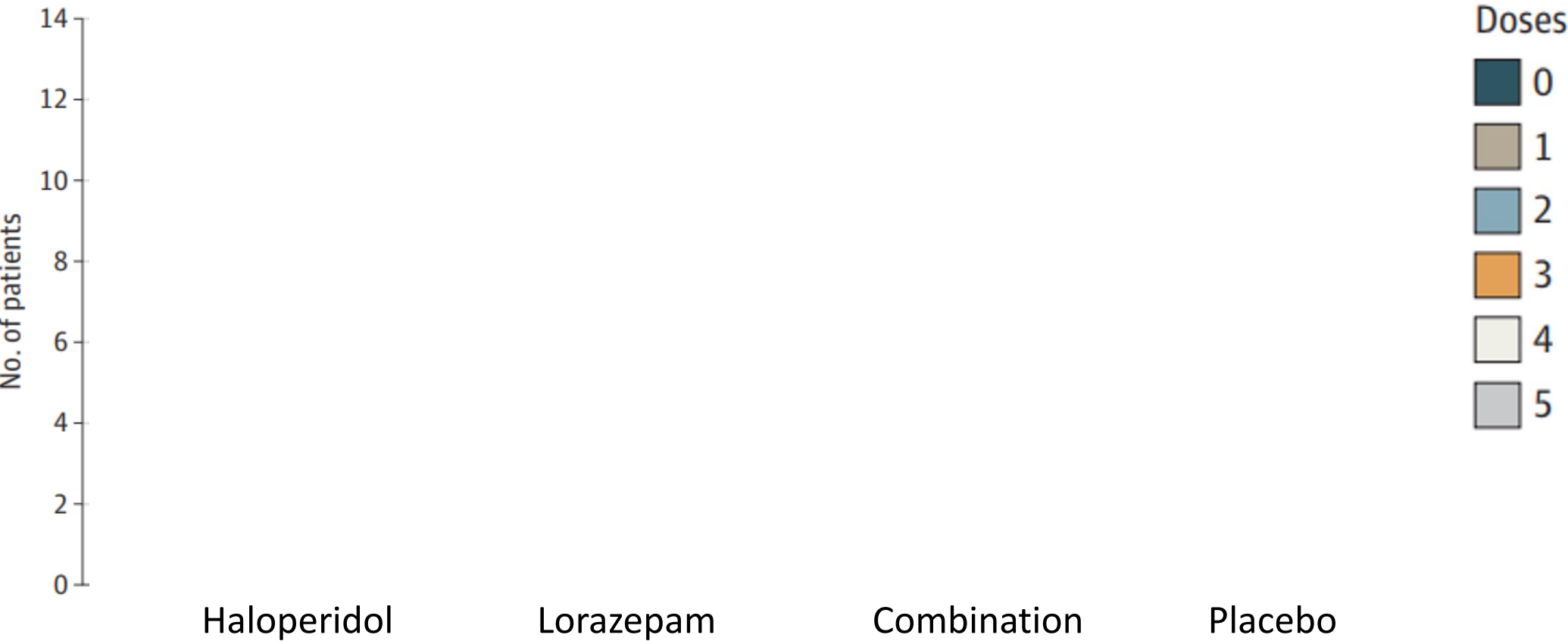
Intravenous placebo every 4 h and  
intravenous lorazepam every 1 h, as needed





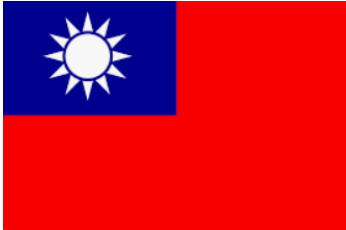
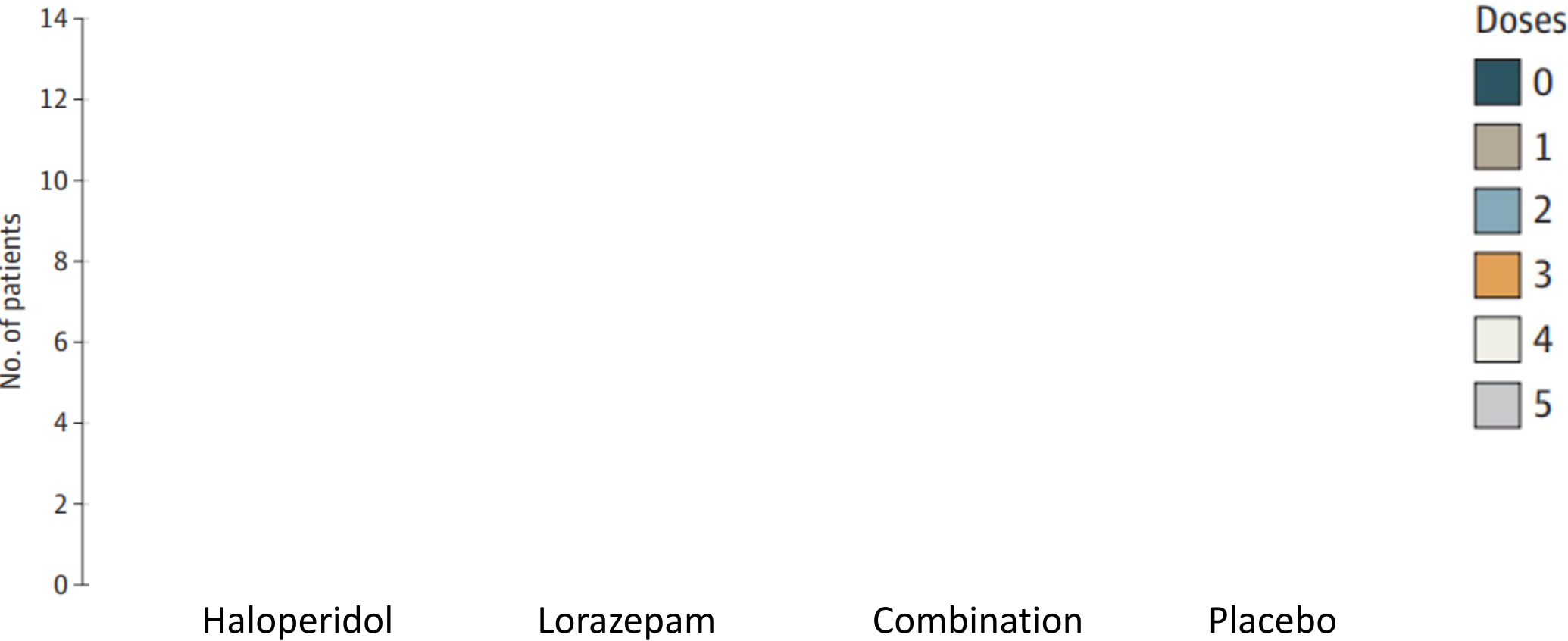
Sedation: A look at practice abroad USA/Taiwan

How many rescue doses in first 24 hours ?



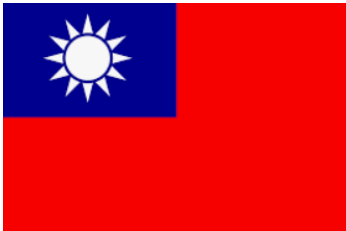
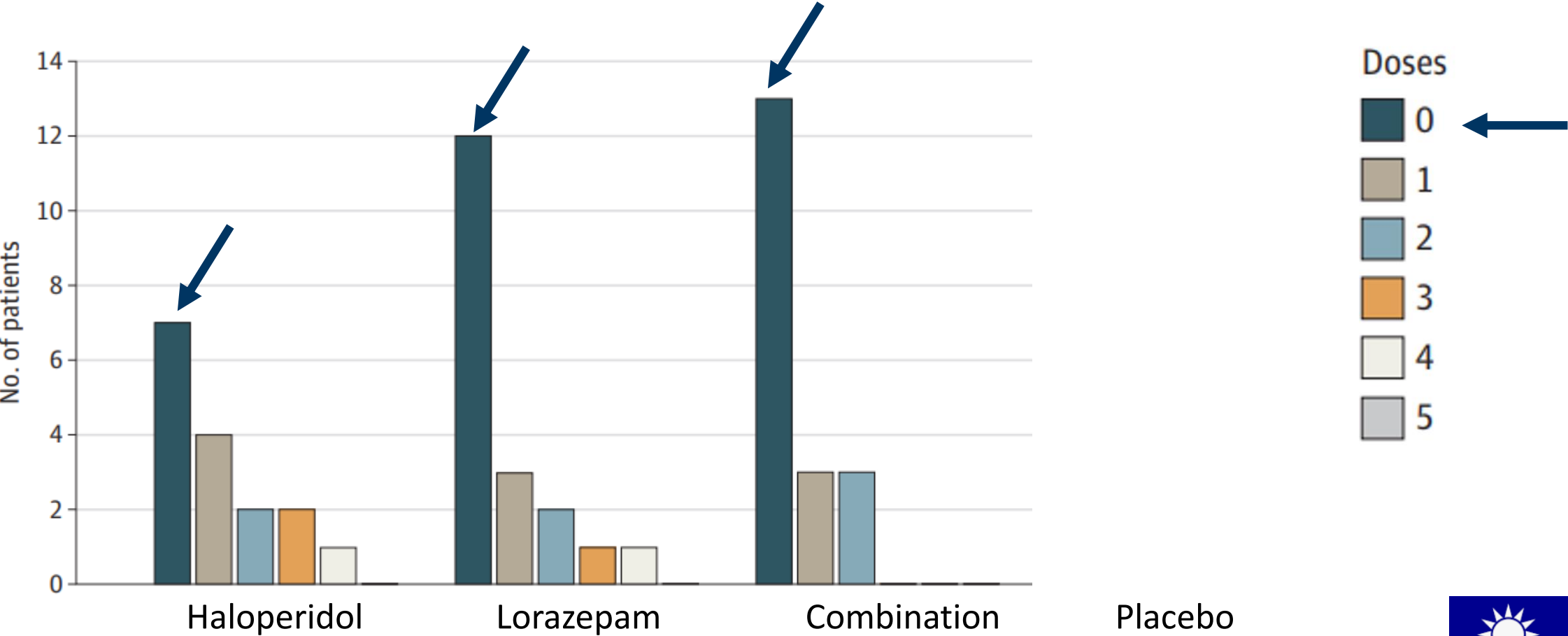
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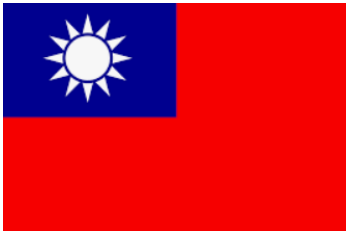
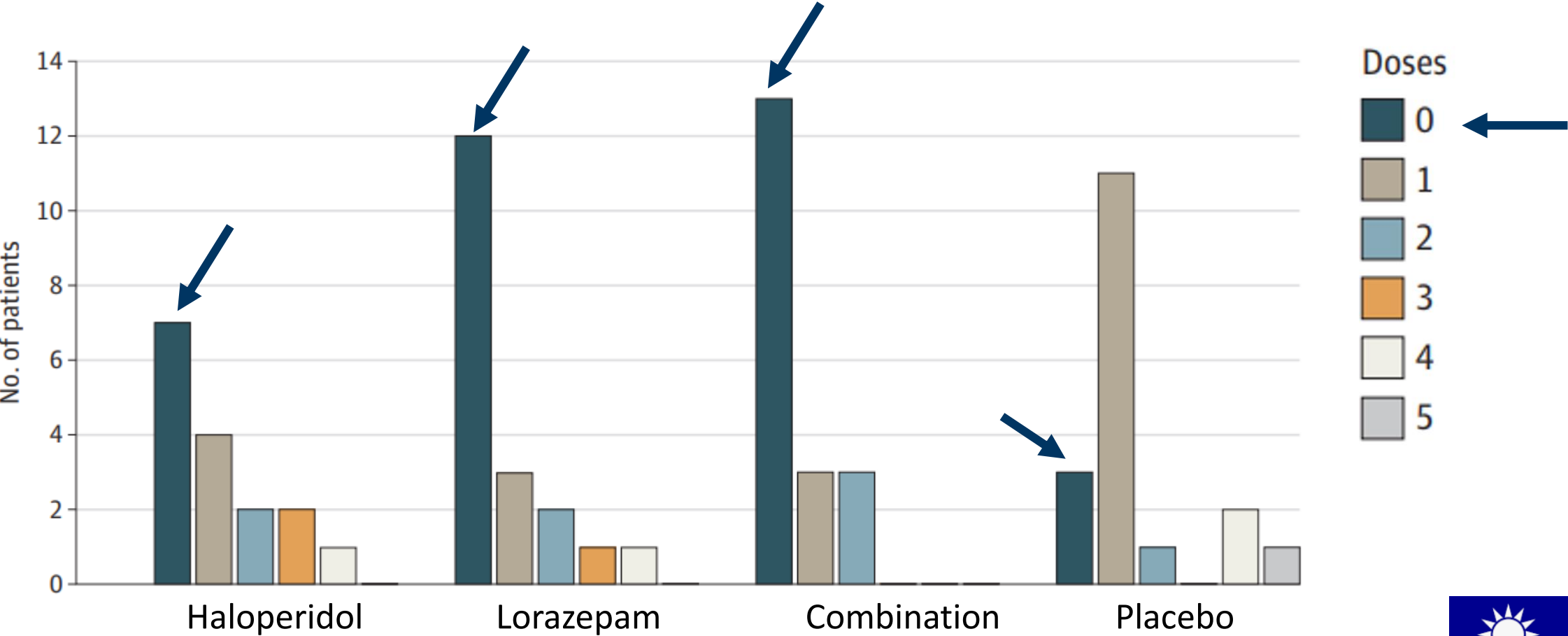
# Sedation: A look at practice abroad USA/Taiwan

How many rescue doses in first 24 hours ?



# Sedation: A look at practice abroad USA/Taiwan

How many rescue doses in first 24 hours ?



Bar chart showing the number of patients for different doses of Haloperidol, Lorazepam, Combination, and Placebo. The y-axis is 'No. of patients' (0-14). The x-axis lists the treatments. A legend on the right shows doses 0 to 5 with corresponding colors. Red arrows point to dose 5 in the legend and the Placebo bar.

| Treatment   | Dose 0 | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|-------------|--------|--------|--------|--------|--------|--------|
| Haloperidol | 7      | 4      | 2      | 2      | 1      | 0      |
| Lorazepam   | 12     | 3      | 2      | 1      | 1      | 0      |
| Combination | 13     | 3      | 3      | 0      | 0      | 0      |
| Placebo     | 3      | 11     | 1      | 0      | 2      | 1      |

## Sedation: A look at practice abroad USA/Taiwan

**Delirium: MDAS** *memorial delirium assessment scale, cut-off for delirium: 12*

Baseline: median 24 IQR: 18-29

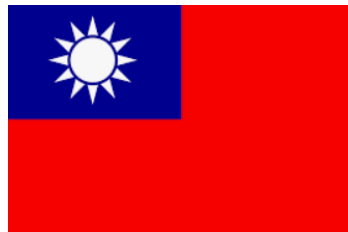
Reduction: No differences between groups

Mean after 24hrs: 13

Caregiver-perceived comfort: No differences

Adverse events: No differences

Neuroleptic side effects: No differences



## Sedation: A look at practice abroad USA/Taiwan

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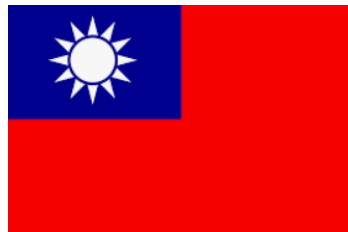
Mean after 24hrs: 13

?why?

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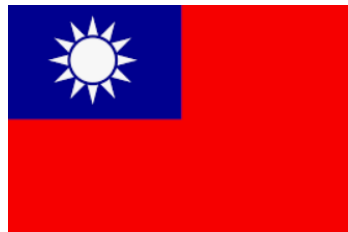
Mean after 24hrs: 13

# Neuroleptics and benzodiazepins never treat delirium....

Caregiver-perceived comfort: No differences

Adverse events: No differences

Neuroleptic side effects: No differences

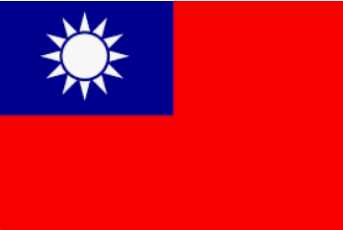






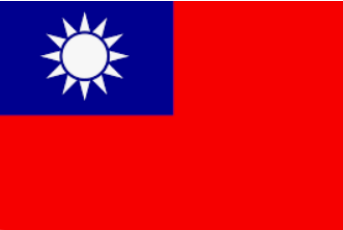
Sedation: A look at practice abroad USA/Taiwan

|                                                                      |             |                                       |
|----------------------------------------------------------------------|-------------|---------------------------------------|
|                                                                      | Haloperidol |                                       |
| Time period                                                          | No.         | Mean difference (95% CI) <sup>a</sup> |
| Change in Memorial Delirium Assessment Scale between baseline and 24 |             |                                       |
| Mean (SD)                                                            | 14          | 0.36 (6.1)                            |



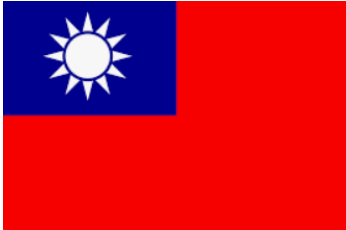
Sedation: A look at practice abroad USA/Taiwan

|                                                                        | Haloperidol |                                       | Lorazepam |                                       | Combination |                                       | Placebo |                                       |         |
|------------------------------------------------------------------------|-------------|---------------------------------------|-----------|---------------------------------------|-------------|---------------------------------------|---------|---------------------------------------|---------|
| Time period                                                            | No.         | Mean difference (95% CI) <sup>a</sup> | No.       | Mean difference (95% CI) <sup>a</sup> | No.         | Mean difference (95% CI) <sup>a</sup> | No.     | Mean difference (95% CI) <sup>a</sup> | P value |
| Change in Memorial Delirium Assessment Scale between baseline and 24 h |             |                                       |           |                                       |             |                                       |         |                                       |         |
| Mean (SD)                                                              | 14          | 0.36 (6.1)                            | 13        | 2.9 (6.5)                             | 12          | 2.4 (3.6)                             | 16      | 2.8 (4.5)                             | .55     |



Sedation: A look at practice abroad USA/Taiwan

|                                                                        | Haloperidol |                                       | Lorazepam |                                       | Combination |                                       | Placebo |                                       |         |
|------------------------------------------------------------------------|-------------|---------------------------------------|-----------|---------------------------------------|-------------|---------------------------------------|---------|---------------------------------------|---------|
| Time period                                                            | No.         | Mean difference (95% CI) <sup>a</sup> | No.       | Mean difference (95% CI) <sup>a</sup> | No.         | Mean difference (95% CI) <sup>a</sup> | No.     | Mean difference (95% CI) <sup>a</sup> | P value |
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| Improvement in patient comfort between baseline and day 1 <sup>g</sup> |             |                                       |           |                                       |             |                                       |         |                                       |         |
| Bedside nurse agrees/strongly agrees                                   | 15          | 9 (60)                                | 16        | 16 (100)                              | 13          | 12 (92)                               | 18      | 13 (68)                               | .009    |
| Caregiver agrees/strongly agrees                                       | 15          | 12 (80)                               | 13        | 10 (83)                               | 9           | 6 (67)                                | 16      | 12 (75)                               | .84     |



Improvement in agitation

|                                                                  | Haloperidol |                                       | Lorazepam |                                       | Combination |                                       | Placebo |                                       |         |
|------------------------------------------------------------------|-------------|---------------------------------------|-----------|---------------------------------------|-------------|---------------------------------------|---------|---------------------------------------|---------|
| Time period                                                      | No.         | Mean difference (95% CI) <sup>a</sup> | No.       | Mean difference (95% CI) <sup>a</sup> | No.         | Mean difference (95% CI) <sup>a</sup> | No.     | Mean difference (95% CI) <sup>a</sup> | P value |
| Improvement in agitation between baseline and day 1 <sup>g</sup> |             |                                       |           |                                       |             |                                       |         |                                       |         |
| Bedside nurse agrees/strongly agrees                             | 15          | 10 (67)                               | 16        | 16 (100)                              | 13          | 12 (92)                               | 18      | 13 (68)                               | .02     |

Improvement in agitation

67 %

100 %

92 %

68 %

|  |             |  |           |  |             |  |         |  |
|--|-------------|--|-----------|--|-------------|--|---------|--|
|  | Haloperidol |  | Lorazepam |  | Combination |  | Placebo |  |
|--|-------------|--|-----------|--|-------------|--|---------|--|

| Time period                                                      | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | P value |
|------------------------------------------------------------------|-----|---------------------------------------|-----|---------------------------------------|-----|---------------------------------------|-----|---------------------------------------|---------|
| Improvement in agitation between baseline and day 1 <sup>g</sup> |     |                                       |     |                                       |     |                                       |     |                                       |         |
| Bedside nurse agrees/strongly agrees                             | 15  | 10 (67)                               | 16  | 16 (100)                              | 13  | 12 (92)                               | 18  | 13 (68)                               | .02     |

Improvement in agitation

|                                                                  |             |                                       |           |                                       |             |                                       |         |                                       |         |
|------------------------------------------------------------------|-------------|---------------------------------------|-----------|---------------------------------------|-------------|---------------------------------------|---------|---------------------------------------|---------|
|                                                                  | 67 %        |                                       | 100 %     |                                       | 92 %        |                                       | 68 %    |                                       |         |
|                                                                  | Haloperidol |                                       | Lorazepam |                                       | Combination |                                       | Placebo |                                       |         |
| Time period                                                      | No.         | Mean difference (95% CI) <sup>a</sup> | No.       | Mean difference (95% CI) <sup>a</sup> | No.         | Mean difference (95% CI) <sup>a</sup> | No.     | Mean difference (95% CI) <sup>a</sup> | P value |
| Improvement in agitation between baseline and day 1 <sup>g</sup> |             |                                       |           |                                       |             |                                       |         |                                       |         |
| Bedside nurse agrees/strongly agrees                             | 15          | 10 (67)                               | 16        | 16 (100)                              | 13          | 12 (92)                               | 18      | 13 (68)                               | .02     |

?  
Why so litte difference...  
?

Improvement in agitation

67 %

100 %

92 %

68 %

|  |             |  |           |  |             |  |         |  |
|--|-------------|--|-----------|--|-------------|--|---------|--|
|  | Haloperidol |  | Lorazepam |  | Combination |  | Placebo |  |
|--|-------------|--|-----------|--|-------------|--|---------|--|

| Time period                                                      | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | No. | Mean difference (95% CI) <sup>a</sup> | P value |
|------------------------------------------------------------------|-----|---------------------------------------|-----|---------------------------------------|-----|---------------------------------------|-----|---------------------------------------|---------|
| Improvement in agitation between baseline and day 1 <sup>g</sup> |     |                                       |     |                                       |     |                                       |     |                                       |         |
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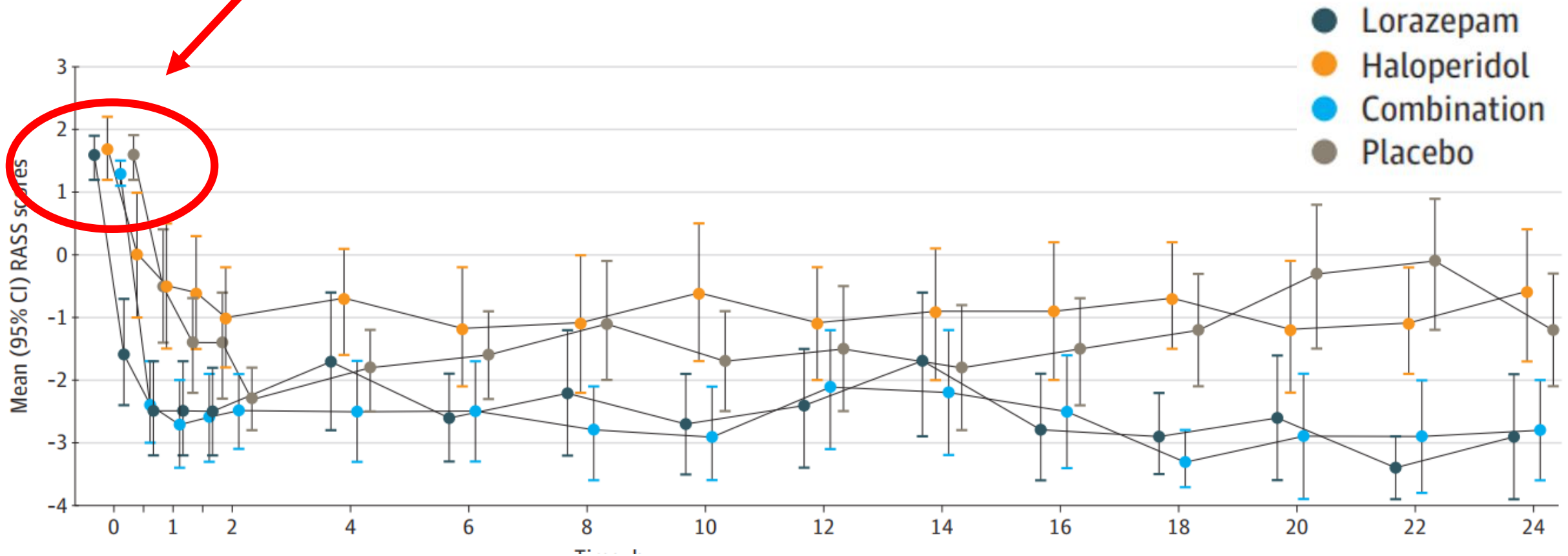
!!  
delirium is (often) self limiting  
fluctuation is part of the definition  
!!





## RASS-PALL

Is this agitation ?



# Ten Minute Teaching

## P2X3 Antagonists

Prof. Dr. Jan Gärtner  
Palliativzentrum Bethesda  
Medizinische Fakultät  
Departement Klinische Forschung

P2X3 Antagonisten

Summer School 2022

Prof. Dr. Jan Gärtner  
Palliativzentrum Bethesda  
Medizinische Fakultät  
Departement Klinische Forschung

Summer School 2022

**COMING UP**

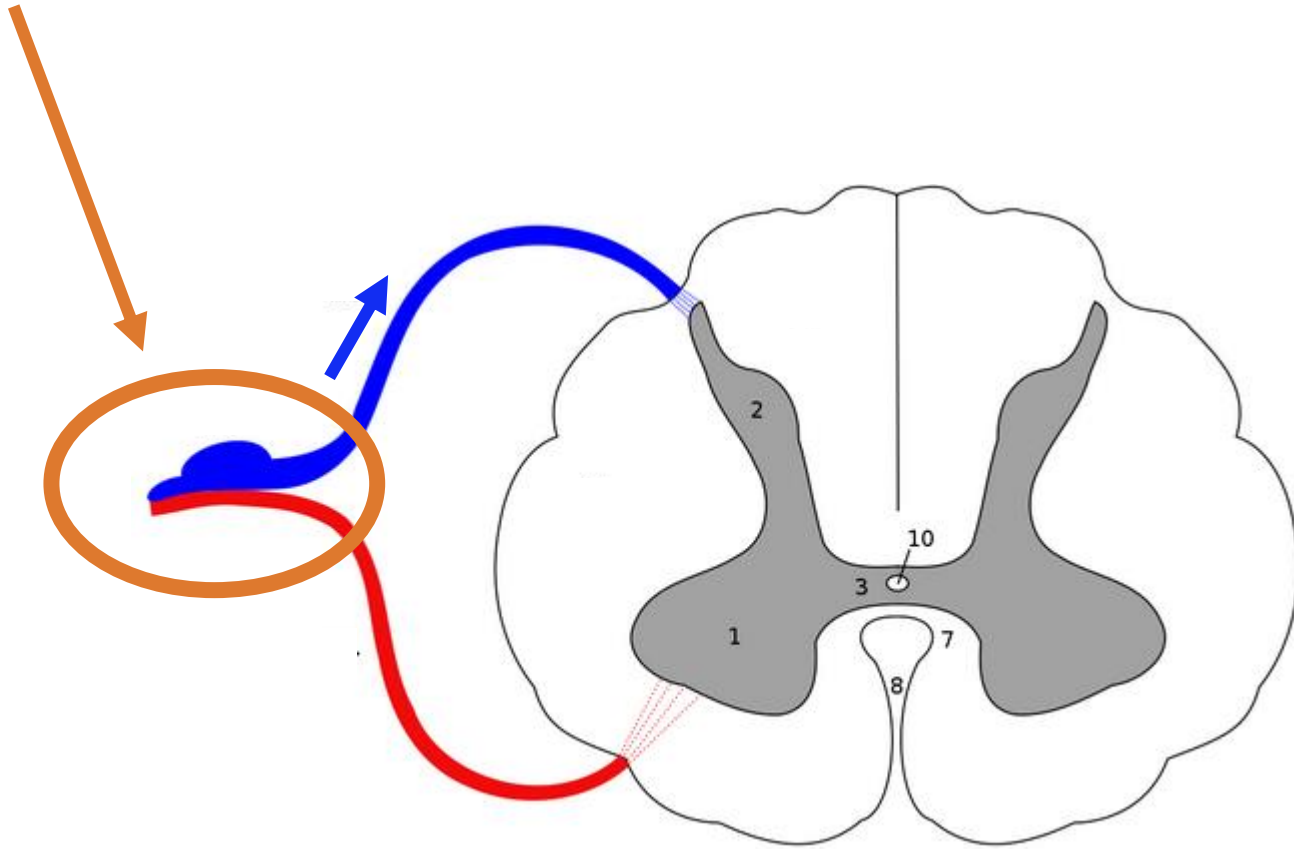


# P2X3 Inhibitors



P2X3 Receptor

# P2X3 Inhibitors



# P2X3 Inhibitors

## P2X3 receptor

**P2:** purinergic receptor family

Natural ligand: ATP

Permeable to  $\text{Na}^+$ ,  $\text{K}^+$  and  $\text{Ca}^{2+}$

In sensory dorsal root ganglia, afferents from viscera



# P2X3 Inhibitors

## Gefapixant:





# P2X3 Inhibitors

## Gefapixant:

**No conflict of interest !**



# P2X3 Inhibitors

## Gefapixant: 2 RCTs *COUGH-1, COUGH-2*

Patients with refractory chronic cough

732 patients in COUGH-1 and 1317 in COUGH-2

Mean duration of cough > 11 years !

Study duration: 12 / 24 weeks

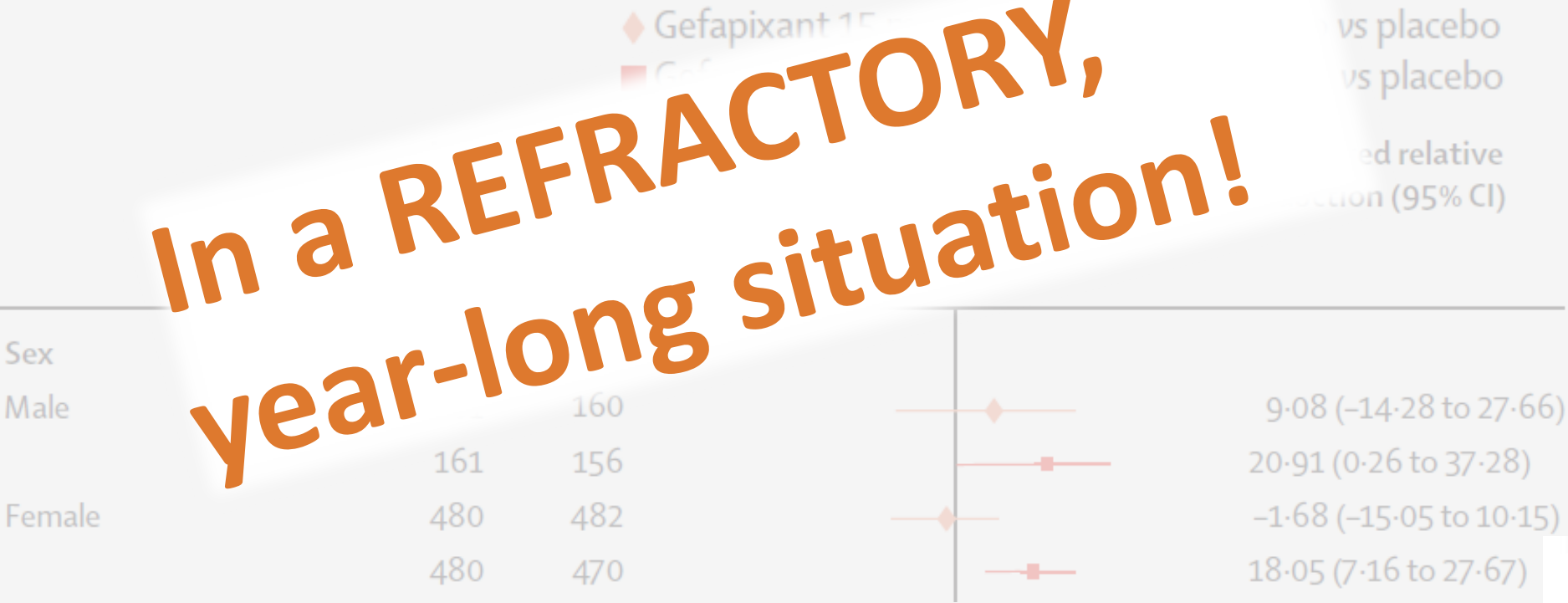
Prim. Outcome: Change in 24-h cough frequency



P2X3 Inhibitors?

Gefapixant: 2 RCTs *COUGH-1, COUGH-2*

In a REFRACTORY,  
year-long situation!



## Gefapixant: 2 RCTs *COUGH-1, COUGH-2*

### Adverse events:

Ageusia

Dysgeusia

Hypergeusia

Hypogeusia

Taste disorder

3-8%



## Gefapixant: 2 RCTs *COUGH-1, COUGH-2*

### Adverse events:

Ageusia

Dysgeusia

Hypergeusia

Hypogeusia

Taste disorder



➤ [J Palliat Med.](#) 2026 Feb 11:10966218251385732. doi: 10.1177/10966218251385732.

Online ahead of print.

# Gefapixant Citrate, a Selective P2X<sub>3</sub> Receptor Antagonist, May Improve Cancer-Related Hypergeusia: A Case Report

Satoshi Murakami <sup>1</sup>, Kazutaka Yamagishi <sup>2</sup>, Akira Kitani <sup>3</sup>, Toru Ueta <sup>4</sup>, Yasuaki Matsuura <sup>1</sup>,  
Toru Kubota <sup>1</sup>, Yasuhito Uezono <sup>5</sup>



## Future indications, promising in animal model?

Visceral pain

Dyspnea

Hyperactive bladder

And many more



## Future indications, promising in animal model?

Visceral pain

Dyspnea

Hyperactive bladder

And many more







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## European Journal of Pharmacology

journal homepage: [www.elsevier.com/locate/ejphar](http://www.elsevier.com/locate/ejphar)

### P2X3 and P2X2/3 receptors inhibition produces a consistent analgesic efficacy: A systematic review and meta-analysis of preclinical studies

Miguel Á. Huerta<sup>a,b,c</sup>, Daniel Marcos-Frutos<sup>d</sup>, Javier de la Nava<sup>e</sup>, Amador García-Ramos<sup>d,f</sup>, Miguel Ángel Tejada<sup>a,b,c,\*</sup>, Carolina Roza<sup>g</sup>



# P2X3 Inhibitors

## Rodent model

### Hot plate test



# P2X3 Inhibitors

## Rodent model



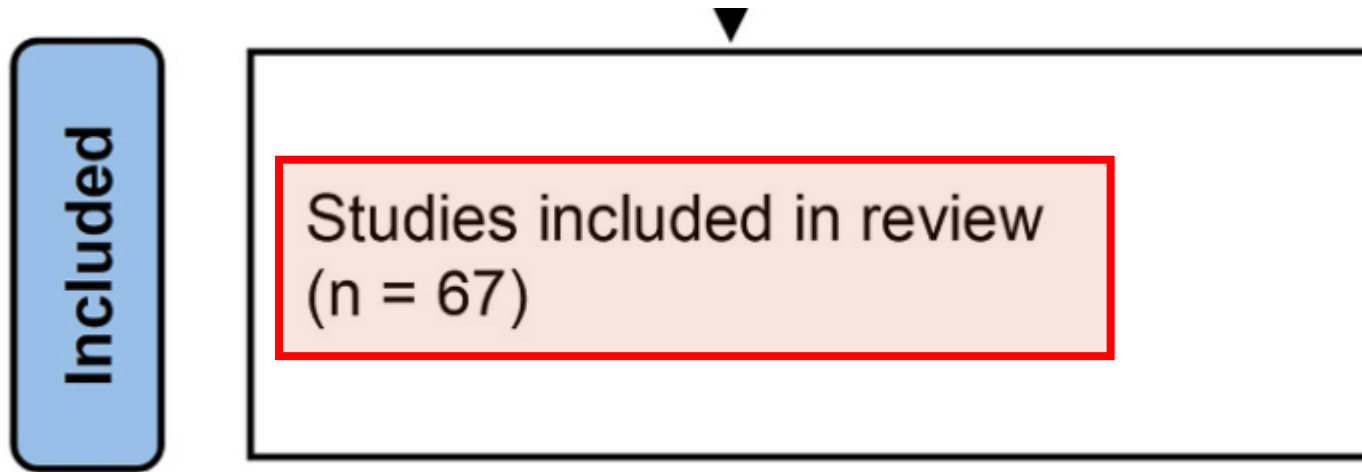
# P2X3 Inhibitors

## Rodent model

## Colorectal distension

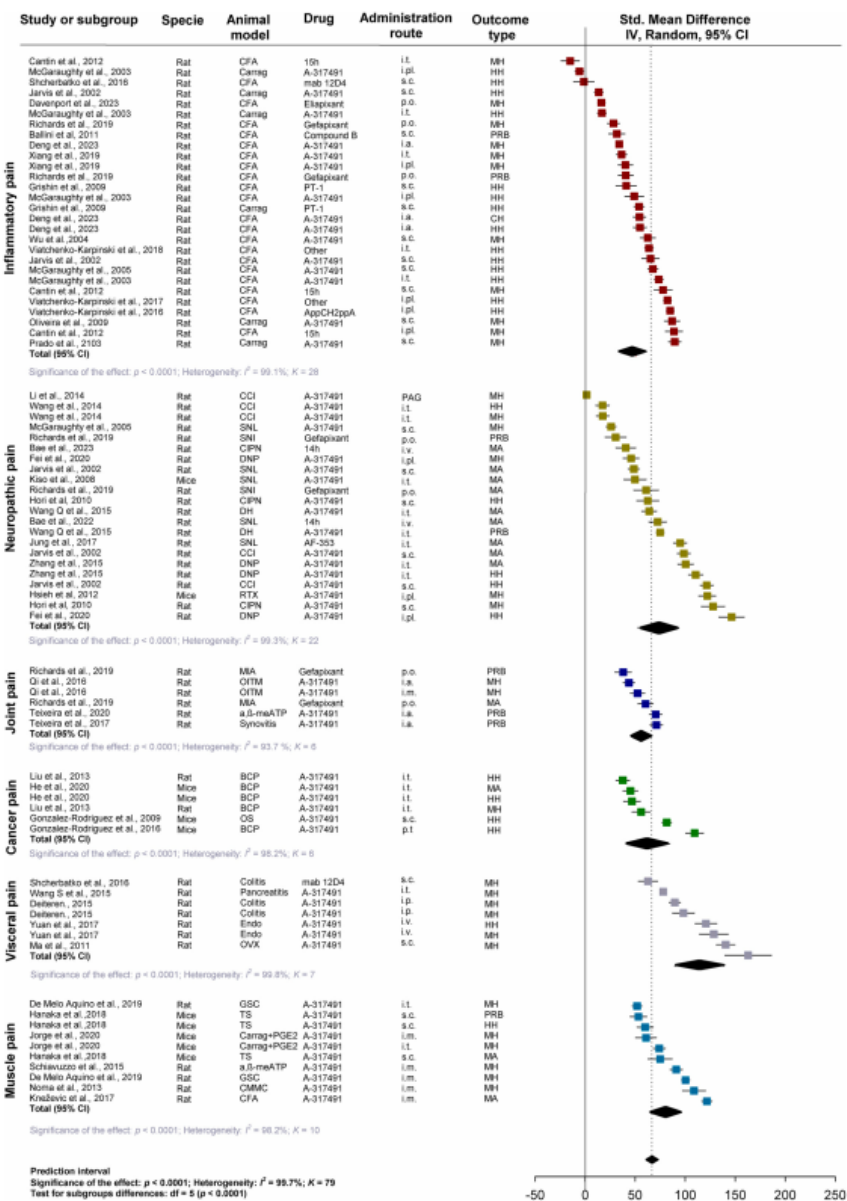


## PRISMA-Flowchart



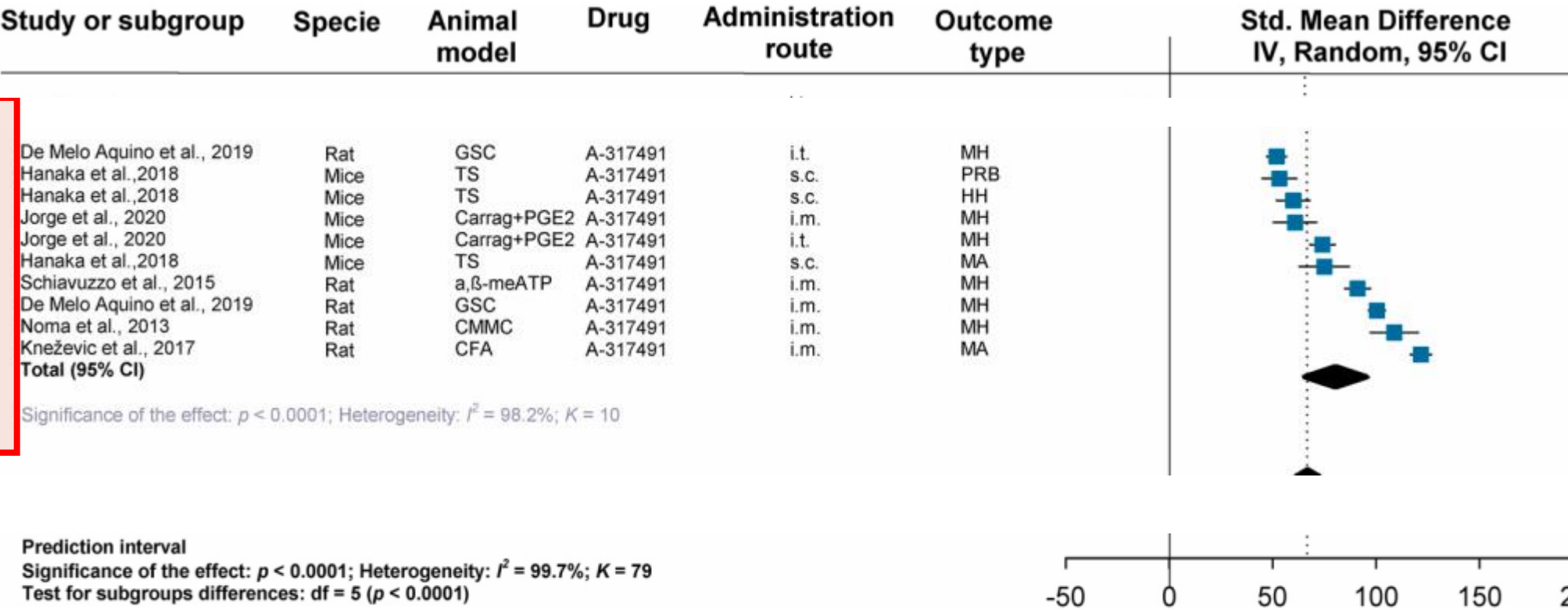
**67 Studien**





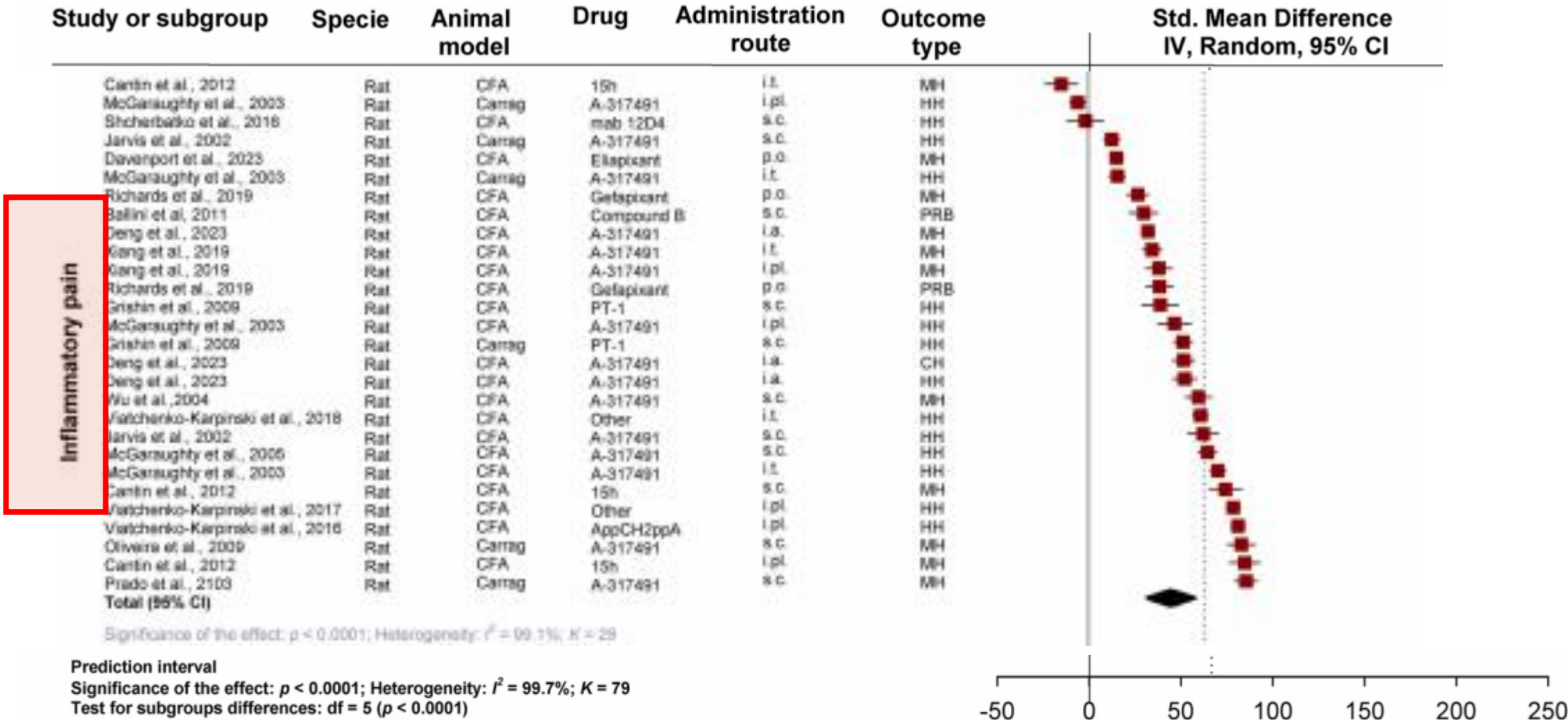
Pain physiology

Muscle pain





Pain physiology





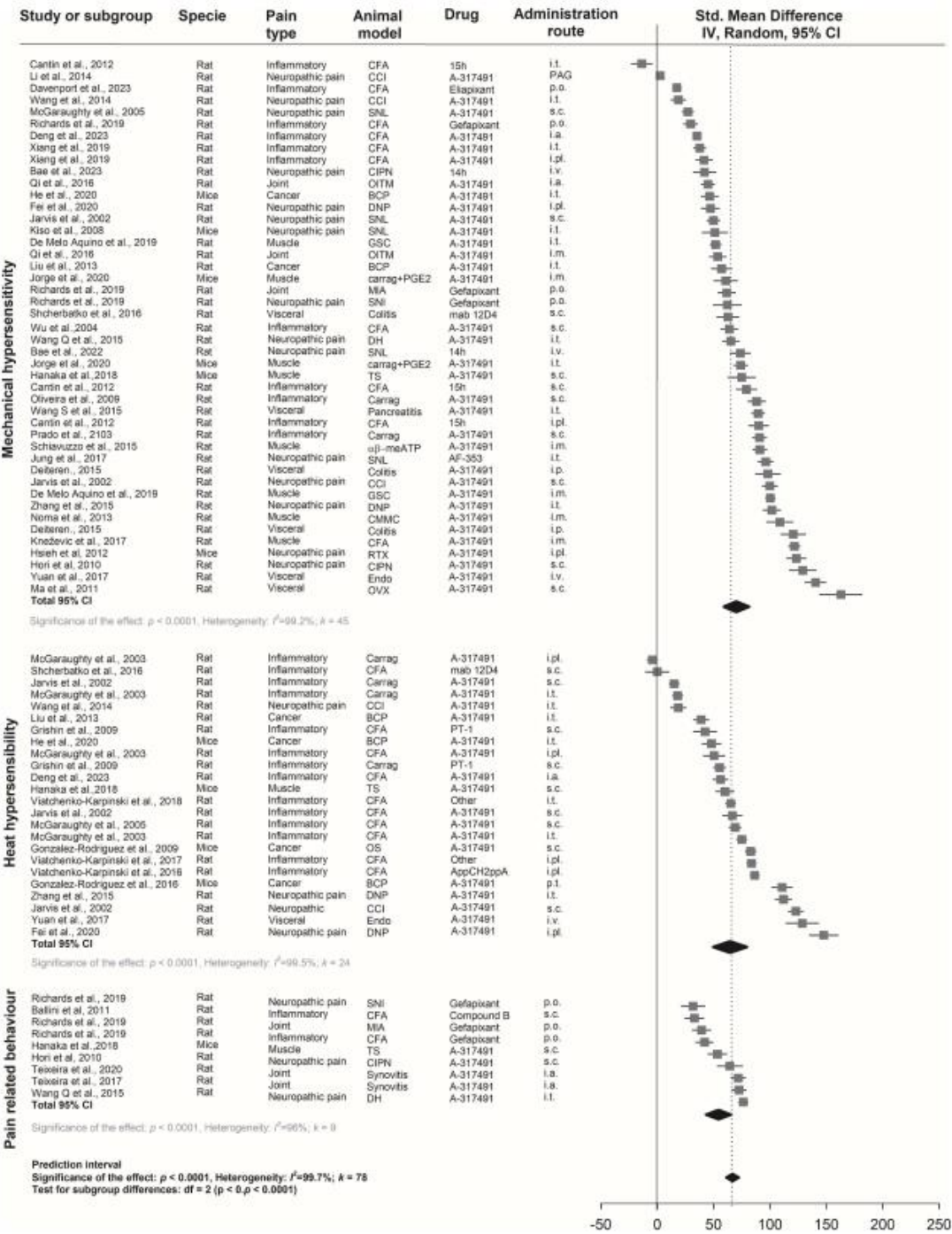
P2X3 Inhibitors

Investigating technique

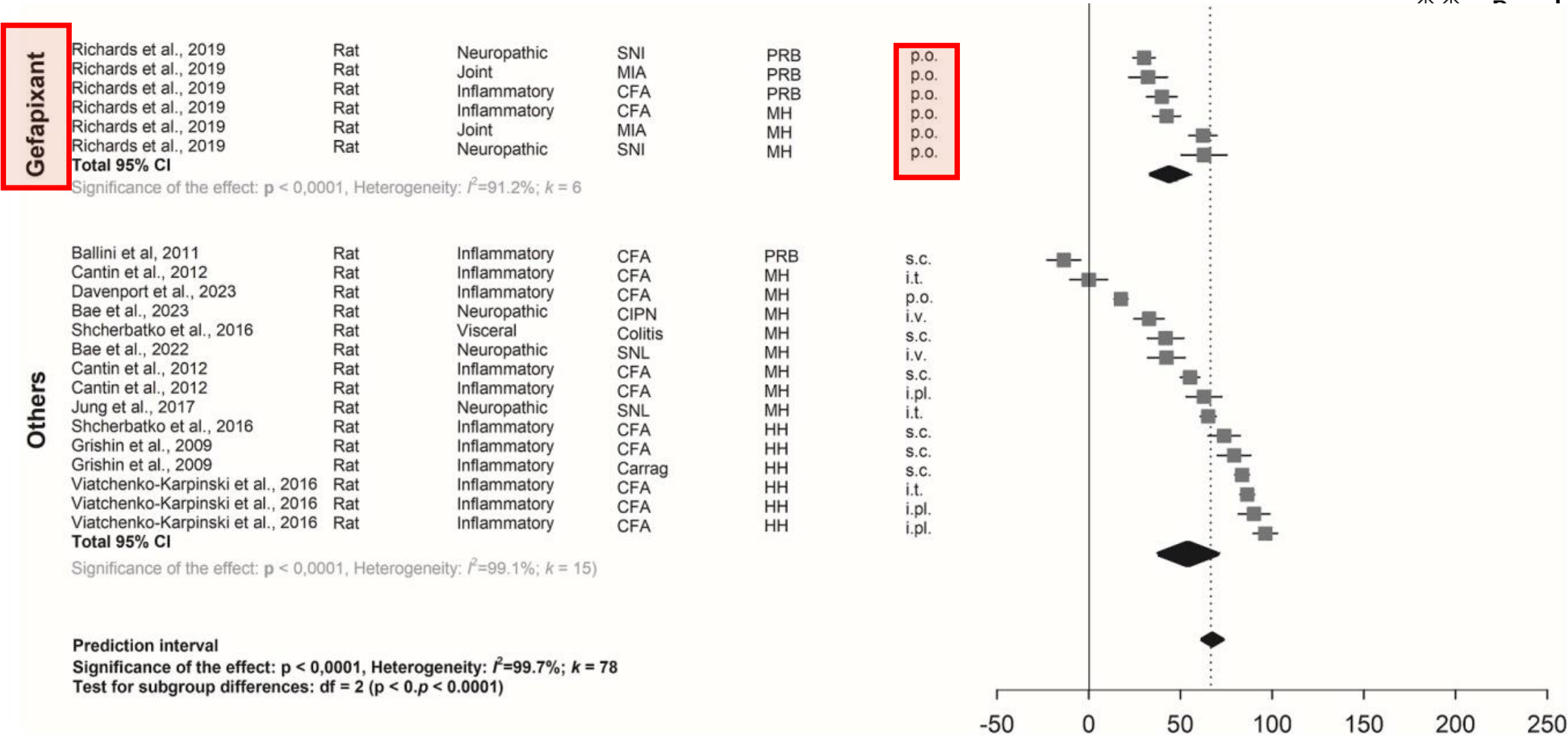
Mechanical hypersensitivity

Heat hypersensitivity

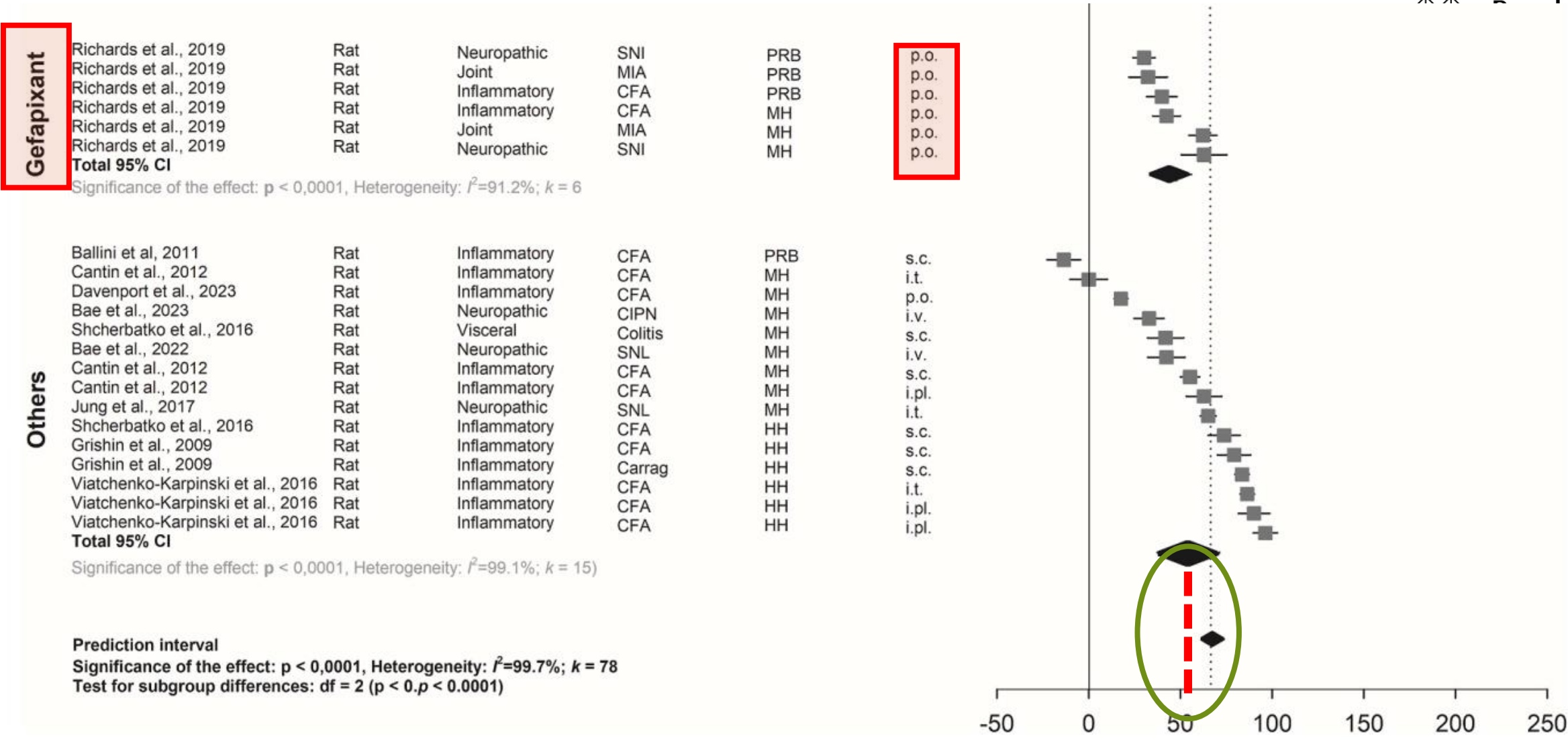
Pain related behaviour



P2X3 Inhibitors  
Gefapixant, p.o.



P2X3 Inhibitors  
Gefapixant, p.o.



## Authors conclusion

Robust analgesic effects in animal models

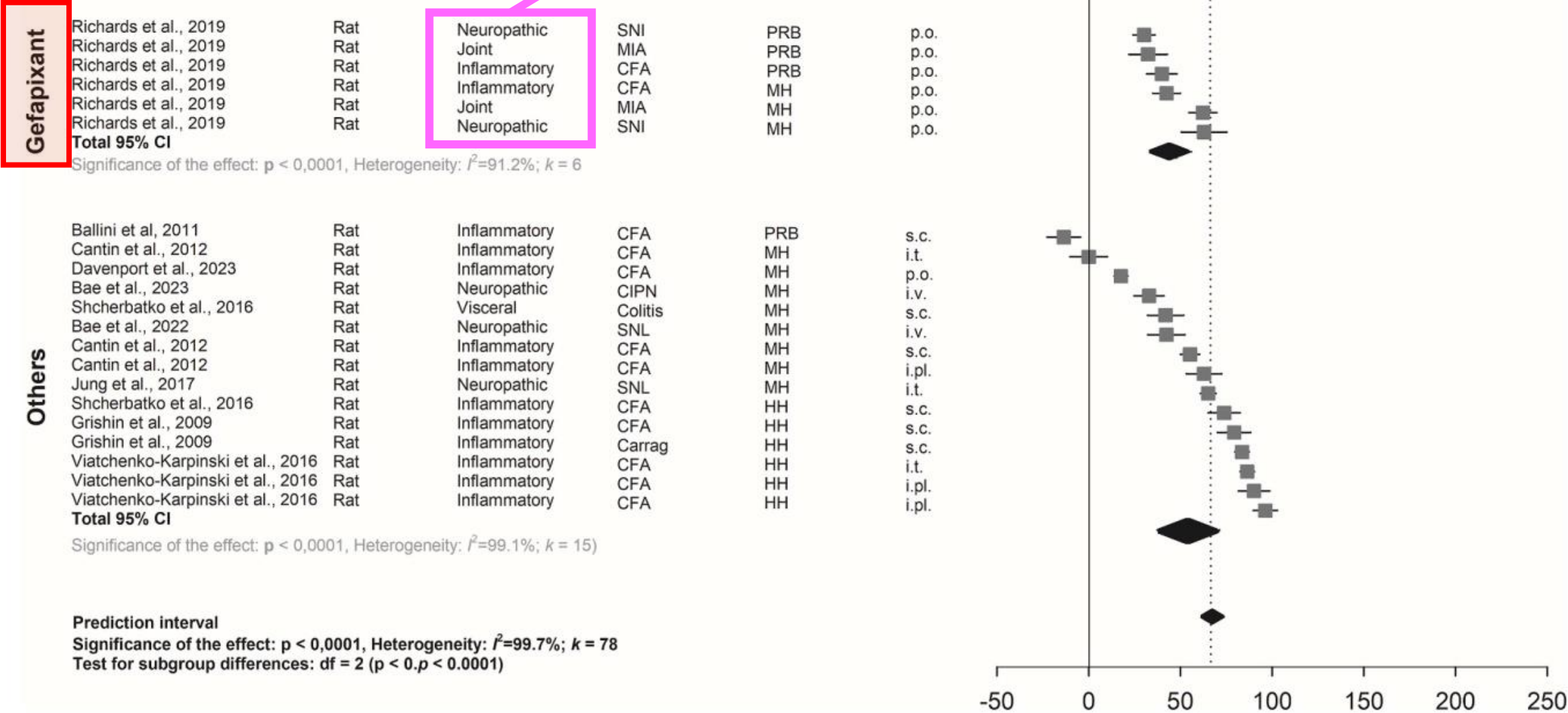
Best results: Visceral, muscle and neuropathic pain

Low effect: Inflammatory pain.

Administration route: Highest effect with i.t. and s.c.



Gefapixant, p.o.



# P2X3 Inhibitors

Breathlessness , Cardiac failure: if no pulmonary edema, no hypoxemia:

Baroreceptor atrium  $\Rightarrow$  dorsal root  $\Rightarrow$  P2X3 Inhibition

(Breathlessness COPD ?)

Pain

Dys-, An-, Hypergusia ?

COUGH !



# **EPCOG Study:**

Integration of specialist Palliative Care  
Glioblastoma patients..



# EPCOG Study:

**The anti-Temel study ?**





## ORIGINAL ARTICLE

# Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A.,  
Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H.,  
Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N.,  
Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H.,  
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J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

- Better survival ? **NO – refer to metanalyses....**
- Relevant improvement of quality of life? **NO fraudulent statistics Meta-analysis: YES**
- Publication bias? **YES – senior author chief editor of NEJM**



## Inclusion criteria:

a) Newly diagnosed glioblastoma within 4 weeks of diagnosis

OR

b) Recurrent glioblastoma within 4 weeks after diagnosis

AND

ECOG 0-2\*

and many more....

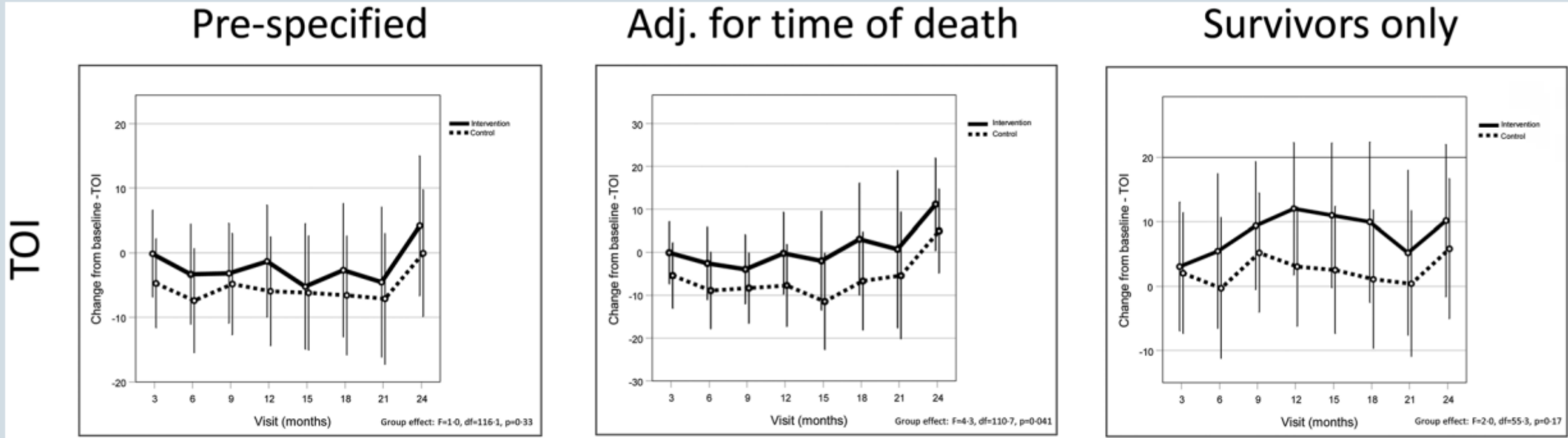


## Intervention:

Specialist Palliative Care on demand (reactive) vs routinely (proactive)

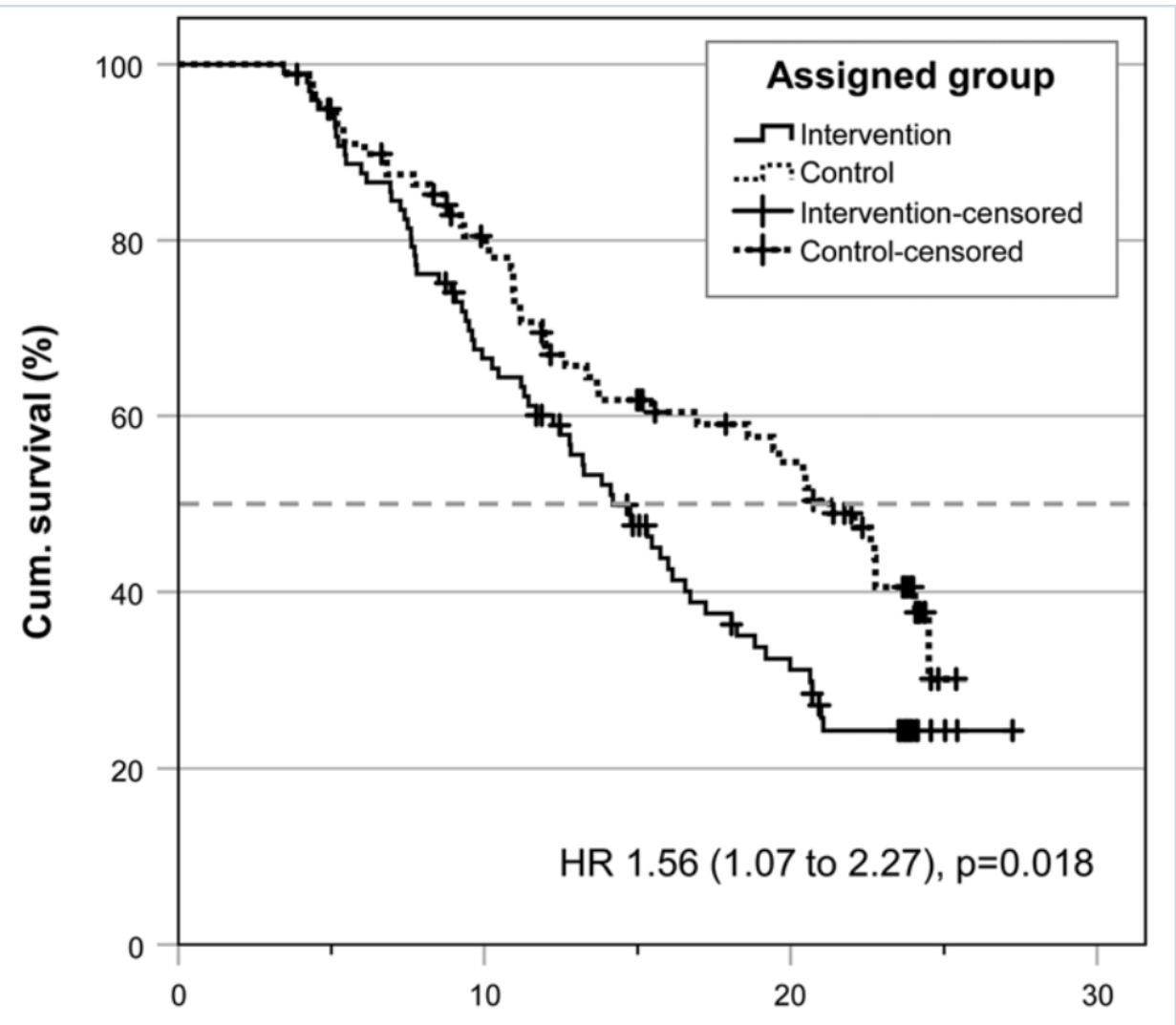


## Results primary outcome Quality of life



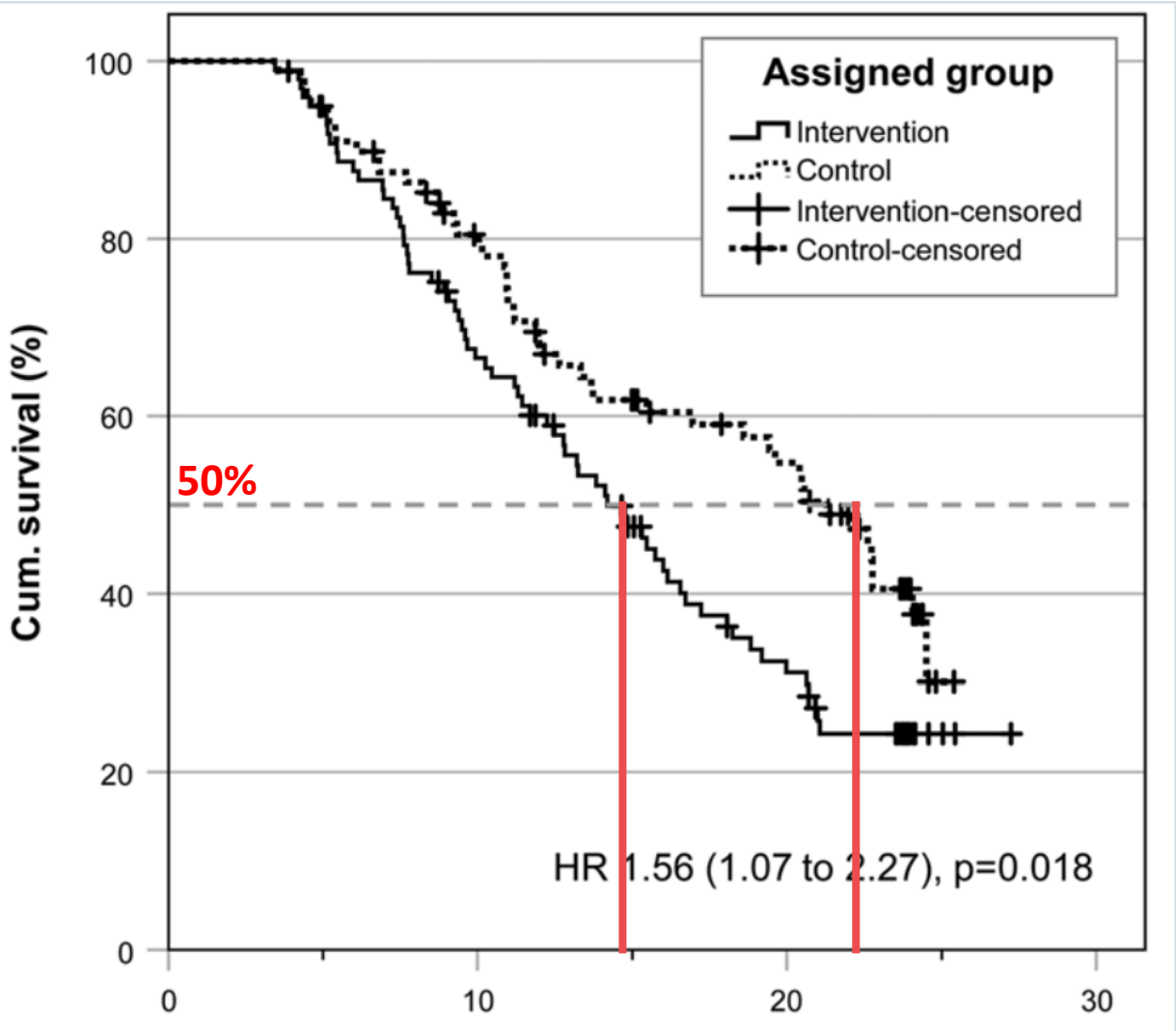
**Figure 3.** Change in the Trial Outcome Index (TOI) of the Functional Assessment of Cancer Therapy-Brain (FACT-Br) from baseline (EMM with 95% CI). Change = post value (month 3-24) minus baseline value. Higher scores indicating better QoL with respect to physical, functional and brain specific factors; range of TOI 0-148. Solid line: intervention, dotted line: control, EMM = estimated marginal mean, CI = confidence interval.





56% increase in the hazard of death





56% increase in the hazard of death



- Prespecified primary analysis was negative for QoL
- Adjusted analyses “suggested” benefit *statistically not significant*





- Prespecified primary analysis was negative for QoL
- Adjusted analyses “suggested” benefit *statistically not significant*
- Caregivers: no difference
- Place of death and other outcomes: No differences



Let`s talk....



# Palliative Care Intervention for Patients With End-Stage Liver Disease: A Cluster Randomized Clinical Trial

Manisha Verma<sup>1</sup>, Victor Navarro<sup>1</sup>, Andrzej Kosinski<sup>2</sup>, Tamar Taddei<sup>3</sup>, Richard Kalman<sup>1</sup>, A Sidney Barritt Iv<sup>4</sup>, Simona Jakab<sup>5</sup>, Marina Serper<sup>6</sup>, Eric Orman<sup>7</sup>, Maya Balakrishnan<sup>8</sup>, Mina Rakoski<sup>9</sup>, Don Rockey<sup>10</sup>, Kristel Hunt<sup>11</sup>, Roniel Cabrera<sup>12</sup>, Ayse Aytaman<sup>13</sup>, Binu John<sup>14</sup>, Gyorgy Baffy<sup>15</sup>, Rohit Nathan<sup>16</sup>, Elliot Tapper<sup>17</sup>, Marina Roytman<sup>18</sup>, Brendan McGuire<sup>19</sup>, Nicholas Hoppmann<sup>19</sup>, Christopher Woodrell<sup>20</sup>, Marie Bakitas<sup>19</sup>, Yang Yue<sup>2</sup>, Bryce Reeve<sup>2</sup>, Li Lin<sup>2</sup>, Rebecca Tantala<sup>1</sup>, Michael Volk<sup>21</sup>



# Palliative Care Intervention for Patients With End-Stage Liver Disease: A Cluster Randomized Clinical Trial

Manisha Verma<sup>1</sup>, Victor Navarro<sup>1</sup>, Andrzej Kosinski<sup>2</sup>, Tamar Taddei<sup>3</sup>, Richard Kalman<sup>1</sup>,  
A Sidney Barritt Iv<sup>4</sup>, Simona Jakab<sup>5</sup>, Marina Serper<sup>6</sup>, Eric Orman<sup>7</sup>, Maya Balakrishnan<sup>8</sup>,  
Mina Rakoski<sup>9</sup>, Don Rockey<sup>10</sup>, Kristel Hunt<sup>11</sup>, Roniel Cabrera<sup>12</sup>, Ayse Aytaman<sup>13</sup>, Binu John<sup>14</sup>,  
Gyorgy Baffy<sup>15</sup>, Rohit Nathan<sup>16</sup>, Elliot Tapper<sup>17</sup>, Marina Roytman<sup>18</sup>, Brendan McGuire<sup>19</sup>,  
Nicholas Hoppmann<sup>19</sup>, Christopher Woodrell<sup>20</sup>, Marie Bakitas<sup>19</sup>, Yang Yue<sup>2</sup>, Bryce Reeve<sup>2</sup>,  
Li Lin<sup>2</sup>, Rebecca Tantala<sup>1</sup>, Michael Volk<sup>21</sup>

**Conclusions and relevance:** This cluster trial found that palliative care delivered by trained hepatologists was comparable with palliative care delivered by palliative care specialists in improving QoL in patients with ESLD and was associated with greater improvement in patient satisfaction, demonstrating the effectiveness among enrolled patients.



Mr. F. 44 yrs

**Malignant Melanoma Stage IV Metastases: Lung, bone, liver  
3lines of Chemotherapy, physical condition limited. Breathlessness**

**Patient** on admission to Palliative Care ward:

*“My aim is to be cured from the disease by the anti-cancer therapy”*

**Oncologist**, called by the Palliative Care condition:

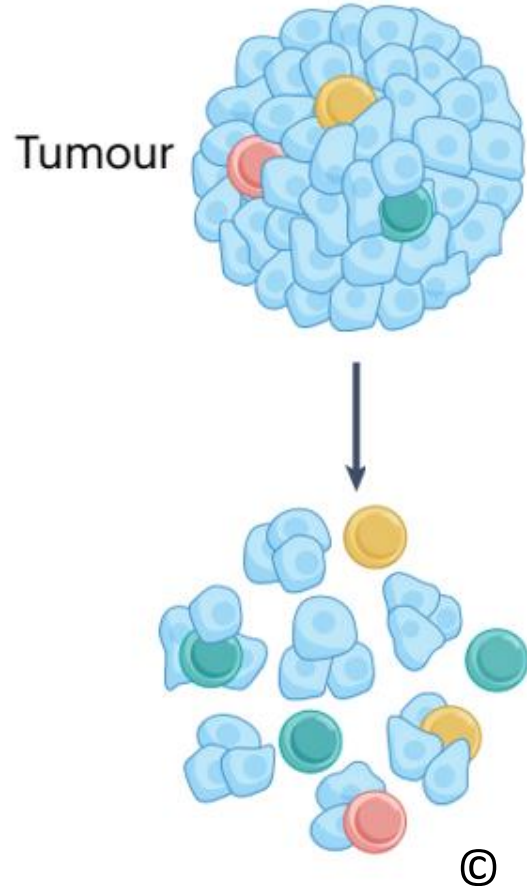
*“Correct, we want to cure the patient.”*

## Tumour-infiltrating lymphocyte therapy

1987: National Cancer Institute (NCI) in **Bethesda**, Maryland

# Tumour-infiltrating lymphocyte therapy

1987: National Cancer Institute (NCI) in Bethesda, Maryland



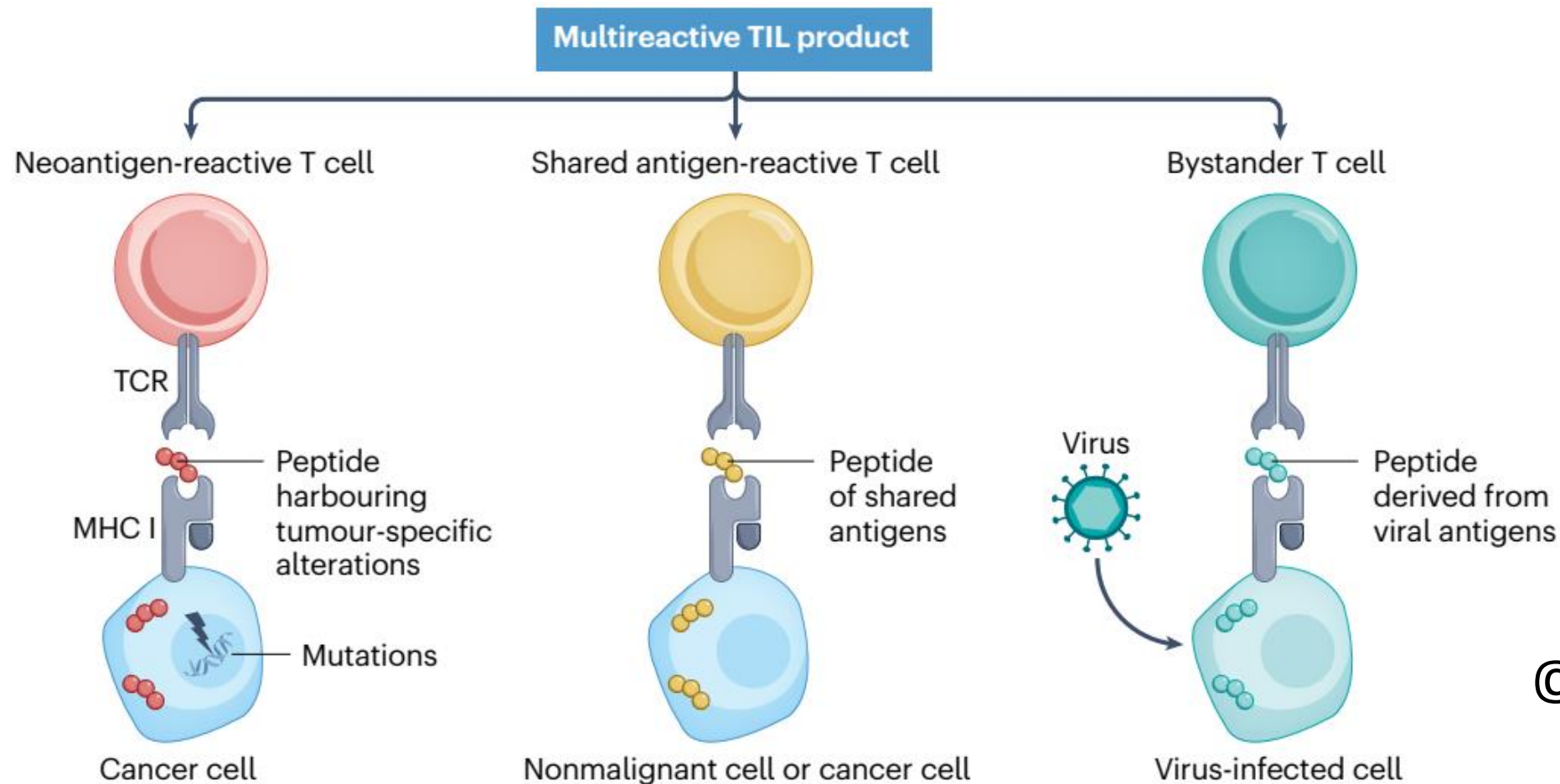
- 1.: Surgical removal of metastasis *minimum: 2 cm*
2. Tumour material: a) mechanically dissected into fragments of 1 mm<sup>3</sup>  
or  
b) enzymatically digested to single-cell suspensions
3. Material cultured for 2–4 weeks with IL-2 to initiate T cell growth.
4. Rapid expansion process (REP) in T cell population for 2-weeks
5. Final tumour-infiltrating lymphocyte (TIL) product

# Tumour-infiltrating lymphocyte therapy

## Tumour lymphocyte (TIL) *Multireactive T cells* :

T cells recognizing:

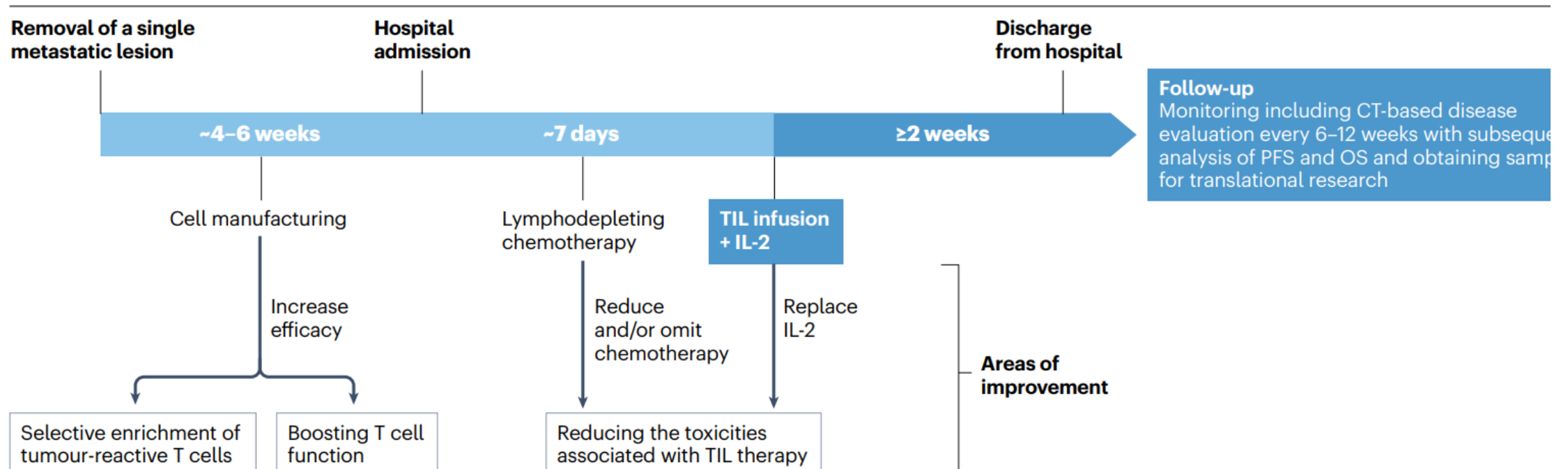
- a) cancer-specific neoantigens from mutations
- b) 'shared' antigens
- c) non-tumour-derived antigens (i.e. EBV, CMV)





# Tumour-infiltrating lymphocyte therapy

## Patient Journey:



# Tumour-infiltrating lymphocyte therapy

## Patient Journey:

- "Averse events occur in 100% of patients"\*
- Cause: high-dose IL-2 or NMA-LD chemotherapy\*
- All patients: grade 3–4 neutropenia\* *median duration of 7 days*
- Grade  $\geq 3$  anaemia, thrombocytopenia and febrile neutropenia in 32–82% of patients \*
- Grade 3–4 capillary leak syndrome due to IL-2 in 30%\*
- Skin hypopigmentation, uveitis (8%) and hearing impairment (4%)\*
- Fatal adverse events rare\*.

## Tumour-infiltrating lymphocyte therapy

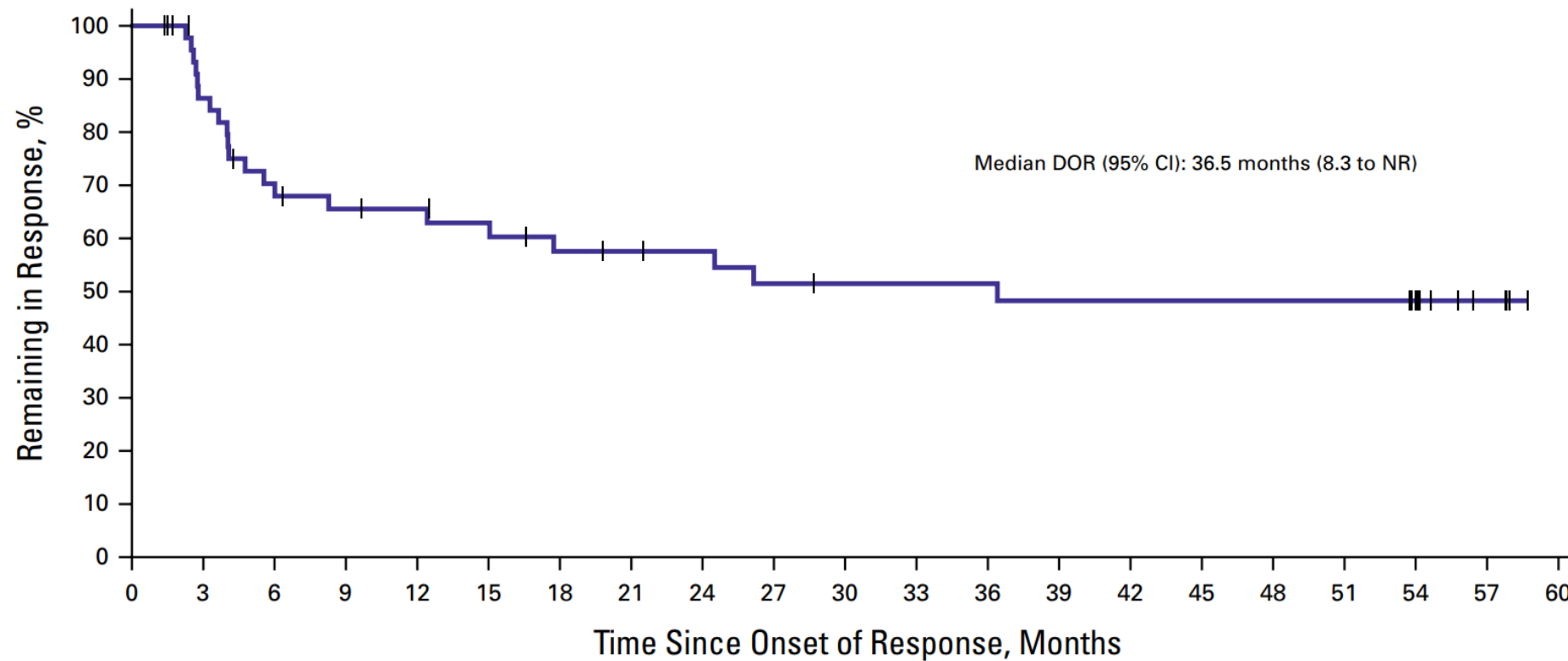
- The use of TILs exploded in the academic and [private](#) sectors\*.
- Lifileucel (*Amtagvi*®) will change the way solid tumors are treated\*.

\*Shoushtari AN et al Tumor-infiltrating Lymphocyte Therapy\*. Transplant Cell Ther 2025 ([LIEGT VOR](#))

# Tumour-infiltrating lymphocyte therapy

| Characteristic                         | Pooled Cohorts, 2 + 4<br>(N = 153) | All Responders<br>(n = 48) |
|----------------------------------------|------------------------------------|----------------------------|
| Median age (range), years              | 56 (20-79)                         | 55 (25-77)                 |
| Melanoma stage at study entry, No. (%) |                                    |                            |
| IIIC                                   | 10 (6.5)                           | 5 (10.4)                   |
| IV                                     | 143 (93.5)                         | 43 (89.6)                  |

# Tumour-infiltrating lymphocyte therapy



# Tumour-infiltrating lymphocyte therapy

Why do I talk about this:

Ethical, logistic and “supportive-therapy” challenges for Palliative Care?

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verywellmind

[Conditions A-Z](#) [Therapy](#) [Living Well](#) [Relationships](#) [Psychology](#) [Trending](#) [About Us](#)

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## 10 of the Most Famous Psychologists

Influential psychologist who shaped our ideas about the mind and behavior

verywellmind

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## 10 of the Most Famous Psychologists

Influential psychologist who shaped our ideas about the mind and behavior



Albert Bandura



## Self-efficacy

Influences a person's motivation and persistence when facing challenges

The belief in your own capability to succeed in a specific task or achieve a goal.



Albert Bandura

# Self-efficacy

Influences a person's motivation and persistence when facing challenges

The belief in your own capability to succeed ~~in a specific task or achieve a goal.~~

... to not give up ?

... to keepion going ?

... to endure the suffering ?

... to know, the breathlessness episode will go away?



Albert Bandura

## Locus of control and breathlessness: a cross-sectional analysis of 28 730 people

Max Olsson <sup>1</sup>, Jacob Sandberg <sup>1,2</sup>, Slavica Kochovska <sup>3</sup>, Anders Blomberg <sup>4</sup>, Mats Börjesson<sup>5,6</sup>,  
Gunnar Engström <sup>7</sup>, Andrei Malinovski <sup>8</sup>, Magnus Sköld<sup>9,10</sup>, Per Wollmer<sup>11</sup>, Kjell Torén<sup>12,13</sup>,  
Carl Johan Östgren<sup>14,15</sup>, David C. Currow<sup>3</sup> and Magnus Ekström <sup>1</sup>

## Locus of control *LOC*

### Internal LOC:

- Believe that one has control of his/her own life and life events.

### External LOC:

- Believe that life and life events are controlled mainly by external factors outside the individual's own reach, such as fate or being unlucky.

- Is related to worse coping with pain, increased healthcare use, worse asthma control and increased anxiety among COPD patients

LOC Domains: Questionnaire

|  |                                                          |
|--|----------------------------------------------------------|
|  |                                                          |
|  | my life is often determined by factors beyond my control |
|  |                                                          |
|  |                                                          |
|  |                                                          |
|  |                                                          |
|  |                                                          |

LOC Domains: Questionnaire

|                   |                                                                                                 |
|-------------------|-------------------------------------------------------------------------------------------------|
| Work              | At work, I feel that I have control over what happens in most situations                        |
| Life events       | I feel that what happens in my life is often determined by factors beyond my control            |
| Future            | Over the next 5–10 years I expect to have more positive than negative experiences               |
| Treated           | I often have the feeling that I am being treated unfairly                                       |
| Past changes      | In the past 10 years, my life has been full of changes without my knowing what will happen next |
| Life improvements | I gave up trying to make big improvements or changes in my life a long time ago                 |

**Locus of control** *LOC*  
**Cross-sectional cohort study**

Substudy of Swedish CARDioPulmonary bioImage Study (SCAPIS)

People aged 50–64 years

28 730 participants (52% women)

4% with breathlessness

Breathlessness measurement: mMRC breathlessness scale (0-4)

Cut-off: mMRC  $\geq 2$  :            “Breathlessness while walking on level ground with someone your own age  
or  
have to stop because of breathlessness while walking at own pace

**Results, all patients**

**mMRC breathlessness rating**

|                                                                                |             |
|--------------------------------------------------------------------------------|-------------|
| 0 (Breathless only with strenuous exercise)                                    | 26 014 (91) |
| 1 (Breathless when hurrying or walking up a slight hill)                       | 1507 (5)    |
| 2 (Breathless while walking with other people of your own age on level ground) | 947 (3)     |
| 3 (Need to stop for breath after 100 m)                                        | 125 (1)     |
| 4 (Too breathless to leave home or breathless when dressing)                   | 137 (1)     |



**Locus of control** *LOC*  
Cross-sectional cohort study

LOC Measurement:

Questionnaire above

Six statements on VRS (0-4)

Internal LOC: VRS 0-2, external LOC: VRS 3-4

Sum score:                      Max 20 points (work was not included)

Higher values indicate more external LOC

**Locus of control** *LOC*  
Cross-sectional cohort study

Known **confounders** were adjusted statistically:

- Age, sex, BMI, pack-years
- pack-years of smoking
- ratio of forced expiratory volume in 1 s and forced vital capacity (FEV1/FVC)
- Depression, level of education
- COPD, atrial fibrillation/ flutter, heart failure, emphysema, asthma

**Locus of control** *LOC*  
Cross-sectional cohort study

**Results, all patients**

|                               |            |    |             |                         |
|-------------------------------|------------|----|-------------|-------------------------|
| -mean BMI:                    | 26.9 ± 4.4 | vs | 31 ± 6.0    | for breathless patients |
| -mean FEV1/FVC:               | 0.78 ± 0.1 | vs | 0.76 ± 0.1  | for breathless patients |
| -chronic airflow limitation*: | 8          | vs | 18%         |                         |
| -mean pack-years:             | 7.5±12.0   |    |             |                         |
| -University degree            | 45%        |    |             |                         |
| -Pack years                   | 7.5 ± 11.9 | vs | 13.8 ± 17.3 |                         |

\*FEV1/FVC <0.70

Locus of control *LOC*  
Cross-sectional cohort study

|                                                     | All participants | Breathlessness (when walking on level ground or worse) |
|-----------------------------------------------------|------------------|--------------------------------------------------------|
| Experiencing a strong external locus of control by: |                  |                                                        |
| Work                                                | 15 681 (55)      | 392 (32)                                               |
| Life                                                | 5380 (19)        | 414 (34)                                               |
| Future                                              | 1631 (6)         | 163 (14)                                               |
| Treated                                             | 2249 (8)         | 245 (20)                                               |
| Past changes                                        | 6655 (23)        | 504 (42)                                               |
| Life improvements                                   | 1270 (4)         | 210 (17)                                               |
| Total external LOC score 0–20 <sup>¶</sup>          | 5.52±3.3         | 8.04±4.0                                               |

**Locus of control** *LOC*  
Cross-sectional cohort study

**Severity of breathlessness and locus of control**

Strong external LOC

Work

Life events

Future

Treated

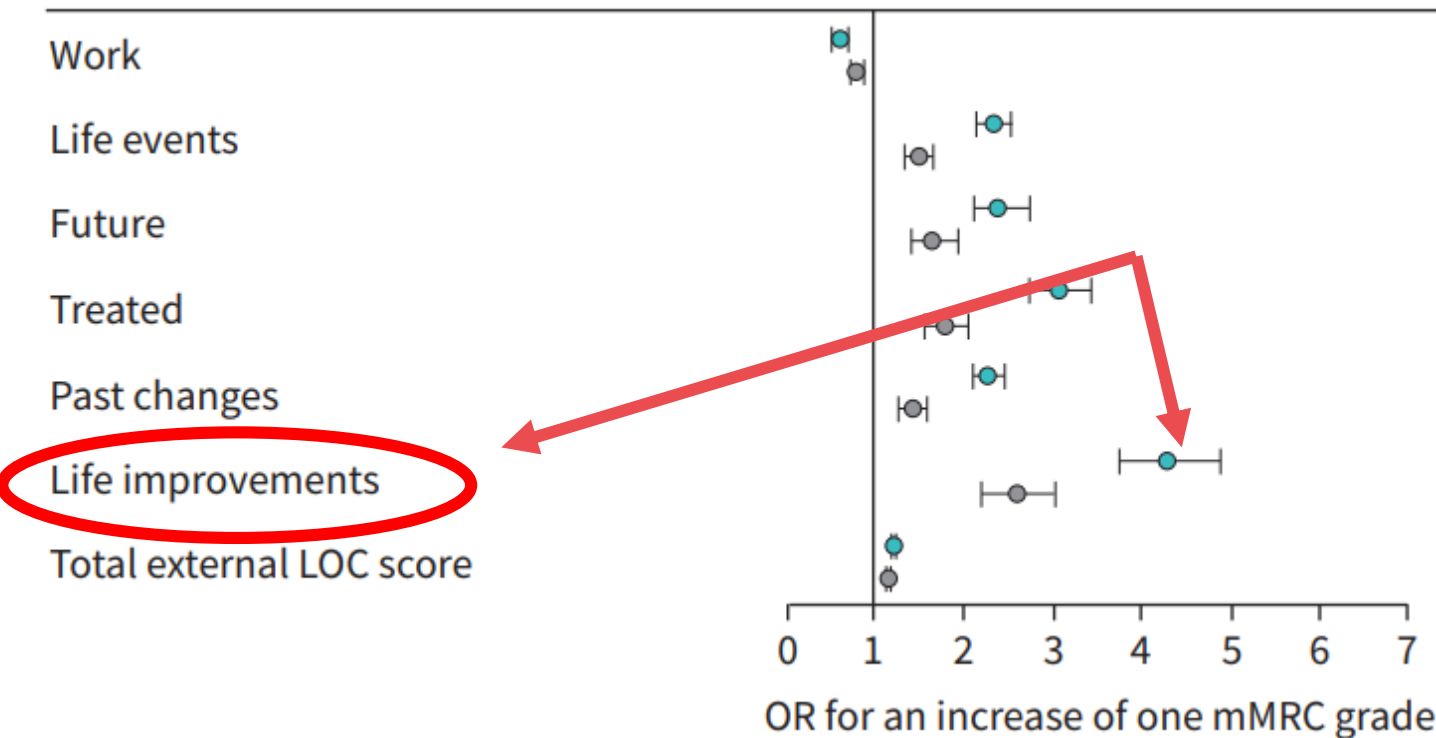
Past changes

Life improvements

Total external LOC score

OR for an increase of one mMRC grade

● Adjusted OR ● Unadjusted OR



**Locus of control** *LOC*  
Cross-sectional cohort study

**Severity of breathlessness and locus of control**



**Locus of control** *LOC*  
Cross-sectional cohort study

**Discussion:**

“the participants’ experiences of giving up improvements or changes in life were especially strongly associated with breathlessness.”

**Locus of control** *LOC*  
Cross-sectional cohort study

Discussion:

“the participants’ experiences of giving up improvements or changes in life were especially strongly associated with breathlessness.”

“Despite controlling for depression, we saw a strong relationship between external LOC and breathlessness, which means that the association is not confounded by depression. “



## **Locus of control** *LOC* **Cross-sectional cohort study**

### Discussion:

“the participants’ experiences of giving up improvements or changes in life were especially strongly associated with breathlessness.”

“Despite controlling for depression, we saw a strong relationship between external LOC and breathlessness, which means that the association is not confounded by depression. “

“In chronic pain, multidisciplinary services have been shown to increase the internal LOC. Thus, for breathlessness, this opens up possibilities breaking the vicious circle of deconditioning\* in chronic breathlessness”

\*and demoralisation...

**Locus of control** *LOC*  
Cross-sectional cohort study

Maybe this explains the positive effect of specialist Palliative Care  
In breathlessness patients *i.e. heart failure Gaertner et al BMJ 2017*



**Lidocain** *i.v./s.c*

Prophylaxis and treatment of neuropathic pain

????????? *i.v./s.c*

Prophylaxis and treatment of neuropathic pain

????????? *i.v./s.c*

Prophylaxis and treatment of neuropathic pain

Example: Reduced incidence of chronic [postsurgical\\*](#) neuropathic pain

Meta-analysis\*: 132 RCTs, 23 902 participants

????????? i.v./s.c

## Prophylaxis and treatment of neuropathic pain

### Example: Reduced incidence of chronic postsurgical\* neuropathic pain

Meta-analysis\*: 132 RCTs, 23 902 participants

- In order of efficacy:
1. ?????? *OR 0.32; 95% CrI 0.17-0.58*
  2. Ketamine *OR 0.64; 95% CrI 0.44-0.92*
  3. Gabapentinoids *OR 0.67; 95% CrI 0.47-0.92*
  4. Dexmedetomidine *OR 0.36; 95% CrI 0.12-1.00*

## Prophylaxis and treatment of neuropathic pain

### Example: Reduced incidence of chronic postsurgical\* neuropathic pain

Meta-analysis\*: 132 RCTs, 23 902 participants

|                       |                     |                                   |
|-----------------------|---------------------|-----------------------------------|
| In order of efficacy: | 1. <b>Lidocaine</b> | <i>OR 0.32; 95% CrI 0.17-0.58</i> |
|                       | 2. Ketamine         | <i>OR 0.64; 95% CrI 0.44-0.92</i> |
|                       | 3. Gabapentinoids   | <i>OR 0.67; 95% CrI 0.47-0.92</i> |
|                       | 4. Dexmedetomidine  | <i>OR 0.36; 95% CrI 0.12-1.00</i> |

# Lidocaine *i.v./s.c.* **Cancer Pain** Feasibility study



## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

N = 17

Completion rate 93%

88% completed 72 hours of study medication

Adverse events\* : infrequent  
generally mild  
nervous system, cardiac and vascular abnormalities  
no ECG abnormalities

\* Literally copied from abstract)

Attachment: Tremor, paresthesia, perioral numbness, ataxia

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

### Authors conclusion:

Clinical trial of continuous s.c. lidocaine infusion is feasible

Relative safety suggest higher lidocaine doses could be cautiously evaluated.

As the first prospective trial, it informs clinical use of s.c. lidocaine infused over days.

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

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Clinical trial of continuous s.c. lidocaine infusion is feasible

### What interested me:

Intervention: Dose and titration, duration of infusion....

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

### Authors conclusion:

Clinical trial of continuous s.c. lidocaine infusion is feasible

Relative safety suggest higher lidocaine doses could be cautiously evaluated.

**As the first prospective trial,** it informs clinical use of s.c. lidocaine infused over days.

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

### What interested me:

- Results, even though not adequately powered
- Intervention: Dose and titration, duration of infusion....

Outcome

Randomized:

Control

Pain

N=7

|                                                         |                     |
|---------------------------------------------------------|---------------------|
| Worst Pain, median (min, max)                           | -2.00 (-5.00, 2.00) |
| Average Pain, median (min, max)                         | -2.00 (-7.00, 1.00) |
| No. of breakthrough medications used, median (min, max) | 1.00 (-2.00, 2.00)  |

| Outcome                                                 | Randomized:<br>Lidocaine | Randomized:<br>Control |
|---------------------------------------------------------|--------------------------|------------------------|
| Pain                                                    | N=10                     | N=7                    |
| Worst Pain, median (min, max)                           | -1.00 (-3.00, 1.00)      | -2.00 (-5.00, 2.00)    |
| Average Pain, median (min, max)                         | 0.00 (-3.00, 3.00)       | -2.00 (-7.00, 1.00)    |
| No. of breakthrough medications used, median (min, max) | 1.00 (-5.00, 5.00)       | 1.00 (-2.00, 2.00)     |



| Outcome                                                 | Randomized:<br>Lidocaine | Randomized:<br>Control |
|---------------------------------------------------------|--------------------------|------------------------|
| Number of participants with improvement of<br>≥1 point: | N=9                      | N=7                    |
| Burning (superficial) spontaneous pain on NPSI<br>(%)   | 3 (33%)                  | 4 (57%)                |
| Pressing (deep) spontaneous pain on NPSI (%)            | 2 (22%)                  | 4 (57%)                |
| Paroxysmal pain on NPSI (%)                             | 4 (44%)                  | 5 (71%)                |
| Evoked pain on NPSI (%)                                 | 2 (22%)                  | 4 (57%)                |
| Paresthesia/Dysesthesia on NPSI (%)                     | 3 (33%)                  | 4 (57%)                |

| Outcome                                                            | Randomized:<br>Lidocaine | Randomized:<br>Control |
|--------------------------------------------------------------------|--------------------------|------------------------|
| <b>Neuropathic Pain Symptom Inventory</b>                          | <b>N=9</b>               | <b>N=7</b>             |
| Total Intensity on Neuropathic Pain Symptom Inventory (out of 100) | 2.00 (-17.00, 62.00)     | -27.00 (-41.00, -1.00) |
| Burning (Superficial Spontaneous) Pain                             | 0.00 (-9.00, 2.00)       | -2.00 (-9.00, 6.00)    |
| Pressing (Deep Spontaneous) Pain                                   | 0.00 (-5.00, 2.50)       | -3.00 (-6.50, 0.00)    |
| Paroxysmal Pain                                                    | -0.50 (-8.00, 0.50)      | -1.00 (-10.00, 0.00)   |
| Evoked Pain                                                        | 1.17 (-3.33, 6.33)       | -1.33 (-3.67, 1.67)    |

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

**Outcome**

**Randomized:  
Lidocaine**

**Randomized:  
Control**

**An so on.... No difference...**

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

### Intervention:

Lidocaine 10%, 30 mL: 3000mg  
Dilution: NaCl 0.9%  
Continuous s.c. infusion titrated daily for 72 hours.  
Starting Dose: 1mg/kg/h  
Increase: 2mg/kg/h  
Max: 120mg/h (2800mg/rounded down)

## Lidocaine *i.v./s.c.* Cancer Pain Feasibility study

### Intervention:

Lidocaine 10%, 30 mL: 3000mg

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Increase: 2mg/kg/h

**Max: 120mg/h** (2800mg/rounded down)

## Lidocaine i.v./s.c.: Cancer Pain Feasibility study

Would you dare ? ;)

Lidocaine i.v./s.c.: **Pruritus**

Randomized Controlled Trial > Int J Obstet Anesth. 2026 Feb;65:104826.

doi: 10.1016/j.ijoa.2025.104826. Epub 2025 Dec 2.

# Intravenous lidocaine infusion reduces intrathecal opioid-induced pruritus after cesarean delivery: a randomized controlled trial and proof-of-concept

Ayman Mohamady Eldemrdash <sup>1</sup>, Mohamed A Alazhary <sup>2</sup>, Soudy S Hammad <sup>2</sup>, Tarek S Hemaida <sup>2</sup>,  
Ahmed Mohamed Reda Ragheb <sup>2</sup>, Gamal Hendawy Shams <sup>2</sup>, Taha Tairy Dardeer <sup>2</sup>,  
Zaher Zaki Zaher <sup>2</sup>

.....

## Lidocaine i.v./s.c.: Pruritus

|                       |                                                                                       |
|-----------------------|---------------------------------------------------------------------------------------|
| <b>Study:</b>         | Double-blind randomized                                                               |
| <b>Patients:</b>      | 136 women, cesarean delivery spinal anesthesia intrathecal morphine 150 µg            |
| <b>Intervention:</b>  | Lidocaine i.v. bolus 1.5 mg/kg followed by infusion 1.5 mg/kg/h for 6 h<br>vs placebo |
| <b>Prim. outcome:</b> | Incidence of pruritus within 24 h.                                                    |
| <b>Sec. outcomes:</b> | Pruritus severity over time, rescue nalbuphine use, and adverse events.               |



## Lidocaine i.v./s.c.: Pruritus

**Pruritus incidence:** Lidocaine 36.2% vs 73.1% placebo *risk reduction 36.9%, 95% CI 21.4, 52.4*

**Number needed to treat:** 3 95% CI 2- 5.

No symptoms of lidocaine toxicity or increased adverse events

## Pruritus

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®



## **Aprepitant** *Emend*<sup>®</sup>

Antagonist to Substance P

NK-1 Receptor

## **Aprepitant** *Emend*<sup>®</sup>

Antagonist to Substance P

NK-1 Receptor

## Aprepitant for Pruritus

- Pruritus (itch) from epidermolysis bullosa EB or atopic dermatitis AD
- Retrospective record review
- 37 patients, 17 female: EB 24 or AD 13 patients
- Age 10 months to 37 years *pediatrics?*
- Aprepitant dosing as in chemotherapy nausea prophylaxis: 3 mg/kg up to 125mg (d1), 2 mg/kg up to 80mg (day 2,3),  
frequency: monthly to biweekly.
-

## Aprepitant for Pruritus

**Epidermolysis bullosa :** 58% reported improvement

**Atopic dermatis:** 85% noted improvement pruritus

**Adverse effects:** in 8%

Increase in pruritus

Appetite suppression

Insomnia

## Aprepitant for Pruritus

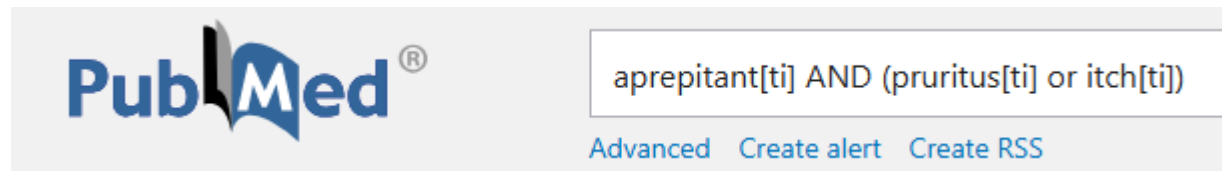
**Epidermolysis bullosa :** 58% reported improvement  
increasing efficacy in older ages  
ineffective in patients younger than 2 years

**Atopic dermatis:** 85% noted improvement pruritus  
regardless of age

**Adverse effects:** in 8%  
Increase in pruritus  
Appetite suppression  
Insomnia

## Aprepitant for Pruritus

- Pruritus (itch) from epidermolysis bullosa EB or atopic dermatitis AD
- 37 patients: EB 24 or AD 13 patients
- Aged 10 months to 37 years *pediatrics?*





# Constipation

## Opioid-Induced Constipation *OIC*

## Opioid-Induced Constipation *OIC*



## Opioid-Induced Constipation *OIC*



## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

**Does Targin® hold it`s promise ?**



## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

### Patients:

Cancer pain  $\geq$  NRS 4

Exclusion: cirrhosis, portal hypertension

### Intervention:

Oxycodone / Naloxone ret

### Comparator:

Oxycodone ret.

### Outcome:

prim: Pain NRS

sec.: Constipation:

Bowel Function Index\* *BFI*

0 - 100

High scores: more constipation

MCID: 12

\*one of few constipation tools assessing PROMs, not only “counts”

\*Gaertner J et al J Clin Gastroenterol 2015

## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

Definition of “one laxative dose” *nota bene:*

50 mg docusate/8 mg sennoside tablet

1 macrogol sachet

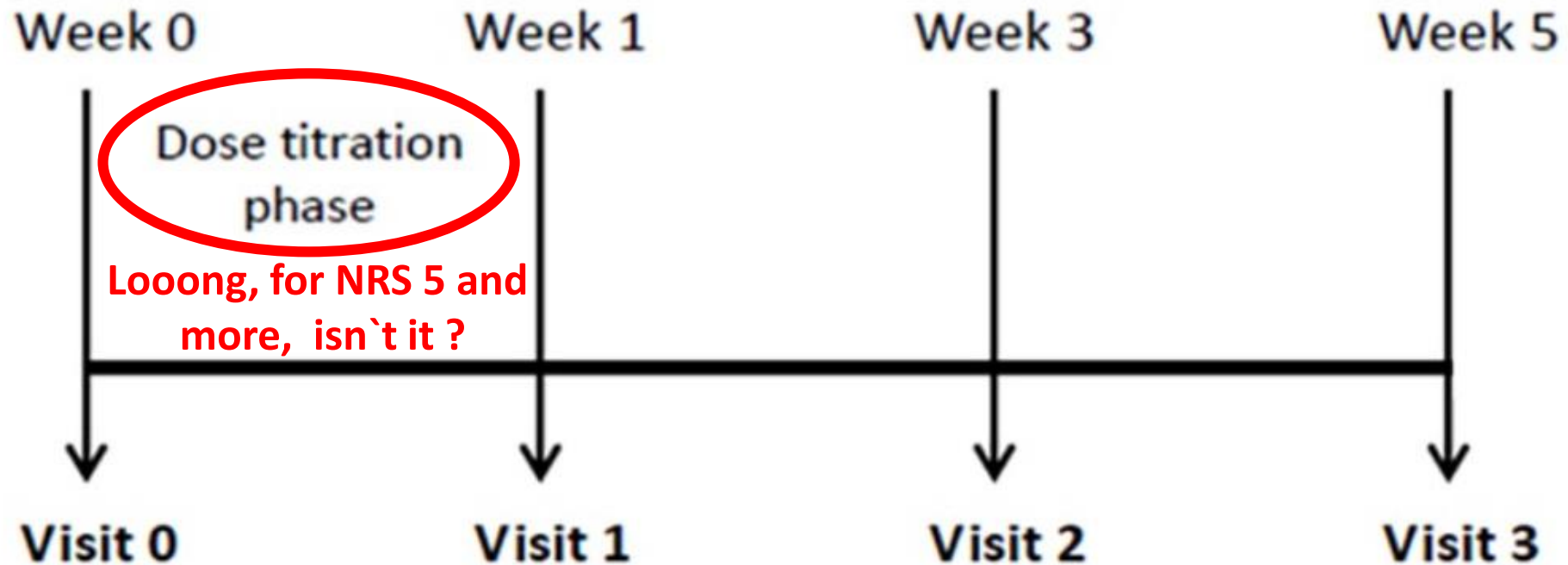
20 ml lactulose

20 ml agarol *paragol...*

1 suppository or enema.

\*Gaertner J et al J Clin Gastroenterol 2015

## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*





# Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

**Table 1.** Baseline demographics: Mean (SD) or *n* (%).

| Item                                                         | OXN PR             | Oxy PR      |
|--------------------------------------------------------------|--------------------|-------------|
| Australian <u>Karnofsky</u> performance score (mean, 95% CI) | <u>60 (50; 70)</u> | 65 (60; 70) |
| Time since metastatic diagnosis (years)                      | 2.0 (2.6)          | 1.1 (1.5)   |

## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

### Constipation

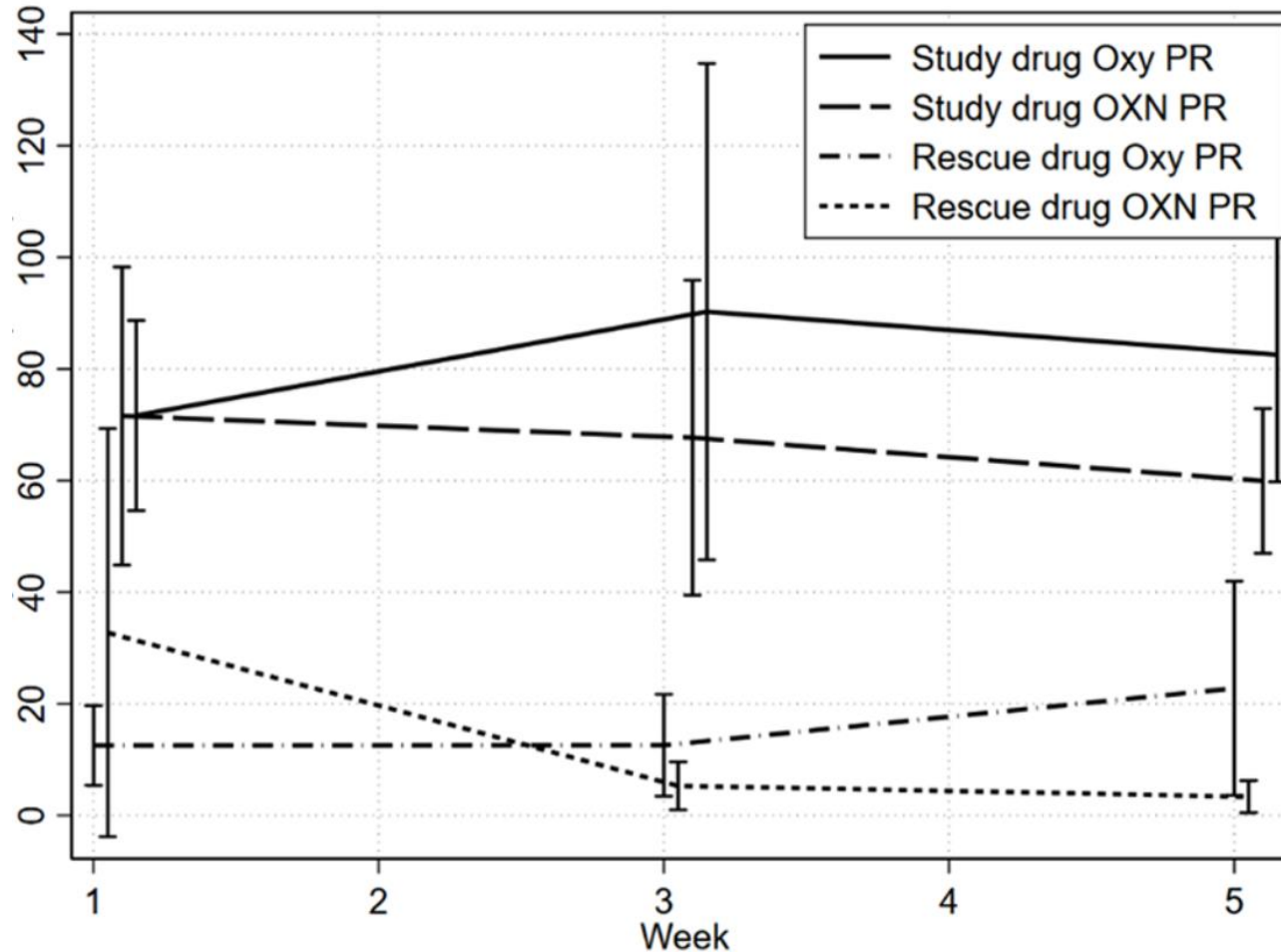
Oxy-Naloxone at week 5: Less constipation:

BFI: **7.6** vs **32.5** 95% CI: -9.6; 24.8 vs 17.8; 47.1

Mean difference: 24.87 95% CI 47.54; 2.21  $p = 0.03$  MCID: 12....

# Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

Daily oral morphine dose equivalent



## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

### Pain: Surprise, Surprise !

Average pain at 5 weeks lower for Oxy-Naloxon: 2.6 vs 4.1 95% CI: 1.2- 4.0 vs 2.9-5.3

Mean difference over the entire study period better for Oxy-Naloxon: -2.37 -6.19; 1.45

Worst pain, least pain, pain now at week 5: Also lower for Oxy-Naloxon

At each timepoints, average pain scores were lower for Oxy-Naloxon

## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

### Authors:

*The results of (i) lower pain scores and (ii) lower study drug dose and rescue drug doses was unexpected.*

*We are unable to explain this finding.*

*It is possible that with a larger sample size, a greater variation of participants may have been observed and this effect may potentially be diluted*

## Oxycodone / Naloxone vs Oxycodone ret. *ENhANCE trial*

**Me:** I use Oxy-Naloxone only in rare exceptions.

Am I ignorant ?

# **Methadone In addition To other opioids**

# Methadone as add-on

## Inclusion criteria

---

- > adults with advanced cancer
- > cancer pain
- > NRS  $\geq 4$
- > „adequate dose titration of opioids“
- > Morphine oral equivalent: 60 mg/d or more

## Exclusion *examples*

---

- > ongoing radiotherapy
- > 1<sup>st</sup> line chemotherapie startet within 7 days around inclusion
- > QTc- elongation *man* >470 ms, *women* >480 ms
- > contraindication for methadone



# Methadone as add-on

## Inclusion criteria

---

- > adults with advanced cancer
- > cancer pain
- > NRS  $\geq 4$
- > „adequate dose titration of opioids“
- > Morphine oral equivalent: 60 mg/d or more

## Exclusion *examples*

---

- > ongoing radiotherapy
- > 1<sup>st</sup> line chemotherapie startet within 7 days around inclusion
- > QTc- elongation *man* >470 ms, *women* >480 ms **Do you agree?**
- > contraindication for methadone **which ?**

## Methadone as add-on

### Treatment

---

- > Methadone 5mg/d p.o.
- > Methadone 10mg if oral morphine equivalent >120
- > In case of sleepyness Reduction of 20mg morphine equivalent per 5 mg methadone
- > After 7 days:
  - > In case of pain increase methadone

19 Patients

---

- > N: 19
- > Median survival 66 days 5mg: 12 patents
- > Initial methadone dose 10mg: 7 patients
  
- > Co-medication:

|                  |             |
|------------------|-------------|
| NSAID            | 13 (68.4%), |
| Paracetamol      | 8 (42.1%),  |
| Antikonvulsants: | 8 (42.1%)   |
| Steroids         | 2 (20.5%)   |
  
- > Methadone after 15 days:

|          |   |
|----------|---|
| - 5 mg:  | 4 |
| - 10 mg: | 6 |
| - 15 mg: | 1 |
| - 20 mg: | 3 |

### Pain reduction day 15

---

- > Reduction of  $\geq 33\%$  NRS: 13 (68.4%)
- > Mean reduction: 2.6 NRS
- > Reduction „worst pain“ 2.5 NRS

## Methadone as add-on

### Side effects

---

|                  |       |
|------------------|-------|
| > Nausea         | 26.3% |
| > Vomiting       | 26.3% |
| > Constipation   | 5.3%  |
| > Somnolence     | 26.3% |
| > QTc-Elongation | 10.5% |

Palliative Care assessment goes smart:  
Opioid induced constipation



## Biosensors and Bioelectronics: X

Volume 27, December 2025, 100699



# Smart underwear: A novel wearable for long-term monitoring of gut microbial gas production via flatus

Santiago Botasini <sup>a</sup>, David Zhan <sup>a</sup>, Norman Fischer <sup>a</sup>, Charlotte T. Ravel <sup>a</sup>, Ashley Tien <sup>a</sup>,  
Maggie R. Grant <sup>a</sup>, Glory Minabou Ndjite <sup>a</sup>, Ty Sopko <sup>b</sup>, Holly Childs <sup>c</sup>, Maryann Greenfield <sup>c</sup>,  
Christina X. Qian <sup>a</sup>, Kara E. Gardiner <sup>a</sup>, Nayantara M. Anders <sup>a</sup>, Tasnim F. Ullah <sup>a</sup>,  
Leah T. Redmond <sup>a</sup>, Delaina A. Callaway <sup>a</sup>, Eliya M. Behailu <sup>a</sup>, Grace M. Sarkar <sup>a</sup>, Nakati C. Sany <sup>a</sup>,  
Margaret Slavin <sup>c</sup>...Brantley Hall <sup>a d \*</sup> 

Show more 

## Palliative Care assessment goes smart: Opioid induced constipation

- Smart underwear sensor
- Patient reported outcomes are not objective**
- Aim: **„Human Flatus Atlas“**





Anything  
interesting  
since last  
summer school





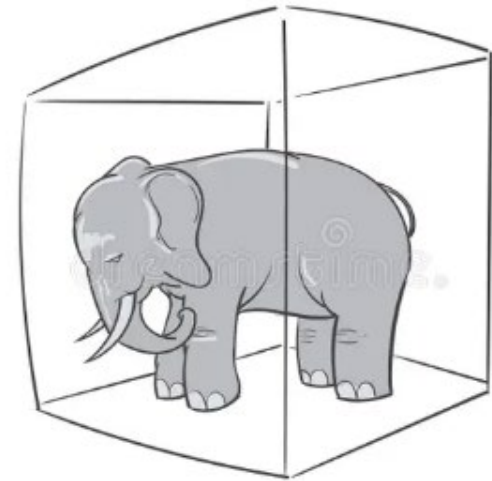
# Überschrift





# CACHEXIA UPDATE

**Prof. David Blum MD PhD**



# Cachexia

- A devastating syndrome characterized by anorexia, reduced nutritional intake, and systemic inflammation
- It leads to impaired function, worsened treatment response, poor quality of life, and shortened survival
- Overlap with other syndromes like malnutrition, sarcopenia, frailty, and asthenia...

No single cause, no single agent treatment

# Still defined by weight loss...

- Weight loss is a predominant marker of cachexia
- Not cancer specific
- Prevalence in various cancer types
- Regularly record body weight assess symptoms, appetite and intake

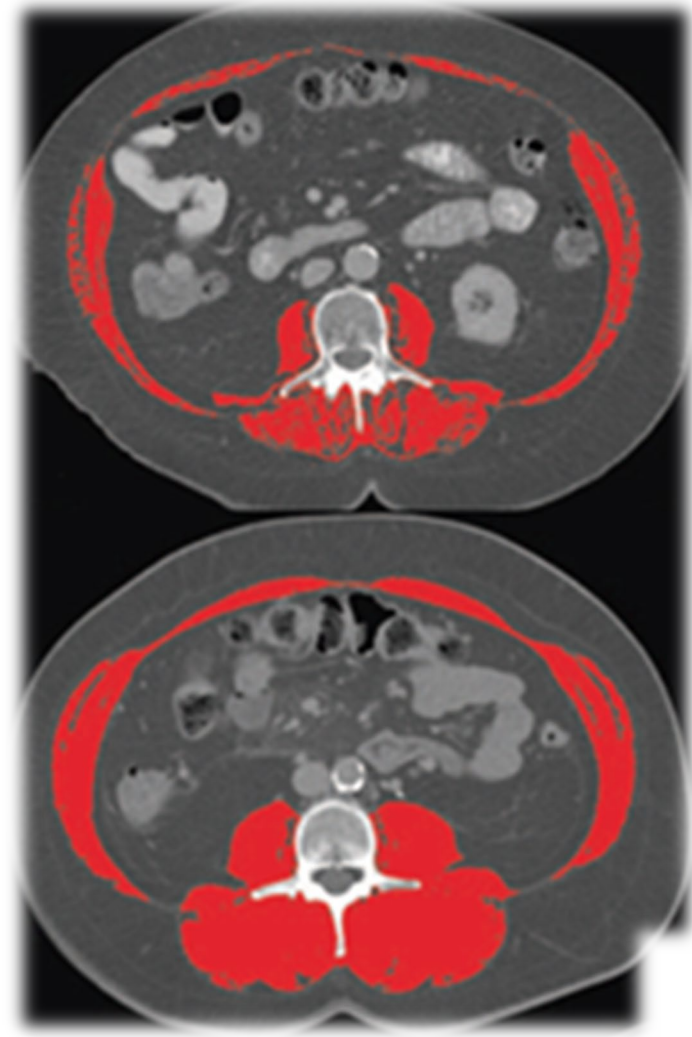


Urrizola A, Dajani O, Aass N, et al Nutrition impact symptom monitoring and weight loss outcomes: a longitudinal Radiotherapy study BMJ Supportive & Palliative Care 2025;15:522-525.

but caused by muscle loss

## Sarcopenia in Cachexia

- Methods for early identification, including CT scans

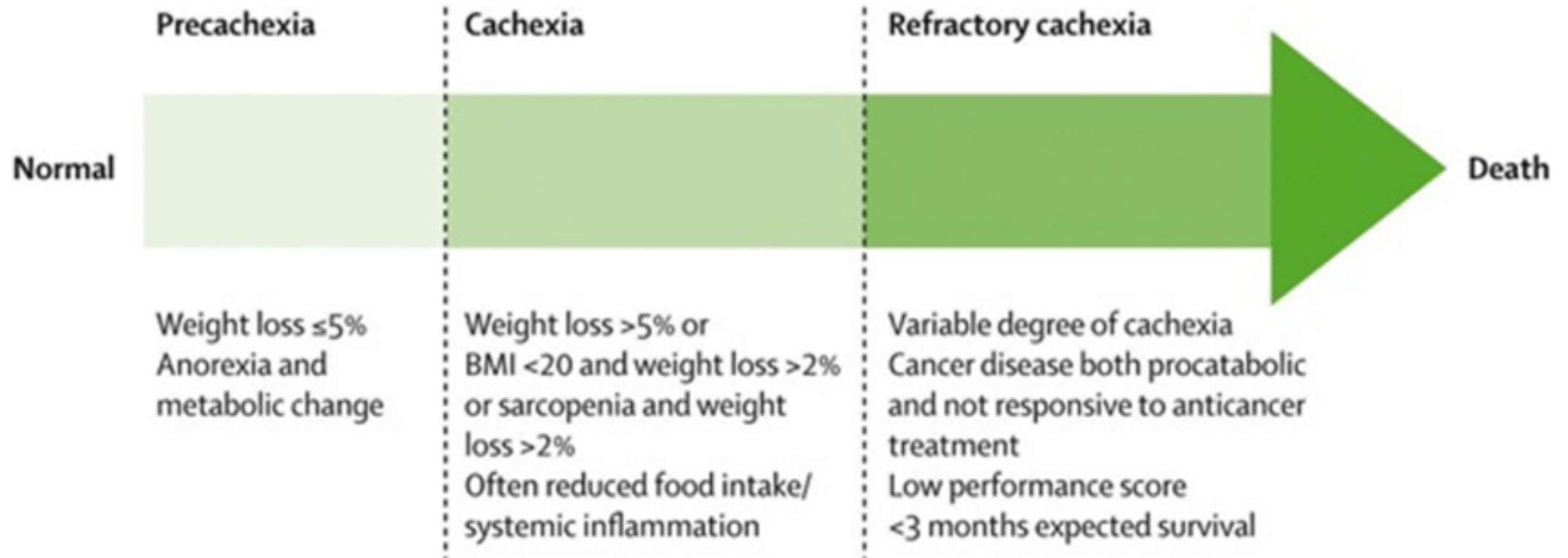


# Functional & Inflammatory Status

- Tools:
  - Karnofsky, ECOG-PS
  - mGPS (modified Glasgow Prognostic Score)
- Inflammation is a central driver in cachexia



# Cachexia Stages





# Proactive symptom management

- Starting interventions early in high-risk groups
- **Screen, Assess and Treat Nutritional Impact Symptoms NIS**
- Goal to maintain or gain muscle mass and quality of life



# Nutritional Impact Symptoms (NIS)

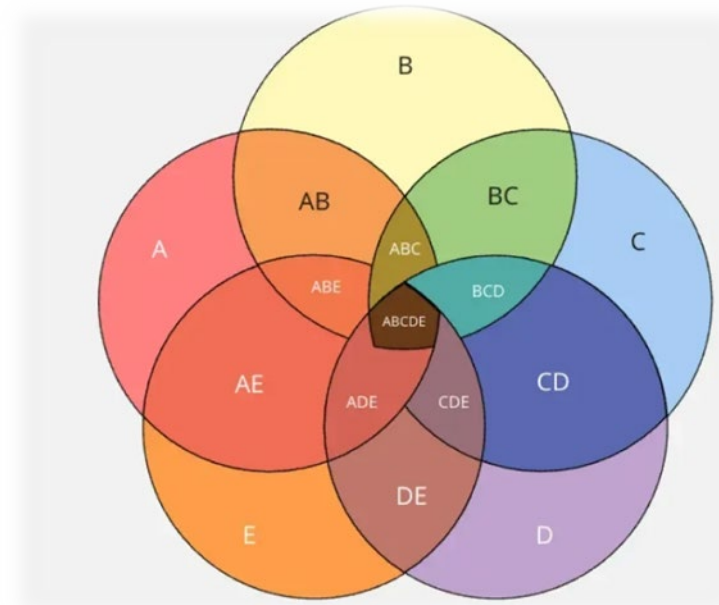
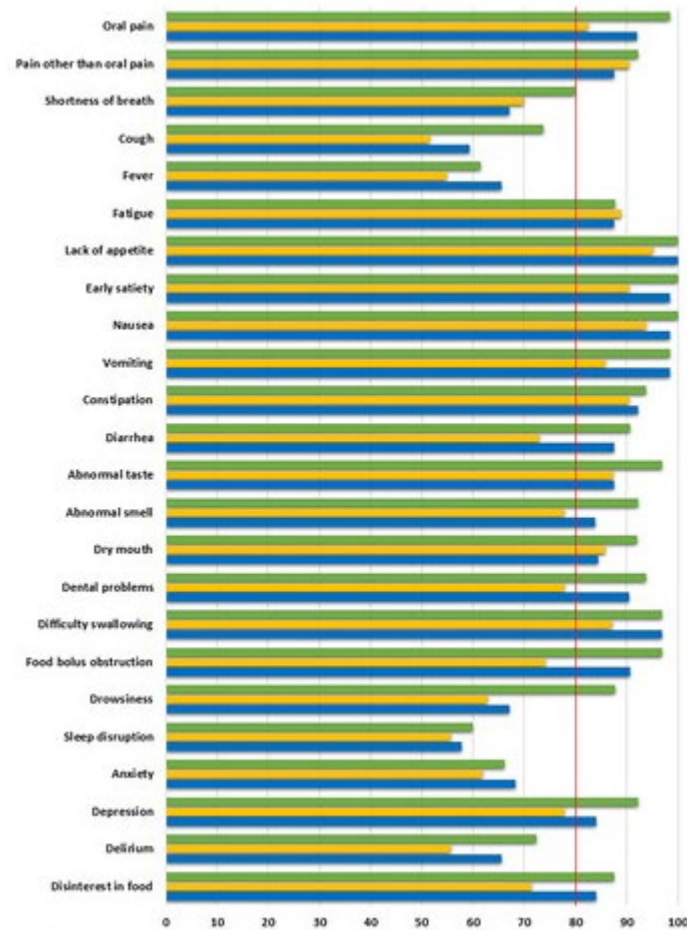
- Highly prevalent and encompass a broad spectrum of manifestations:
- **Eating-related** symptoms such as anorexia or xerostomia
- **Gastrointestinal** disturbances such as nausea and constipation
- **General** symptoms including pain, fatigue, or depression...
- Disease and treatment related

Omlin A, Blum D, Wierecky J, Haile SR, Ottery FD, Strasser F.  
Nutrition impact symptoms in advanced cancer patients:  
frequency and specific interventions, a case-control study. J  
Cachexia Sarcopenia Muscle. 2013 Mar;4(1):55-61

# Assessment, now digital

|                           | Risk assessment |           |     | Advanced assessment |      | MyPath NCP assessment |                           |
|---------------------------|-----------------|-----------|-----|---------------------|------|-----------------------|---------------------------|
|                           | ESPEN-screening | PG-SGA SF | MST | ESPEN-assessment    | GLIM | PROMs                 | EHR/clinical consultation |
| Food intake               | ✓               | ✓         | ✓   | ✓                   | ✓    | ✓                     | ✓                         |
| Weight, height, BMI       | ✓               | ✓         |     |                     | ✓    | ✓                     |                           |
| Weight change             | ✓               | ✓         | ✓   |                     | ✓    | ✓                     |                           |
| Nutrition impact symptoms |                 | ✓         |     | ✓                   |      | ✓                     | ✓                         |
| Muscle mass               |                 |           |     | ✓                   | ✓    |                       | (✓)                       |
| Performance status (ECOG) |                 | ✓         |     | ✓                   |      | ✓                     | ✓                         |
| Inflammation              |                 |           |     | ✓                   | ✓    |                       | ✓                         |

- A major challenge lies in the frequent coexistence of multiple NIS, which can cumulatively lead to a profound reduction in nutritional intake



Amano, K., Dev, R., Naito, T., & Del Fabbro, E. (2025). International Survey on Consensus Definition on Nutrition Impact Symptoms in Patients with Cancer. *Nutrition and Cancer*, 77(2), 210–220.

# ESPEN Guidelines 1

- Antiemetics to relieve nausea
- Antimicrobials to eliminate fungal, bacterial, or viral causes of gastrointestinal or other infections
- Analgesics to relieve chronic pain or pain associated with chewing, swallowing, or intestinal activity
- Agents to induce saliva production in xerostomia

# ESPEN Guidelines 2

- Anti-secretory agents to diminish excessive saliva production or vomiting in cases of impaired intestinal transport
- Inhibitors of gastric acid secretion and other substances to treat or protect against symptomatic mucosal lesions or oesophageal reflux
- Agents to maintain or normalize intestinal motility and to treat or avoid constipation or diarrhoea
- Antidepressants, agents that relieve anxiety, mood modulators

# Anorexia Therapy



# ASCO-Update

- **Updated Recommendations**
- *Note:* There are currently no FDA-approved medications to treat cancer cachexia.
- **Recommendation 2.1**
- For adults with advanced cancer, clinicians may offer low-dose olanzapine once daily to improve weight gain and appetite (Type: Evidence based; Evidence quality: Intermediate; Strength of recommendation: Moderate).



## ACUTE Nausea and Vomiting: SUMMARY

| EMETIC RISK GROUP                                              | ANTIEMETICS            |                     |     |                                                                                                                                                                      |                          |
|----------------------------------------------------------------|------------------------|---------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| High Non-AC                                                    | 5-HT <sub>3</sub>      | +                   | DEX | +                                                                                                                                                                    | NK <sub>1</sub> +/- OLZ* |
| High AC                                                        | 5-HT <sub>3</sub>      | +                   | DEX | +                                                                                                                                                                    | NK <sub>1</sub> +/- OLZ* |
| Carboplatin                                                    | 5-HT <sub>3</sub>      | +                   | DEX | +                                                                                                                                                                    | NK <sub>1</sub>          |
| Moderate (other than carboplatin)                              | 5-HT <sub>3</sub>      | +                   | DEX |                                                                                                                                                                      |                          |
| Low                                                            | 5-HT <sub>3</sub>      | or                  | DEX | or                                                                                                                                                                   | DOP                      |
| Minimal                                                        | No routine prophylaxis |                     |     |                                                                                                                                                                      |                          |
| 5-HT <sub>3</sub> = serotonin <sub>3</sub> receptor antagonist |                        | DEX = DEXAMETHASONE |     | NK <sub>1</sub> = neurokinin <sub>1</sub> receptor antagonist such as APREPITANT or FOSAPREPITANT or ROLAPITANT or NEPA (combination of netupitant and palonosetron) |                          |
|                                                                |                        |                     |     | OLZ = OLANZAPINE                                                                                                                                                     |                          |
|                                                                |                        |                     |     | DOP = dopamine receptor antagonist                                                                                                                                   |                          |

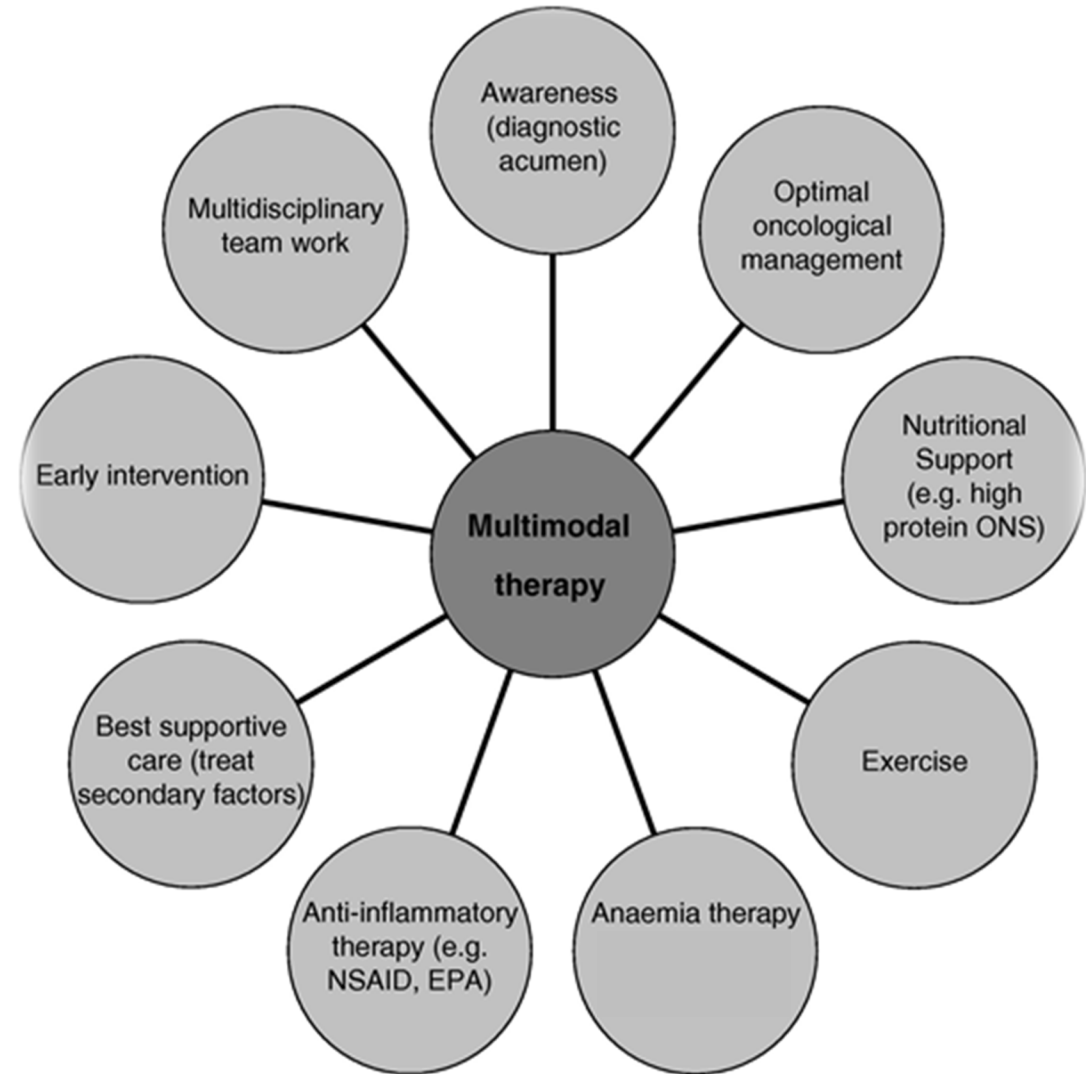
**NOTE:** If the NK<sub>1</sub> receptor antagonist is not available for AC chemotherapy, palonosetron is the preferred 5-HT<sub>3</sub> receptor antagonist.

\* **OLZ:** Olanzapine may be added particularly if nausea is a concern.

# Multimodal Therapy

Ken Fearon;

No simple solution:  
It needs work...

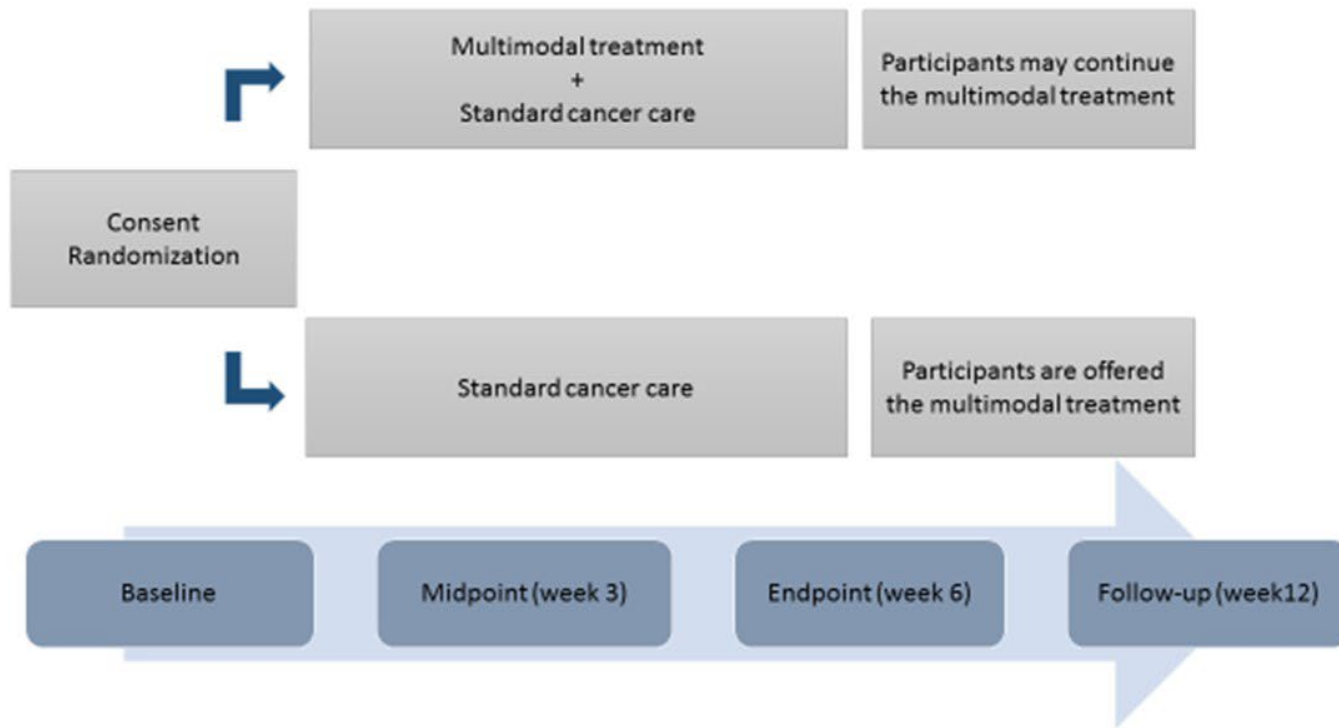


# MENAC - Multimodal, Exercise, Nutrition & Anti-inflammatories for Cachexia

An international, randomised, open-label trial in people with lung or pancreatic cancer

**Tora S. Solheim, Barry J A Laird and Trude R. Balstad,**  
Guro Stene, Vickie Baracos, Asta Bye, Olav Dajani, Andrew Hendifar,  
Florian Strasser, Martin Chasen, Matthew Maddocks, Melanie R. Simpson, Eva Skovlund, Garrett Griffiths,  
Jonathan Hicks, Janet Graham, Fiona Kyle, Joanna Bowden  
Marie Fallon and Stein Kaasa  
(on behalf of the MENAC trial consortium)

# DESIGN



**The primary objective of the MENAC trial was to prevent the development of cachexia and/or to attenuate cachexia progression in high risk patients**

## Primary outcome:

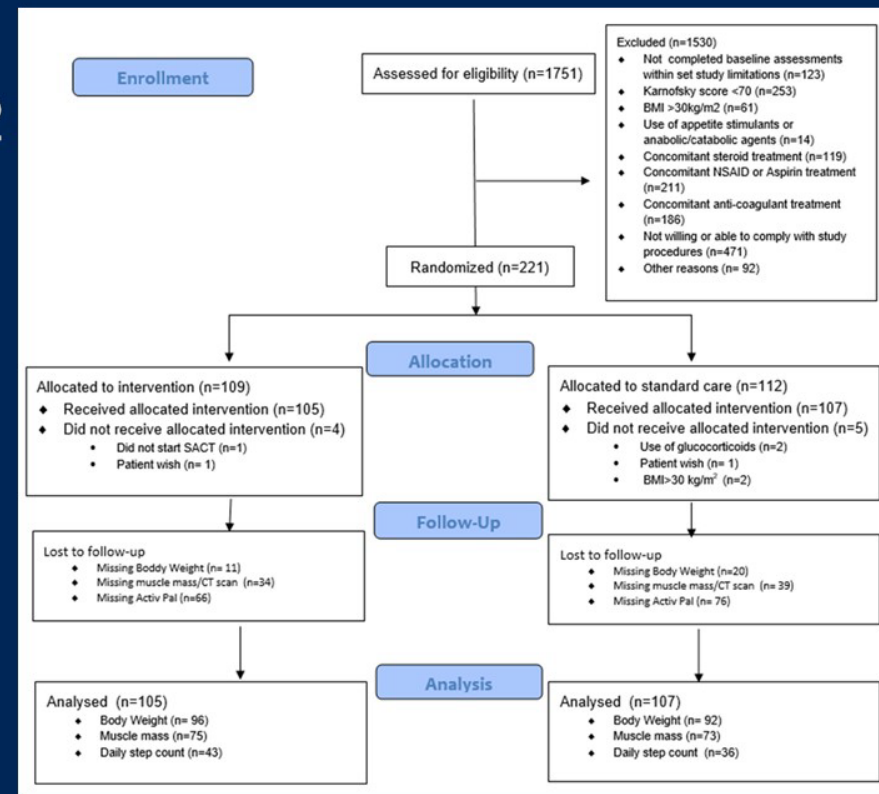
Difference in weight change as it is a key defining factor of cachexia, and is meaningful for both patients and clinicians

## Secondary outcomes:

Difference in muscle mass assessed by CT scans, and physical activity assessed with ActivPal (average daily step)

# RESULTS (1)

- Recruitment from May 2015 to February 2022
  - Randomized:
    - 105 intervention, 107 standard care
  - Lost to follow up:
    - 11 intervention, 20 standard care
  - Analyzed for primary endpoint
    - 96 intervention, 92 standard care

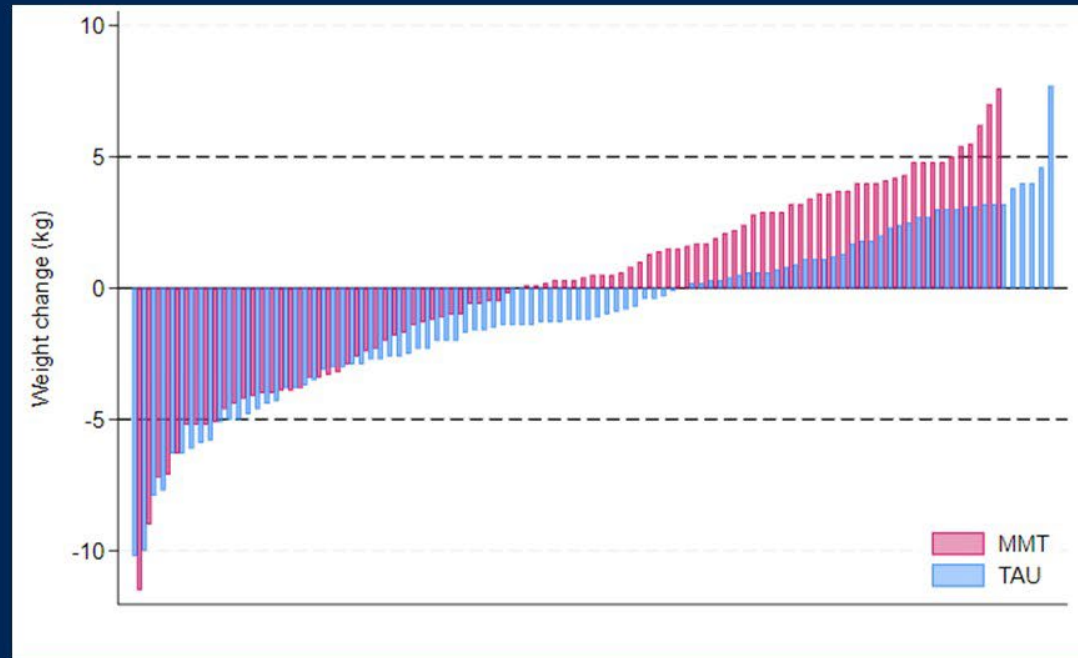




## RESULTS (3)

- Primary endpoint:
  - Mean weight change [SD] 0.05 kg [3.8] MMT vs - 0.99 kg [3.2] control
    - mean difference in weight change between arms of -1.04kg, 95 % CI -2.02 to -0.06, p=0.04
- Secondary endpoints:
  - No difference in
    - muscle mass (mean change [SD] -6.5cm<sup>2</sup> [10.1] MMT vs -6.3cm<sup>2</sup> [11.9] control, p=0.93)
    - mean step counts [SD] (-377.7 [2075] MMT vs -458 [1858] control, p=0.89)
  - There were 28 and 24 reported SAEs in the intervention and control arm respectively, no SUSARs were reported

# RESULTS (4)



# Novel agents

- Ghrelin receptor agonists
  - Selective Androgen Receptor Modulators (SARMs)
  - Myostatin antagonists
  - Espindolol
- 
- Improvement of weight
  - Muscle mass and symptom burden
  - No improvement of muscle power





**TABLE 1.** Targeted Therapeutic Trials in Cancer Cachexia

| Therapeutic Target Area and Mechanism of Action | Compound/Route of Administration | Phase and Design                                    | N   | Population                                                                             | Primary/Secondary Outcomes <sup>a</sup>                                                                                                                                                                                                                                                                                                                                              | Study Start and Completion Dates <sup>b</sup>                                                            | Results                                                | Clinical Trial No. |                                                  |                                                         |                                |                        |                |
|-------------------------------------------------|----------------------------------|-----------------------------------------------------|-----|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------|--------------------------------------------------|---------------------------------------------------------|--------------------------------|------------------------|----------------|
| CNS—appetite/satiety/ hypothalamic inflammation |                                  |                                                     |     |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                          |                                                        |                    |                                                  |                                                         |                                |                        |                |
| Melanocortin type 4 receptor antagonists        | TCMCB07, SQ                      | I, randomized, double-blind, placebo-controlled     | 97  | US, healthy volunteers                                                                 | Safety/pharmacokinetics                                                                                                                                                                                                                                                                                                                                                              | July 12, 2022–ongoing                                                                                    | Recruiting                                             | NCT05529849        |                                                  |                                                         |                                |                        |                |
| Melanocortin type 4 receptor antagonists        | PF-07258669, oral                | I, randomized, double-blind, placebo-controlled     | 29  | US, healthy volunteers                                                                 | MENAC: anti-inflammatory, nutrient signaling, contractile work                                                                                                                                                                                                                                                                                                                       | Ibuprofen + ONS with EPA + nutritional counseling + exercise prescription                                | III, randomized, open-label v standard palliative care | 240                | US and international, advanced NSCLC or pancreas | Weight change                                           | April 2015–September 2022      | Active, not recruiting | NCT02330926    |
| Anti-GDF15                                      | Ponsegromab (PF-06946860), SQ    | II, randomized, double-blind, placebo-controlled    | 168 | US, advanced cancers (NSCLC, pancreatic, CRC) with elevated GDF15 levels               | Nutrient signaling, anti-inflammatory                                                                                                                                                                                                                                                                                                                                                | Arginine + omega-3 fatty acids                                                                           | III, randomized, double-blind, placebo-controlled      | 200                | US, bladder cancer                               | Postoperative complications/changes in body composition | February 21, 2019–May 1, 2026  | Recruiting             | NCT03757949    |
| Anti-GDF15                                      | Ponsegromab (PF-06946860), SQ    | I, randomized, double-blind, placebo-controlled     | 63  | US, healthy volunteers                                                                 | MIRACLE: anti-inflammatory, nutrient signaling, contractile work                                                                                                                                                                                                                                                                                                                     | Ibuprofen + omega-3 fatty acids + ONS + Bojungikki-tang + nutritional counseling + exercise prescription | II, randomized, open-label v standard palliative care  | 112                | Korea, advanced NSCLC or GI cancers              | Weight change and handgrip strength                     | January 31, 2020–June 30, 2022 | Recruiting             | NCT04907864    |
| Anti-GDF15                                      | Ponsegromab (PF-06946860), SQ    | Pilot, randomized, double-blind, placebo-controlled | 18  | US and Canada, advanced cancers (NSCLC, pancreatic, CRC, prostate, breast, or ovarian) | NEXTAC-III: ghrelin receptor agonist, nutrient signaling, contractile work                                                                                                                                                                                                                                                                                                           | Anamorelin + nutritional counseling + home-based resistance training                                     | II, randomized, open-label v SOC                       | 90                 | Japan, advanced NSCLC or pancreas                | Change in 6-minute walking distance                     | September 01, 2021–NP          | Recruiting             | JRCTs041210053 |
| Anti-GDF15                                      | Ponsegromab (PF-06946860), SQ    | IIb, nonrandomized                                  | 11  | US, advanced cancers (NSCLC, pancreatic, CRC)                                          | Abbreviations: BMI, body mass index; CRC, colorectal cancer; EPA, eicosapentaenoic acid; GDF, growth differentiation factor; IV, intravenous; JAK/STAT, Janus kinase-signal transducer and activator of transcription pathway; NP, not provided; NSCLC, non-small-cell lung cancer; ONS, oral nutritional supplement; QOL, quality of life; SOC, standard of care; SQ, subcutaneous. |                                                                                                          |                                                        |                    |                                                  |                                                         |                                |                        |                |
| Anti-GDF15                                      | Ponsegromab (PF-06946860), SQ    | I, randomized, double-blind, placebo-controlled     | 8   | Japanese, healthy volunteers                                                           | <sup>a</sup> For phase I and II trials, select secondary outcomes focused on cachexia-related end points provided as available.                                                                                                                                                                                                                                                      |                                                                                                          |                                                        |                    |                                                  |                                                         |                                |                        |                |
| Anti-GDF15                                      | NGM120, SQ                       | I, randomized, double-blind, placebo-controlled     | 92  | Australia, healthy volunteers                                                          | <sup>b</sup> For trials not completed, estimated study completion dates per ClinicalTrials.gov provided.                                                                                                                                                                                                                                                                             |                                                                                                          |                                                        |                    |                                                  |                                                         |                                |                        |                |
| Anti-GDF15                                      | NGM120, SQ                       | III, randomized, double-blind, placebo-controlled   | 75  | US, advanced solid cancers                                                             | Safety/Bodyweight and Skeletal muscle index change                                                                                                                                                                                                                                                                                                                                   | October 16, 2019–January 2025                                                                            | Recruiting                                             | NCT04058896        |                                                  |                                                         |                                |                        |                |
| Anti-GDF15                                      | AV380, IV and SQ                 | I, randomized, double-blind, placebo-controlled     | 56  | US, healthy volunteers                                                                 | Safety/pharmacokinetics and GDF15 levels by dose and serum level of AV380                                                                                                                                                                                                                                                                                                            | February 22, 2021–January 2022                                                                           | Active, not recruiting                                 | NCT04815551        |                                                  |                                                         |                                |                        |                |
| Anti-GDF15                                      | CTL002, IV                       | III, nonrandomized                                  | 155 | Europe, advanced cancers after progression on one previous anti-PD-1/PD-L1 treatment   | Safety/change in appetite via questionnaire, BMI, and skeletal muscle index                                                                                                                                                                                                                                                                                                          | December 9, 2020–May 31, 2025                                                                            | Recruiting                                             | NCT04725474        |                                                  |                                                         |                                |                        |                |
| Ghrelin receptor agonist                        | Anamorelin, oral                 | III, randomized, double-blind, placebo-controlled   | 318 | US and international, unresectable stage III or stage IV NSCLC                         | Weight change and 5-item Anorexia Symptom Subscale                                                                                                                                                                                                                                                                                                                                   | December 18, 2018–January 31, 2023                                                                       | Active, not recruiting                                 | NCT03743064        |                                                  |                                                         |                                |                        |                |
| Ghrelin receptor agonist                        | Anamorelin, oral                 | III, randomized, double-blind, placebo-controlled   | 316 | US and international, unresectable stage III or stage IV NSCLC                         | Weight change and 5-item Anorexia Symptom Subscale                                                                                                                                                                                                                                                                                                                                   | December 18, 2018–February 2023                                                                          | Active, not recruiting                                 | NCT03743051        |                                                  |                                                         |                                |                        |                |
| Ghrelin receptor agonist                        | Anamorelin, oral                 | II, randomized, double-blind, placebo-controlled    | 100 | US, locally advanced or metastatic pancreatic cancer                                   | Weight change/5-item Anorexia Symptom Subscale, survival, and Fatigue Subscale                                                                                                                                                                                                                                                                                                       | September 30, 2022–December 31, 2023                                                                     | Recruiting                                             | NCT04844970        |                                                  |                                                         |                                |                        |                |
| Dopamine and serotonin receptor antagonist      | Olanzapine, oral                 | III, randomized, open-label v megestrol             | 360 | US, advanced solid or hematologic cancers                                              | Change in appetite                                                                                                                                                                                                                                                                                                                                                                   | October 15, 2021–December 2024                                                                           | Recruiting                                             | NCT04939090        |                                                  |                                                         |                                |                        |                |

### Current Therapeutic Targets in Cancer Cachexia: A Pathophysiologic Approach

Kadakia, Hamilton-Reeves, **Baracos**

American Society of Clinical Oncology Educational Book 2023

Current Therapeutic Targets  
in Cancer Cachexia:  
A Pathophysiologic Approach  
Kadakia, Hamilton-Reeves, **Baracos**  
American Society of Clinical Oncology  
Educational Book 2023

# Ponsegromab for Cancer Cachexia

A PLAIN LANGUAGE SUMMARY

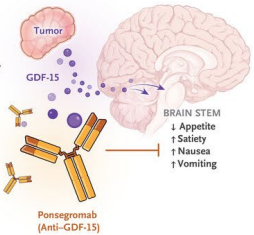
Based on the NEJM publication: Ponsegromab for the Treatment of Cancer Cachexia by J.D. Groarke et al. (published September 14, 2024)

In this trial, researchers examined the safety and efficacy of the monoclonal antibody ponsegromab for treating cancer cachexia.

**Cachexia** — also known as wasting syndrome — occurs commonly in patients with cancer and can lead to weight loss, muscle wasting, functional impairment, and reduced survival.

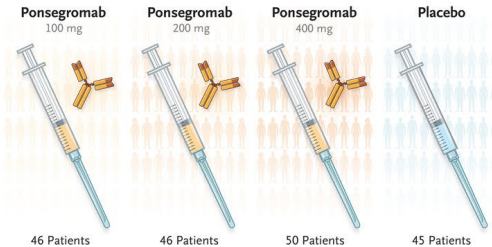
WHY WAS THE TRIAL DONE?

Pharmacologic treatment options for cancer cachexia are limited. Ponsegromab is a humanized monoclonal antibody that binds to growth differentiation factor 15 (GDF-15), a stress-induced cytokine implicated in the development of cachexia. In a small phase 1b study of ponsegromab, patients with cancer cachexia and an elevated circulating GDF-15 level had improved outcomes and few adverse events.



HOW WAS THE TRIAL CONDUCTED?

Adults with cancer cachexia and elevated serum GDF-15 levels were assigned to receive ponsegromab (100 mg, 200 mg, or 400 mg) or placebo, administered subcutaneously every 4 weeks for three doses. The primary end point was the change in body weight at 12 weeks.



PATIENTS

**WHO** 187 adults  
Median age, 67 years  
Men: 63%; Women: 37%

**CLINICAL STATUS** Cachexia (involuntary weight loss of >5% within the previous 6 months or >2% with BMI <20)

Serum GDF-15 level of at least 1500 pg per milliliter

ECOG performance-status score of 3 or less (scale, 0 to 5, with higher numbers reflecting greater disability)

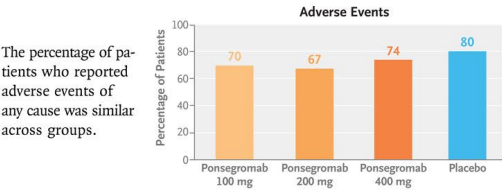
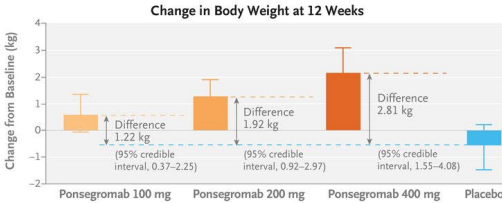
Life expectancy of at least 4 months

TRIAL DESIGN

- PHASE 2
- RANDOMIZED
- DOUBLE-BLIND
- PLACEBO-CONTROLLED
- DOSE-RANGING
- DURATION: 12 WEEKS
- LOCATION: 74 SITES IN 11 COUNTRIES

RESULTS

At 12 weeks, patients in the ponsegromab groups had significantly greater weight gain than those in the placebo group. Patients in the 400-mg ponsegromab group also had improvements in secondary end point measures of anorexia and cachexia symptoms, as well as physical activity, as compared with the placebo group.



LIMITATIONS AND REMAINING QUESTIONS

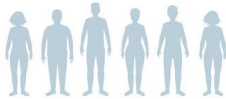
- Nearly all the patients in the trial were Asian or White.
- Although ponsegromab-mediated weight gain did not appear to be related to the magnitude of baseline GDF-15 elevation, larger studies are needed to evaluate a possible association.
- Missing data on physical activity level and gait for some patients may have limited detection of a treatment effect across the ponsegromab dose groups.

LINKS: FULL ARTICLE | NEJM QUICK TAKE | EDITORIAL | SCIENCE BEHIND THE STUDY

FURTHER INFORMATION

Trial registration: ClinicalTrials.gov number, NCT05546476  
Trial funding: Pfizer  
Full citation: Groarke JD, Crawford J, Collins SM, et al. Ponsegromab for the treatment of cancer cachexia. N Engl J Med 2024;391:2291-303. DOI: 10.1056/NEJMoa2409515  
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CANCER TYPE



Non-small-cell lung cancer was the most prevalent cancer (40% of patients), followed by pancreatic cancer (32%) and colorectal cancer (29%).

CONCLUSIONS

Among patients with cancer cachexia and an elevated GDF-15 level, the inhibition of GDF-15 with ponsegromab significantly increased body weight at 12 weeks, as compared with placebo.

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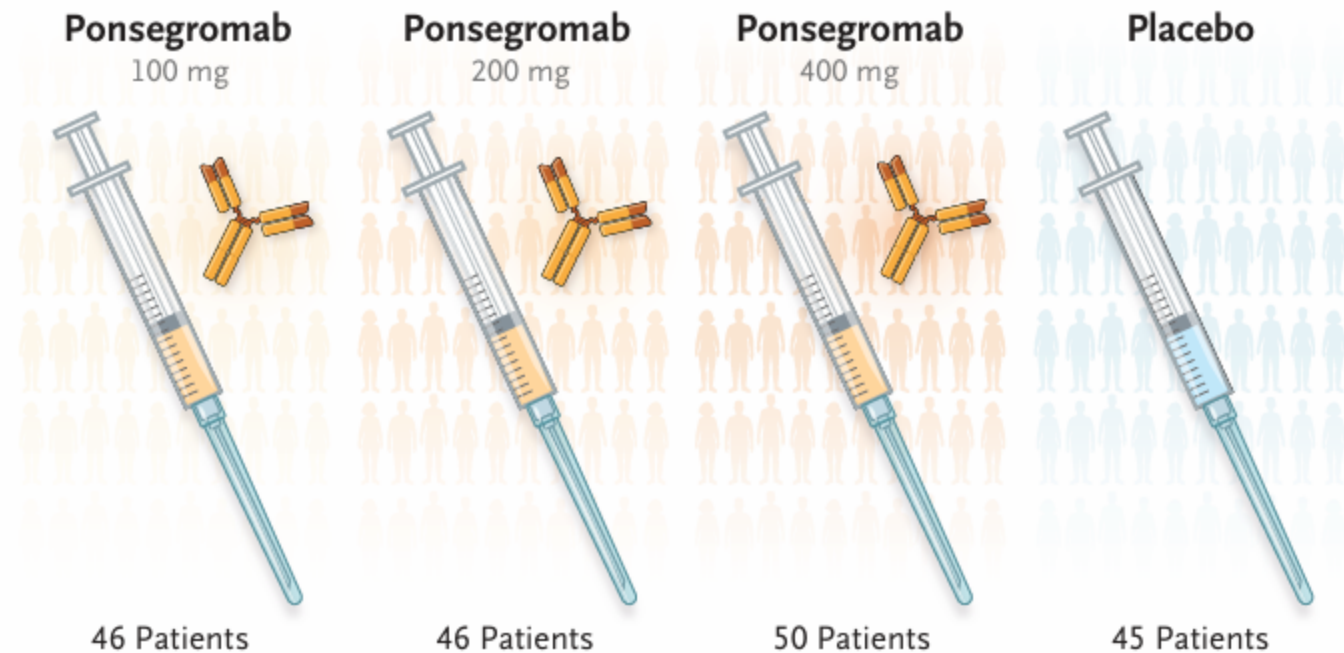
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## TRIAL DESIGN

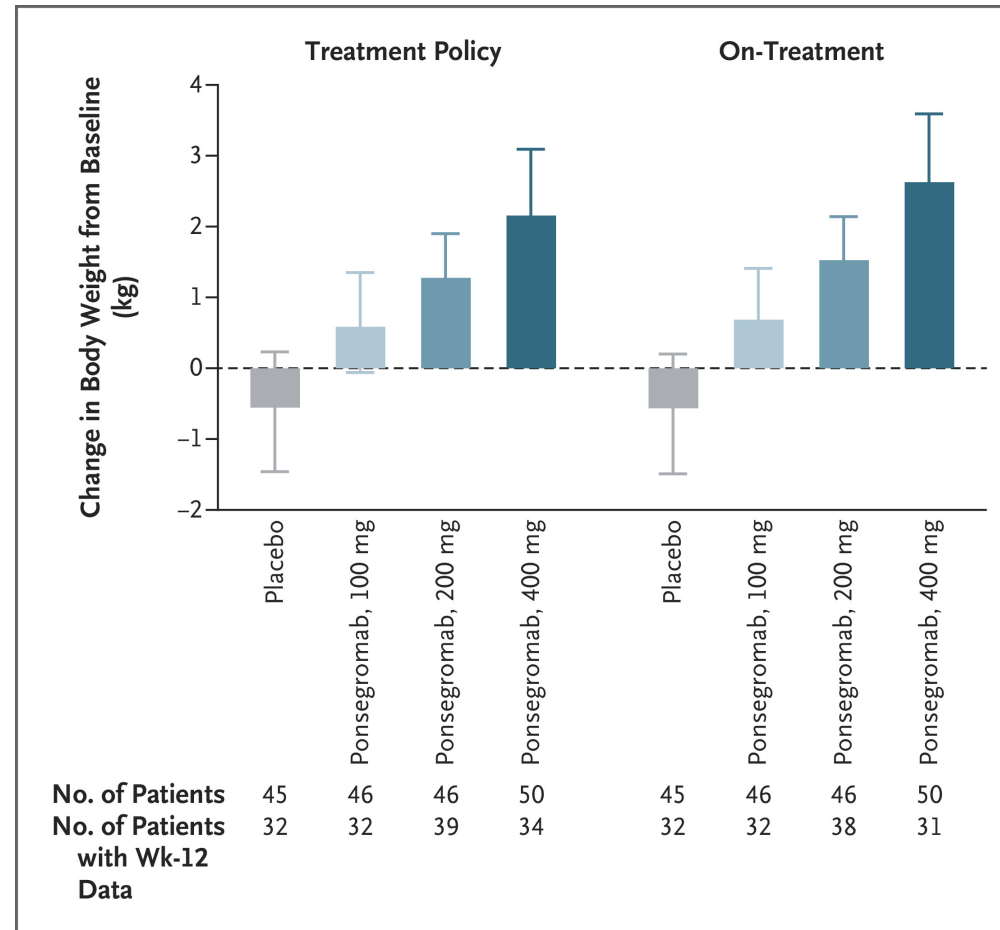
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# Primary outcome





## NEW STUDY

# Adaptive, Phase 2/3, Randomized, Double-Blind Trial Investigating the Efficacy and Safety of Visugromab versus Placebo in Patients with Cancer-associated Cachexia ("VINCIT" trial)

*Open for Recruitment*

## Study Population

- NSCLC
- CRC
- Other

(esoph., gastric, panc.,  
biliary tr.)

## Indication

Cancer-  
associated  
cachexia

(>5% involuntary  
weight loss <6  
months)

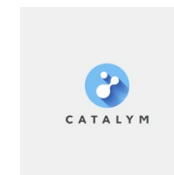
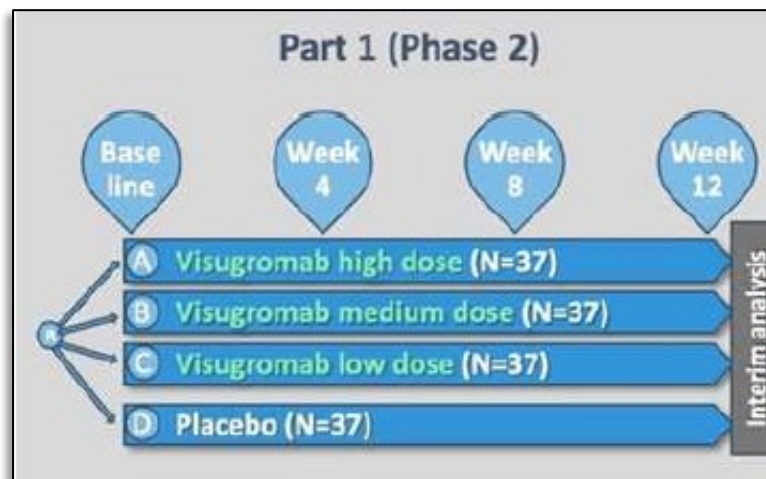
## Intervention

Visugromab  
(GDF-15  
antibody)

## Outcome

- Body weight
- Appetite

(change from  
baseline to week 12)



University of  
Zurich<sup>UZH</sup>

**USZ** Universitäts  
Spital Zürich

# Inclusion Criteria

- **Non-small cell lung cancer (first-line, Stage IIIb-IV)**

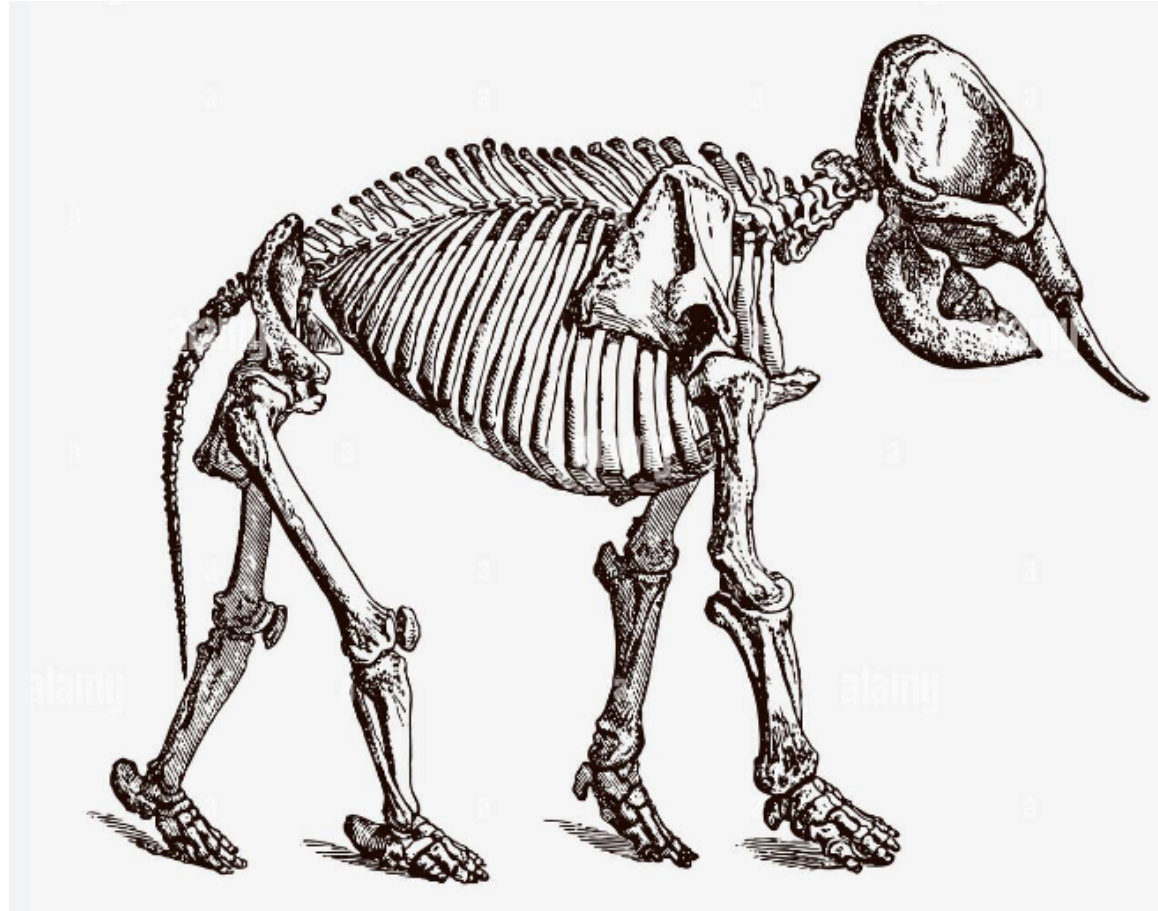
Receiving standard therapy involving immune checkpoint inhibitor ± platinum(singlet/doublet) ± pemetrexed

- **Colorectal cancer (first- or second-line, Stage IV)**

Receiving standard therapy involving fluoropyrimidine backbone + oxaliplatin or irinotecane.g., FOLFOX/FOLFIRI)

- **Other tumor types:** esophageal, gastric, pancreatic, biliary tract (Stage IV, any line, any background therapy)

# Body image dissatisfaction





Gewichtsverlust und Körperbild bei fortgeschrittenem Krebs: Unterschiede je nach Geschlecht und Land – das GRACE-Forschungsprojekt (Global Research on Appearance in Cancer)

Sponsor: Dr. Charlotte Goodrose-Flores  
PI: Prof. Dr. med. David Blum

**USZ** Universitäts  
Spital Zürich





## Objective

Explore perceptions of weight loss and body image among people with advanced cancer across different countries, and to examine whether these perceptions vary by gender and country.

## Illustrations/figures

*Figure 1:*

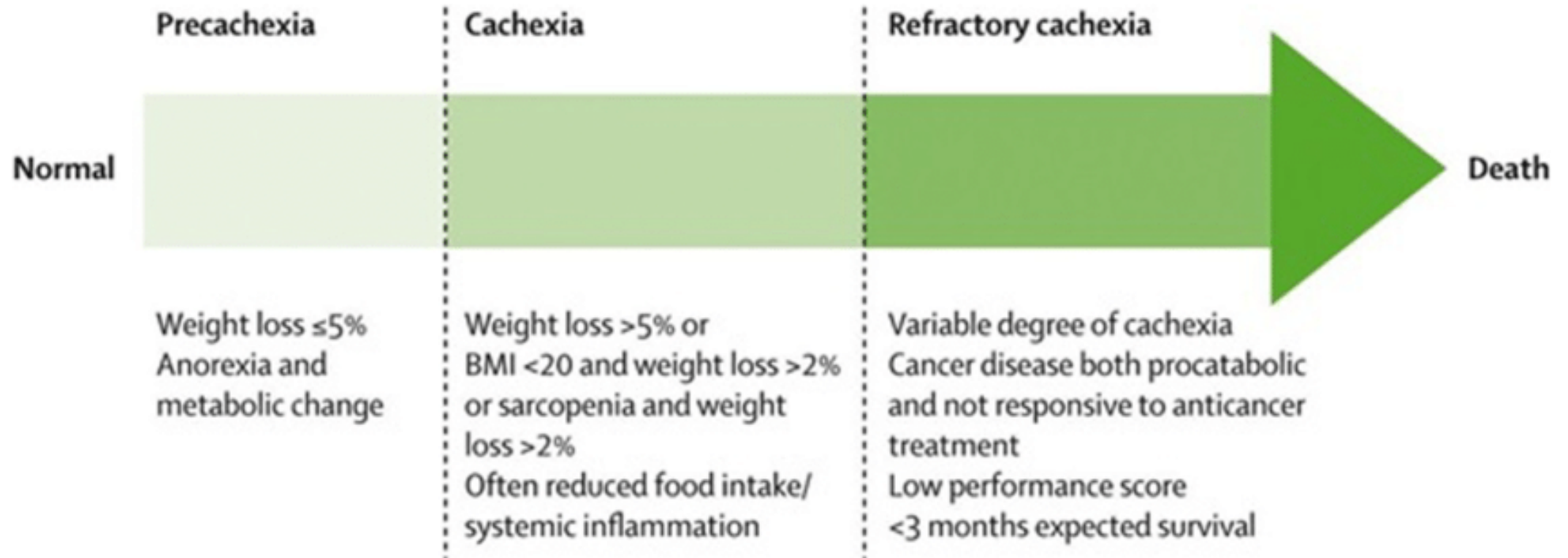


# Back to treatment

Multimodal treatment needs multidisciplinary approach

- Responsibility for their recognition and management is often unclear within the multidisciplinary care team
- Patient-centered care through multidisciplinary collaboration

# Cachexia Stages



# Mitigating Cachexia-Related Distress

- Impact of cachexia on quality of life
- Education and psychosocial support
- Strategies for interdisciplinary team members to support self-management of cachexia-related problems



# Palliation in Refractory Cachexia

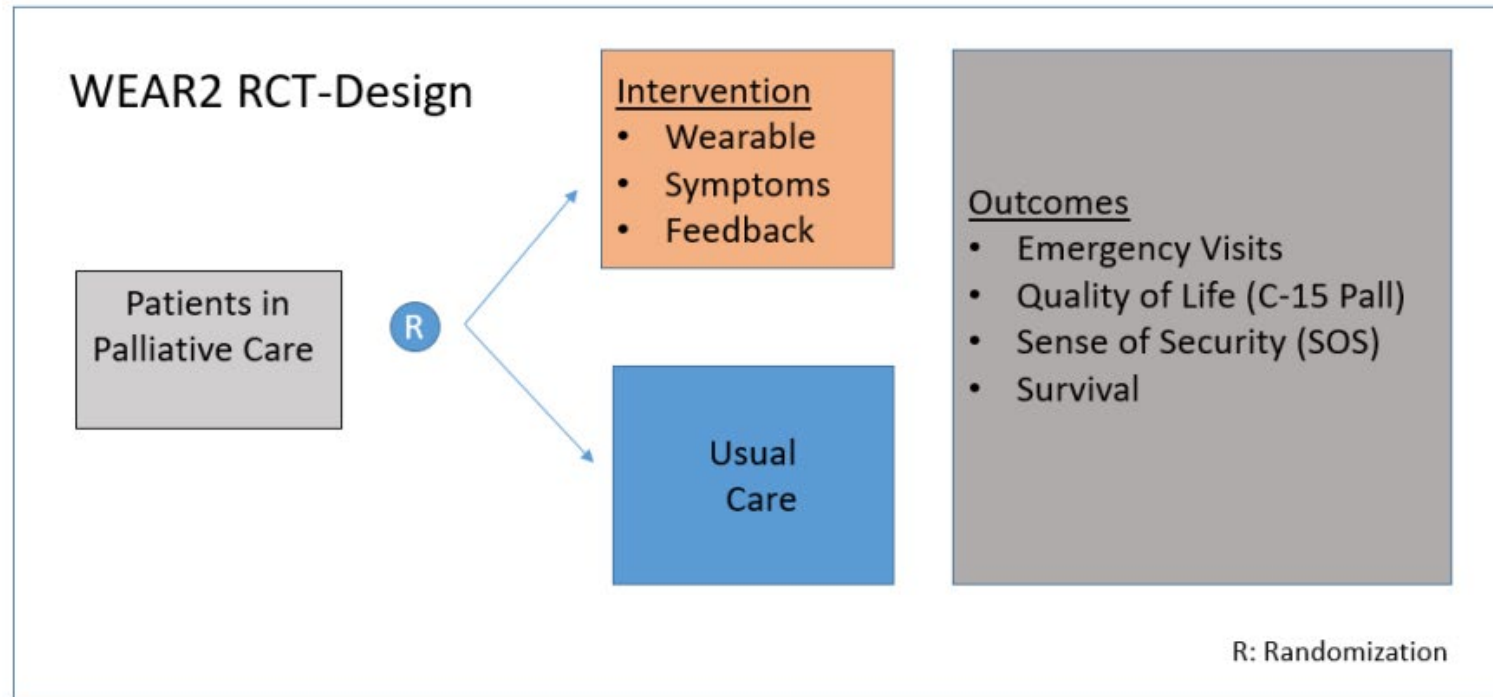
- Focus shifts to palliation in the refractory stage
- Symptom management and compassionate care
- Mitigate cachexia related distress



# Take home message:

- High prevalence, underdiagnosed and undertreated
- NIS: High clinical significance, potentially easy to treat
- Multidisciplinary approach, we need to work together !
- Nutrition and Exercise
- Stage adapted treatment
- New trials open...

## Phase 3 Trial, SNF IICT



6 Palliative Care Centers



Thank you  
for your  
attention.



# Zentrum für Palliative Care

23. Juni 2026

Renate Grathwohl Shaker



Hospital

Interprofessional  
Team

Regional  
Network

**Focus on  
Collaboration and  
Education**

## Interprofessional Team



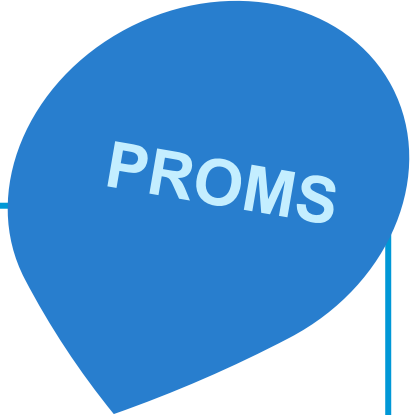
- independant unit within departement of internal medicine



since 2014

- 509 inpatients 2025
- 74% oncological patients
- under direction of Dr. med. Christa Hauswirth Siegenthaler

# Why Patient Reported Outcome Measures?



**PROMS**

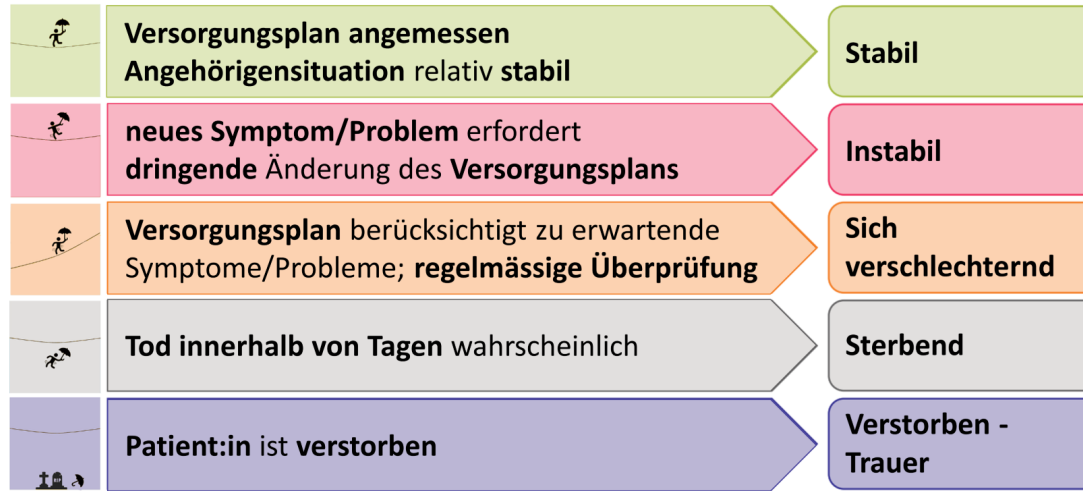
- Identifying patient's needs and priorities
- Informing patient's individual treatment plan
- Verifying individual treatment success
- Implementing quality measures based on systematic evaluation of treatment results
- PROMS in routine care are recommended by EAPC

Donabedian, A. (1980). The definition of quality and approaches to its assessment. Vol 1. Explorations in quality assessment and monitoring. Ann Arbor, MI: Health Administration Press

Carfora, L., et al (2022). Patients' experiences and perspectives of patient-reported outcome measures in clinical care: A systematic review and qualitative meta-synthesis. *PloS one*, 17(4), e0267030.

Bausewein C, et al. (2016). EAPC White Paper on outcome measurement in palliative care: improving practice, attaining outcomes and delivering quality services—Recommendations from the European Association for Palliative Care (EAPC) Task Force on Outcome. Measurement. Palliat Med.

# Palliative Phase of Illness



POI

Graphic adapted from Palliative Vitalparameter, LMU München

Masso M, Allingham SF, Johnson CE, et al. Palliative care problem severity score: reliability and acceptability in a national study. Palliat Med 2015

Lehmann, E., et al. Adaptation of the Australian Palliative Care Phase concept to the German palliative care context: a mixed-methods approach using cognitive interviews and cross-sectional data. BMC palliative care 2021

## Australia-modified Karnofsky Performance Status

| AKPS ASSESSMENT CRITERIA                                                            | SCORE |
|-------------------------------------------------------------------------------------|-------|
| Normal; no complaints; no evidence of disease                                       | 100   |
| Able to carry on normal activity; minor sign of symptoms of disease                 | 90    |
| Normal activity with effort; some signs or symptoms of disease                      | 80    |
| Cares for self; unable to carry on normal activity or to do active work             | 70    |
| Able to care for most needs; but requires occasional assistance                     | 60    |
| Considerable assistance and frequent medical care required                          | 50    |
| In bed more than 50% of the time                                                    | 40    |
| Almost completely bedfast                                                           | 30    |
| Totally bedfast and requiring extensive nursing care by professionals and/or family | 20    |
| Comatose or barely rousable                                                         | 10    |
| Dead                                                                                | 0     |

Abernethy, A. P., Shelby-James, T., Fazekas, B. S., Woods, D., & Currow, D. C. The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice BMC palliative care 2005

- How affected is patient by symptoms and needs (17/21)
- Main concern, additional symptoms (4/21 open questions)
- patient-reported or proxy-/nurse-reported
- In 18 languages

**IPOS Patient Version**

For staff use  
Patient number:

Name:

Date (dd/mm/yyyy):

www.pos-pal.org

Please write clearly, one letter or digit per box. Your answers will help us to keep improving your care and the care of others.

Thank you.

**Q1. What have been your main problems or concerns over the past 3 days?**

1.

2.

3.

**Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick the box that best describes how it has affected you over the past 3 days.**

|                                                | Not at all                 | Slightly                   | Moderately                 | Severely                   | Overwhelmingly             |
|------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Pain                                           | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Shortness of breath                            | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Weakness or lack of energy                     | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Nausea (feeling like you are going to be sick) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Vomiting (being sick)                          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Poor appetite                                  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Constipation                                   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Sore or dry mouth                              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Drowsiness                                     | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Poor mobility                                  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

Please list any other symptoms not mentioned above, and tick the box to show how they have affected you over the past 3 days.

1.

2.

3.

IPOS PATIENT

www.pos-pal.org

Page 1 of 2

IPOSv1-P3-EN 07/03/2015

Over the past 3 days:

|                                                                               | Not at all                 | Occasionally               | Sometimes                  | Most of the time           | Always                     |
|-------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Q3. Have you been feeling anxious or worried about your illness or treatment? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Q4. Have any of your family or friends been anxious or worried about you?     | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Q5. Have you been feeling depressed?                                          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

|                                                                                                        | Always                     | Most of the time           | Sometimes                  | Occasionally               | Not at all                 |
|--------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Q6. Have you felt at peace?                                                                            | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| Q8. Have you had as much information as you wanted?                                                    | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

|                                                                                                             | Problems addressed/ No problems | Problems mostly addressed  | Problems partly addressed  | Problems hardly addressed  | Problems not addressed     |
|-------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Q9. Have any practical problems resulting from your illness been addressed? (such as financial or personal) | 0 <input type="checkbox"/>      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

|                                               | On my own                | With help from a friend or relative | With help from a member of staff |
|-----------------------------------------------|--------------------------|-------------------------------------|----------------------------------|
| Q10. How did you complete this questionnaire? | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>         |

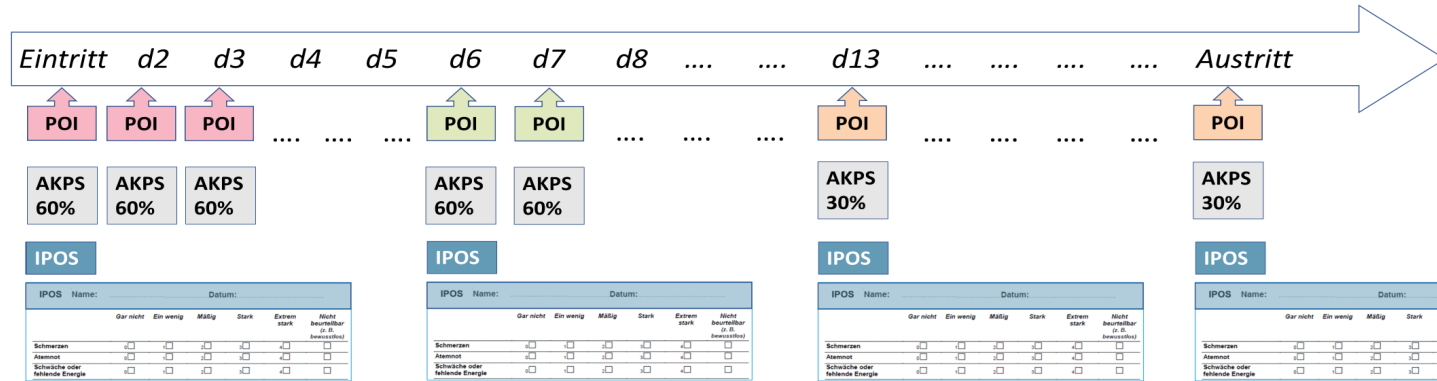
If you are worried about any of the issues raised on this questionnaire, then please speak to your doctor or nurse.

Palliative care Outcome Scale. A resource for palliative care. [www.pos-pal.org](http://www.pos-pal.org).

Murtagh FE, Ramsenthaler C, Firth A, et al. A brief, patient- and proxy-reported outcome measure in advanced illness: Validity, reliability and responsiveness of the Integrated Palliative care Outcome Scale (IPOS). Palliat Med. 2019



# Integrating PROMS in Daily Routine



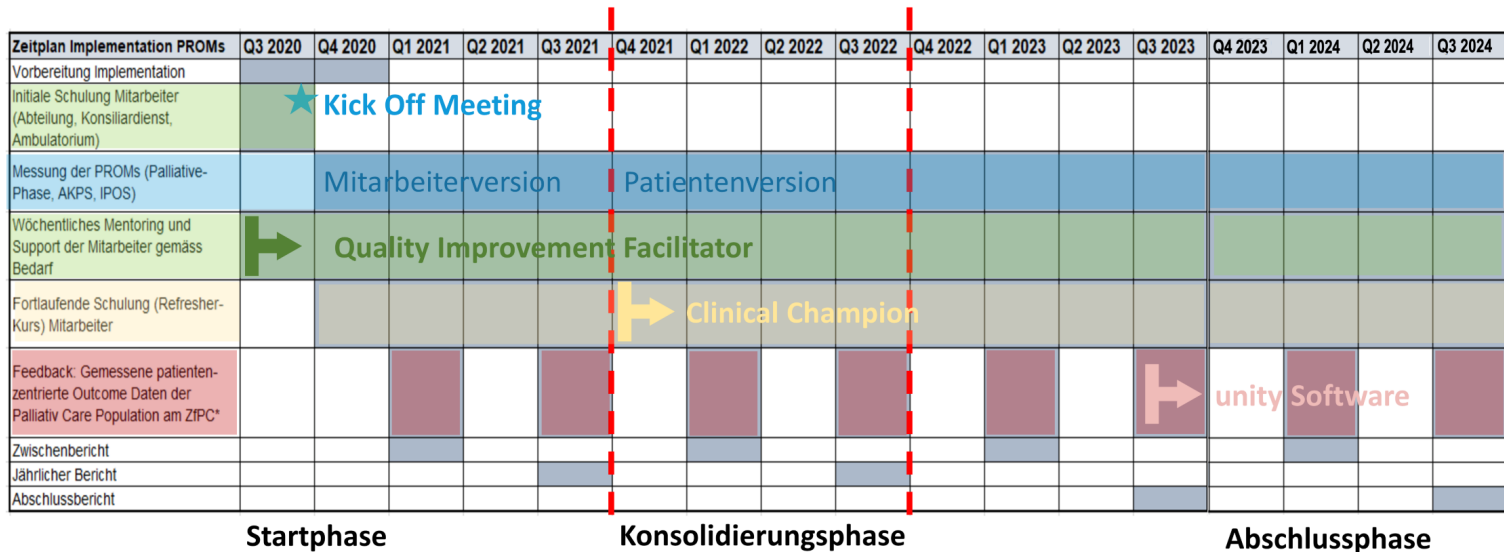
Zürcher Hochschule  
für Angewandte Wissenschaften

**zhaw** Gesundheit

**KSW** Kantonsspital  
Winterthur

# Implementing PROMS

## Project Timeline

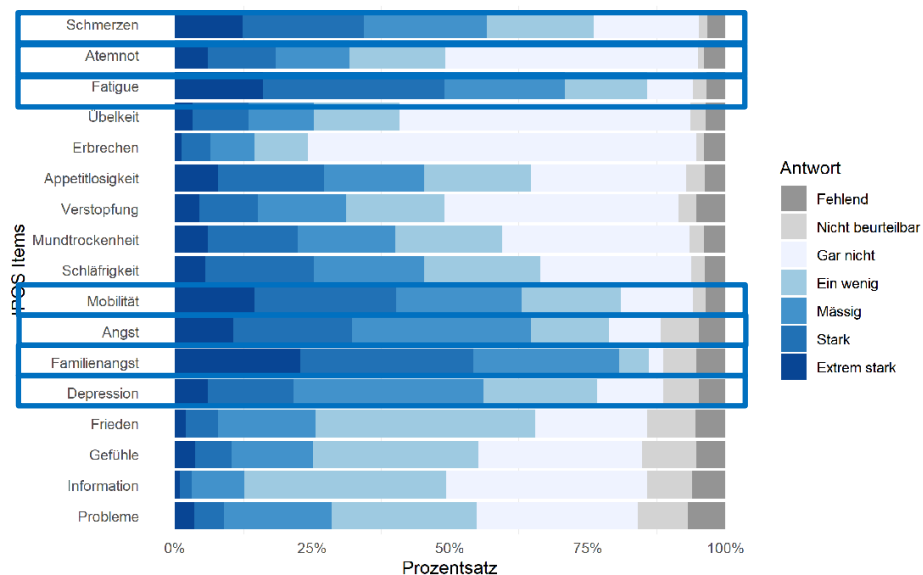


Keith RE, et al. Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. Implementation Science. 2017;12(1):15.

# Outcomes

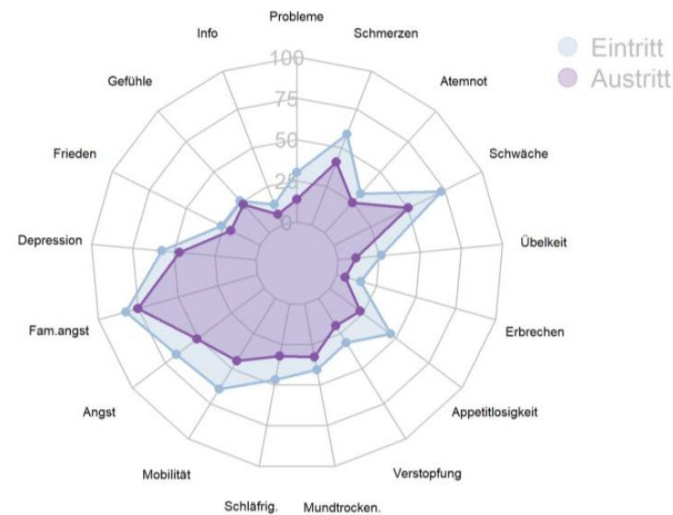
## IPOS Items bei Eintritt

(n = 1'486)



(C)ZHAW, SENIORS-I 2025

## IPOS mässige bis sehr starke Probleme im Längsschnitt (n = 1'486)



(C)ZHAW, SENIORS-I 2025

# PROMS in Interprofessional Collaboration

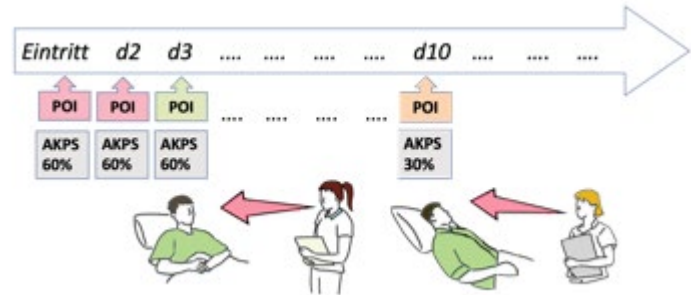
## AKPS

- common understanding
- continuity



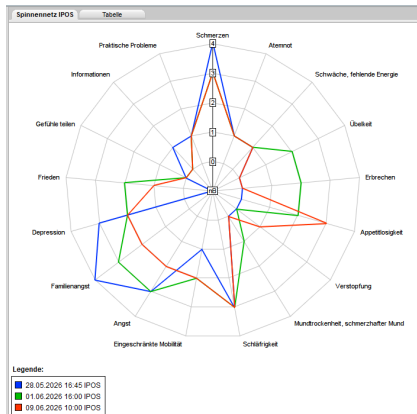
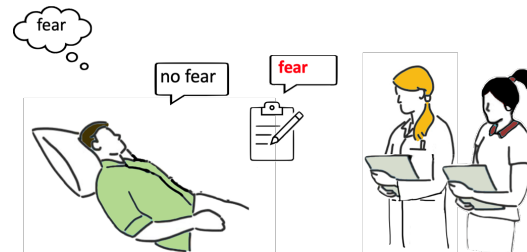
## POI

- common language
- informs and structures handover, ward round, MDT report



# Patient Centered Care

- identifying unmentioned symptoms, needs and burden
- what matters most to patients?
- focus on family/proxy needs
- changes over time

[illegible]



- symptom relief
- rehabilitative measures
- causal treatment



## Aufgaben Physiotherapie



- Evaluation der beitrags
- Evaluation des Beweg
- Evaluation von Hilfsmi
- Entspannung und weite

## Aufgaben Pflege:

- Instruktion
- Titration: Reserven verabrei
- Nicht-medikamentöse Mass
- Antizipieren, Selbstwirksamkeit fördern
- Nebenwirkungen behandeln
- Umgebungs-/ Tagesgestaltung

## Aufgaben Ärzteteam: Therapiekonzept

### Management festlegen (nozizeptiv, neuropathisch, total pain)

- Therapieziel besprechen
- Welches Opiat? Opiatrotation?
- Dosistitration
- Ko-Analgetika evaluieren
- Kausale Therapieoptionen evaluieren
- Interventionelle T



### Dokumentation

- Prozedere stationä

## Aufgaben für Alle

### Kommunikation

- Ressourcen orientiert: „was denken sie hilft in dieser Situation?“
- Zielorientiert: „wollen wir uns zuerst xy als Ziel setzen?“
- positive Kommunikation:  
„wir werden gemeinsam herausfinden, was am besten funktioniert“



### Angehörige einbeziehen

- Information über Therapiekonzept, Therapieziel
- Sorgen, Belastungen ernst nehmen
- Rundtischgespräch



Schmerzzentrum

Über uns

Angebot

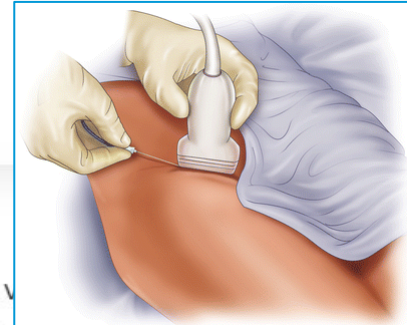
Team

Kontakt / Anmeldung

Interdisciplinary Collaboration  
in Pain Management

## Gemeinsam engagiert

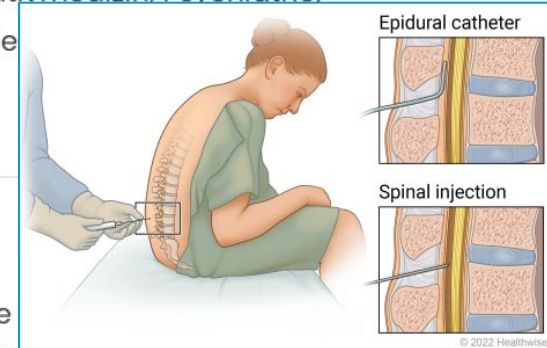
Am KSW sind wir interdisziplinär sehr gut vernetzt und arbeiten mit den Fachspezialistinnen und -spezialisten folgender Disziplinen zusammen: Handchirurgie, Neurochirurgie, Neurologie, Palliativmedizin, Psychiatrie, Rheumatologie, Ergotherapie und Physiotherapie, um das Wohl unserer Patientinnen und Patienten.



## Angebot

Das spezialisierte Schmerzzentrum untersucht und behandelt Patientinnen und Patienten mit akuten und chronischen Schmerzen.

[mehr erfahren](#)







- Inpatient Palliative Care consultation service



since 2018

- 545 patients, 1241 consultations last year

# Promoting General Palliative Care

Dashboard Stammdaten Diagnosen / DRG Workflows **Kurve** Pflegeprozess Berichte Einzelresultate Labor kumulativ Bilder Ext. Tools

REA: **Nein** IPS: **Nein** INT: **Nein** **Cave** **Fall-Info** **ATM** keine Allergien bekannt (0) Patientenverfügung DRG (F67A): **✓Allerg**

Neu **Handeileingabe** x So 21.06.2026 - Di 23.06.2026 < v > Zeige: Alles Extras

Name: **Start für neue Formulare** Heute **Aktuelle Zeit** nach Auswahl schließen **Schliessen**

**Allgemein** **Favoriten Kurve (Ordersets)** Favoriten Anmeldungen Persönlich Übernahme

Suche

- ▶ Lopopädie
- ▶ Medizinische Poliklinik
- ▶ Nephrologie
- ▶ Neurologie
- ▶ **Palliative Care**
  - Komplexbehandlung Palliative Care
  - Eintrittsfavorit Palliative Care
  - Reservemedikamente Palliative Care
- ▶ Pflege Medizin
- ▶ Pflege Onkologie
- ▶ Physiotherapie
- ▶ Pneumologie
- ▶ Rheumatologie

| Name                                                          | Inhalt                                                                 | Start Mo 22.06.26 | Start +1 Di 23.06.26 |
|---------------------------------------------------------------|------------------------------------------------------------------------|-------------------|----------------------|
| <b>Reserven / Limiten</b>                                     |                                                                        |                   |                      |
| <b>Agonie i.v.</b>                                            |                                                                        |                   | Agonie i.v.          |
| - 1. Res. Agonie: max. 2.5 mg, min. Intervall 15Min, als ...  | Morphin HCl Injektionslösung 1 mg/ml 10 ml - 1 ml MORPHIN HCL Sint...  |                   |                      |
| - 1. Res. Agonie: max. 0.5 mg, min. Intervall 15Min, als ...  | Palladon 0.2 mg/ml Bolus 10 ml - 1 ml PALLADON Inject Inj Lös 2 mg/... |                   |                      |
| <b>Agonie s.c.</b>                                            |                                                                        |                   | Agonie s.c.          |
| - 1. Res. Agonie: max. 2.5 mg, min. Intervall 15Min, als ...  | DORMICUM 5 mg/ml Amp [1 ml] / Midazolam 5 mg/Stk                       |                   |                      |
| - 1. Res. Agonie: max. 2.5 mg, min. Intervall 15Min, als ...  | MORPHIN HCL Sintetica Inj Lös 10 mg/ml [1 ml] / Morphin hydrochlori... |                   |                      |
| - 1. Res. Agonie: max. 0.5 mg, min. Intervall 15Min, als ...  | Palladon 0.2 mg/ml Bolus 10 ml - 1 ml PALLADON Inject Inj Lös 2 mg/... |                   |                      |
| <b>Angst</b>                                                  |                                                                        |                   | Angst                |
| - 1. Res. Angst: max. 0.5 Stk max. 2x/24h, min. Intervall...  | TEMESTA 1.0 EXPIDET Tabl 1 mg [20Stk] / Lorazepam 1 mg/Stk             |                   |                      |
| - 2. Res. Angst: max. 1 mg max. 3x/24h, min. Intervall ...    | DORMICUM 5 mg/ml Amp [1 ml] / Midazolam 5 mg/Stk                       |                   |                      |
| - 3. Res. Anxiolyse: Rate: 0.3 (max. 0.5) ml/h; intravenö...  | Dormicum 1 mg/ml Perfusor in NaCl 0.9% 50 ml - 10 ml DORMICUM 5...     | 0.3               |                      |
| <b>Delir</b>                                                  |                                                                        |                   | Delir                |
| - 1. Res. Delir: max. 0.5 Stk max. 4x/24h per os              | QUETIAPIN Sandoz Filmtabl 25 mg / Quetiapin 25 mg/Stk                  |                   |                      |
| - 2. Res. Delir: max. 0.5 mg max. 6x/24h subcutan; s.c...     | HALDOL Inj Lös 5 mg / Haloperidol 5 mg/Stk                             |                   |                      |
| - 2. Res. Delir: max. 5 Tr max. 6x/24h per os - Haloper...    | HALDOL Tropfen 2 mg/ml (=20 Tr) / Haloperidol 2 mg/ml                  |                   |                      |
| <b>Epi-Anfall</b>                                             |                                                                        |                   | Epi-Anfall           |
| - 1. Res. Epi-Anfall: max. 1 Dos, min. Intervall 5Min, als... | Midazolam Nasenspray KA 5 mg/ml (= 0.5mg/Hub) FI 2.5 ml / Midazol...   |                   |                      |
| - 2. Res. Epi-Anfall: max. 2.5 mg, min. Intervall 15Min, a... | DORMICUM 5 mg/5ml Amp [5 ml] / Midazolam 5 mg/Stk                      |                   |                      |
| <b>Nausea p.os.</b>                                           |                                                                        |                   | Nausea p.os.         |
| - 1. Res. Nausea: max. 1 Stk max. 3x/24h, min. Intervall...   | DOMPERIDON Mepha oro Schmelztabl 10 mg / Domperidon 10 mg/Stk          |                   |                      |
| - 1. Res. Nausea: max. 1 Stk max. 3x/24h, min. Intervall...   | PASPERTIN Filmtabl 10 mg / Metoclopramid hydrochlorid 10 mg/Stk        |                   |                      |
| - 3. Res. Nausea: max. 5 Tr max. 6x/24h per os - Halo...      | HALDOL Tropfen 2 mg/ml (=20 Tr) / Haloperidol 2 mg/ml                  |                   |                      |
| <b>Nausea parenteral</b>                                      |                                                                        |                   | Nausea parenteral    |

Torasedid Mepha Tabl 10 mg / Torasedid  Inhalte siehe

Triatet Tabl 5 mg / Ramipril  Inhalte siehe

**Medikamente syst. parenteral**

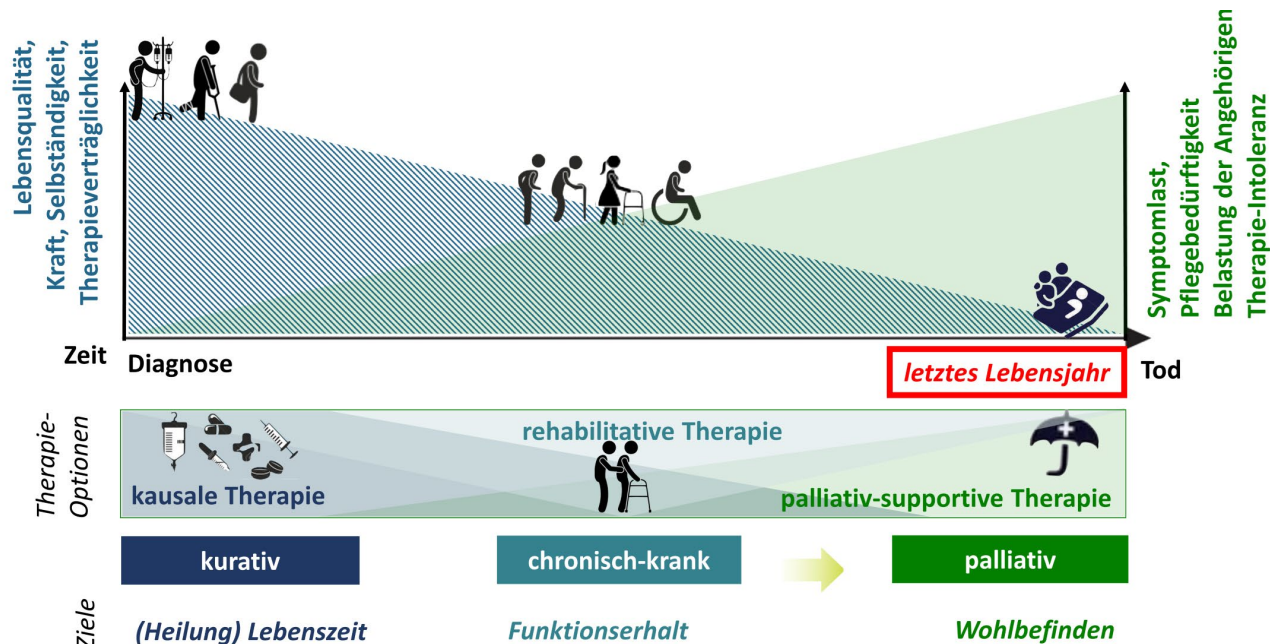
Clexane Inj Lös 40 mg/0.4ml [Fspr] / Enoxaparin nat. 0 - 0 - 40 - 0

**Infusionen**

**Medikamente andere**

**Blutprodukte**

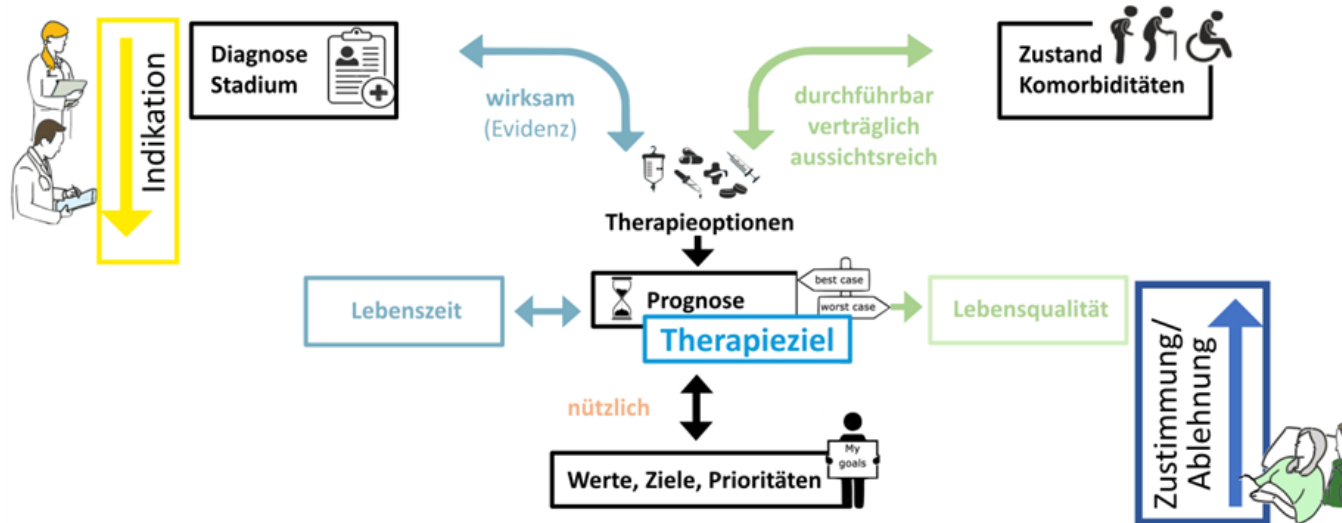
# Education



What's the Goal?

# Shared Decision Making

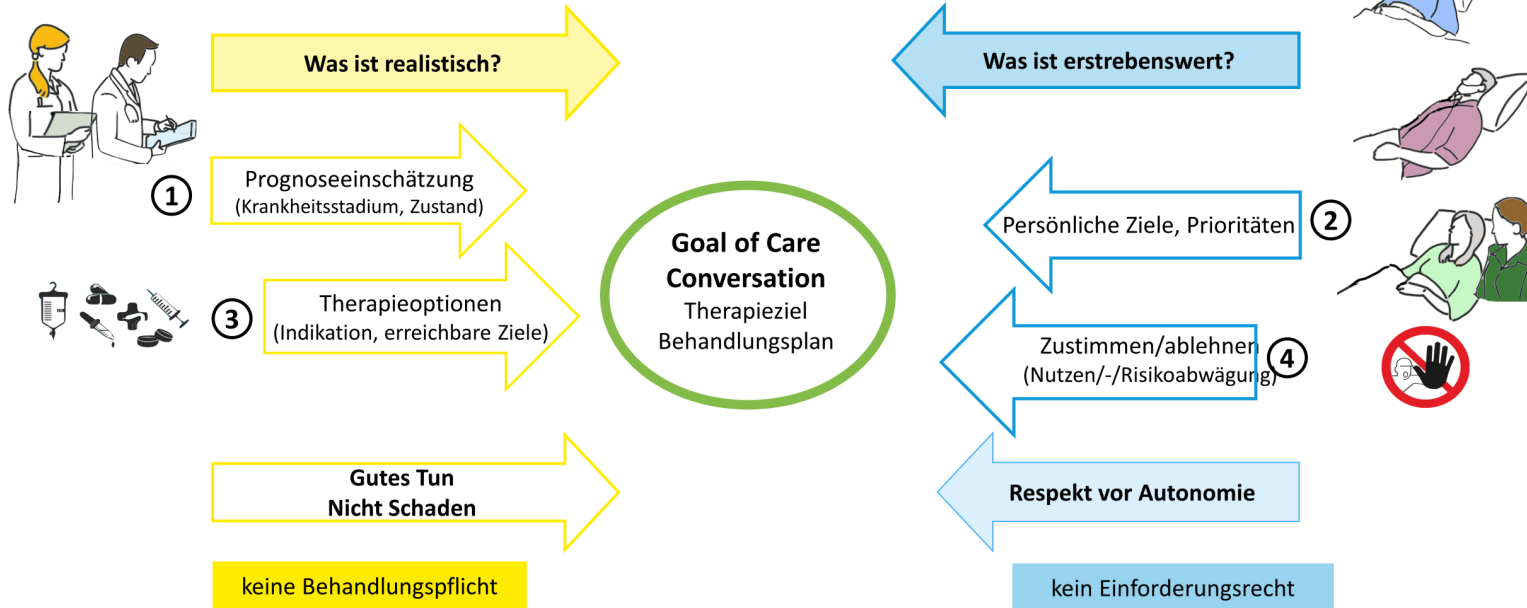
## Prognosis? Goals of Care?



Gerber M. et. al. Grundlagenpapier der DDQ. Shared Decision Making – Arzt und Patient entscheiden gemeinsam. Schweizerische Ärztezeitung 2014;95: 50

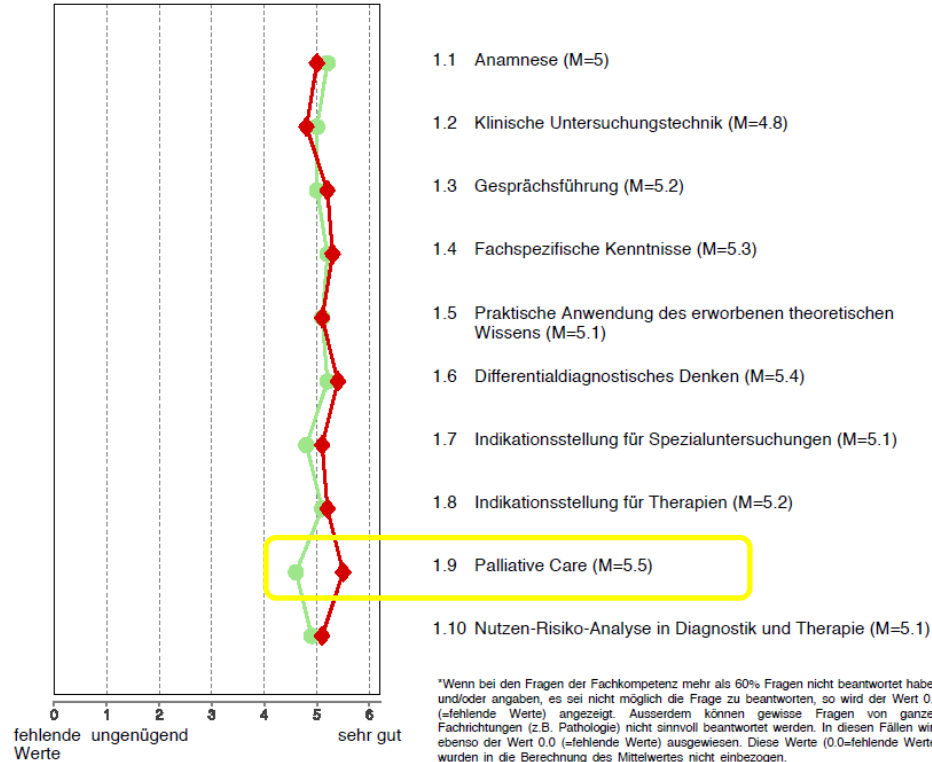
Borasio GD, Jox R. Choosing wisely at the end of life: the crucial role of medical indication. Swiss Med Wkly. 2016;146:w14369

# Shared Decision Making (ff)



Druml et al. ESPEN Guidelines on ethical Aspects of Artificial Nutrition and Hydration. Clin Nutr 2016  
SAMW Medizin-ethische Richtlinien „Umgang mit Sterben und Tod“ 17. Mai 2018

Wie gross ist der Beitrag der Weiterbildungsstätte (an der Sie zurzeit tätig sind) zur Entwicklung der folgenden Kompetenzen, Fähigkeiten beziehungsweise Kenntnisse?\*



\*Wenn bei den Fragen der Fachkompetenz mehr als 60% Fragen nicht beantwortet haben und/oder angeben, es sei nicht möglich die Frage zu beantworten, so wird der Wert 0.0 (=fehlende Werte) angezeigt. Ausserdem können gewisse Fragen von ganzen Fachrichtungen (z.B. Pathologie) nicht sinnvoll beantwortet werden. In diesen Fällen wird ebenso der Wert 0.0 (=fehlende Werte) ausgewiesen. Diese Werte (0.0=fehlende Werte) wurden in die Berechnung des Mittelwertes nicht einbezogen.

Feedback

# When to Involve Palliative Care?

## Screening

### ✓ Triggerkriterien Palliative Care

Erfasst P52/18.06.2026 10:05:05

Geändert P52/18.06.2026 11:12:40

Datum+Zeit 18.06.2026 09:00

#### 1. Hat Patient:in eine fortgeschrittene unheilbare Erkrankung?

Ja Nein



#### Fortgeschrittene Krebserkrankung

Metastasiert oder lokal nicht kurativ behandelbar und / oder anderes Tumorstadium mit limitierten Therapieoptionen (z.B.  $\geq 4^{\circ}$  CTX oder BSC)

#### Demenz oder Erkrankungen des ZNS

(z.B. St. n. Schlaganfall, ALS, M. Parkinson): benötigt Unterstützung in den meisten Bereichen der Selbstversorgung (z.B. bei Mobilisation, Körperpflege) und / oder minimale verbale Ausdrucksmöglichkeit

#### Herzinsuffizienz NYHA IV

chronische Dyspnoe und / oder Thoraxschmerzen und / oder rasche Ermüdbarkeit bei minimaler Anstrengung

#### COPD GOLD D, End Stage Lungenfibrose

kontinuierliche Heimsauerstofftherapie oder chronische Ruhedyspnoe

#### Lebererkrankung im Endstadium

(Ikterus, rez. Aszites, hepatorenales Syndrom, GI-Blutung, Enzephalopathie)

#### End Stage Niereninsuffizienz

(Dialyse / Nierentransplantation nicht gewünscht / nicht geplant)

#### Andere unheilbare / chronische Krankheit mit rascher Verschlechterung und / oder akuter, lebensbedrohlicher Komplikation

(z.B. Sepsis mit Organversagen oder schweres Polytrauma mit hoher Wahrscheinlichkeit für rasch eintretenden bei Patient:in mit relevanten Komorbiditäten)

TOTAL  $\geq 1$  PUNKT: WEITER MIT SCREENING TEIL 2

#### 2. Belastende Symptome und / oder Palliative Care Bedürfnisse?

Ja Nein Punkte

##### Surprise-Question für Prognose $\leq 6-12$ Monate

(Wären Sie überrascht, wenn Patient in den nächsten 6-12 Monaten versterben würde? Ja= 0 Punkte, Nein = 1 Punkt)

☐ ☒ 1

##### Unkontrollierte Symptome

(Schmerzen, Dyspnoe, Nausea, Delir, psychoexistentielles Leiden, Müdigkeit etc.)

☒ ☐ 1

##### Repetitive (ungeplante) Hospitalisationen ( $\geq 2$ Notfälle in 6 Monaten)

☒ ☐ 1

##### Funktionelle Verschlechterung

Mobilitätsverlust, rep. Stürze, Fatigue, ECOG  $\geq 2$ , Dekubitus, verminderte Nahrungsaufnahme, relevanter Gewichtsverlust (BMI  $< 20\text{kg/m}^2$  ODER Gewichtsverlust  $> 5\%$  in 3 Monaten)

☒ ☐ 1

##### Unsicherheit bezüglich der Behandlungsziele und/oder Überlastung der Betreuungsperson(en)

die langfristigen Bedürfnisse können von der Betreuungsperson nicht mehr gewährleistet werden; Unsicherheit / Sorge betreffend der Behandlungsziele

☒ ☐ 1

##### Wunsch Patient:in / Angehörige nach Palliative Care oder ACP

☒ ☐ 2

##### Wunsch nach Suizidbeihilfe, anhaltender Sterbewunsch

☐ ☒ 0

Total 7

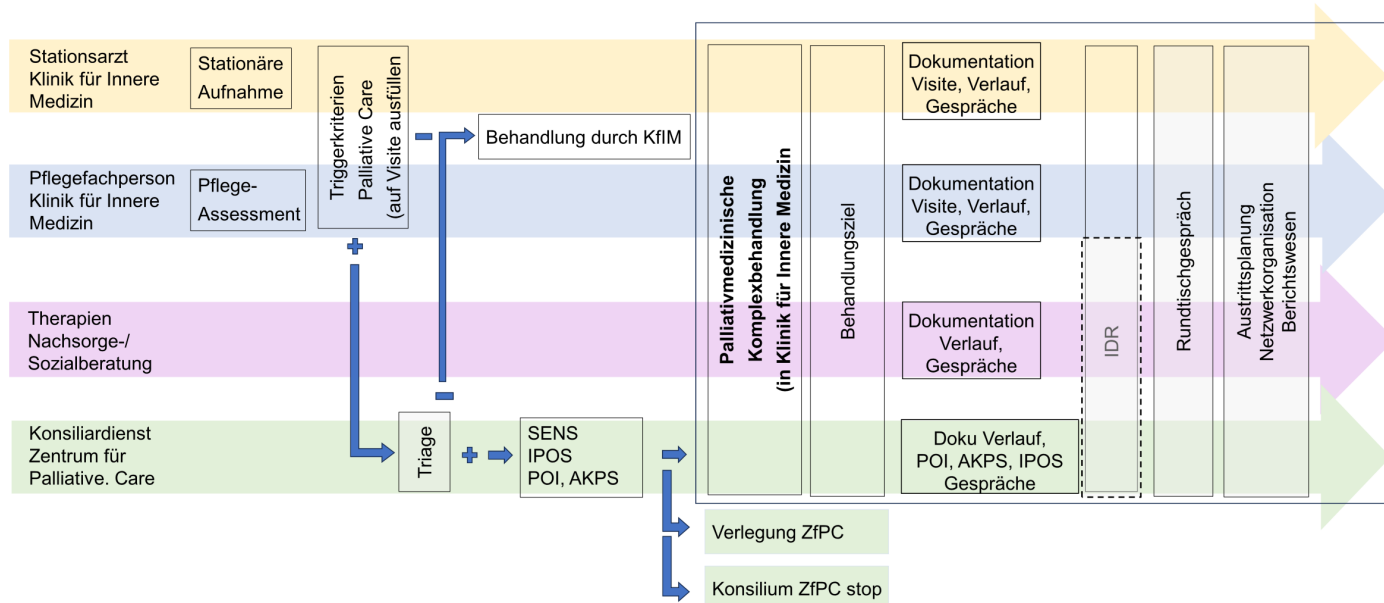
#### Einschätzung

0 - 1 STOP! Screening negativ

$\geq 2$  Palliative Care Konsilium empfohlen

# Project «Pallkomplex»

## Palliativmedizinische Komplexbehandlung 93.8A2





# Boards and Committees

- Board member Cancer Center
- Ethics Committee



[Veranstaltungen](#) | [Bildungsangebote](#) | [Aktuelles](#) | [Kontakt](#) | [Suche](#)

[Palliative Care](#) [Unterstützung](#) [Über uns](#) [Für Fachpersonen](#)

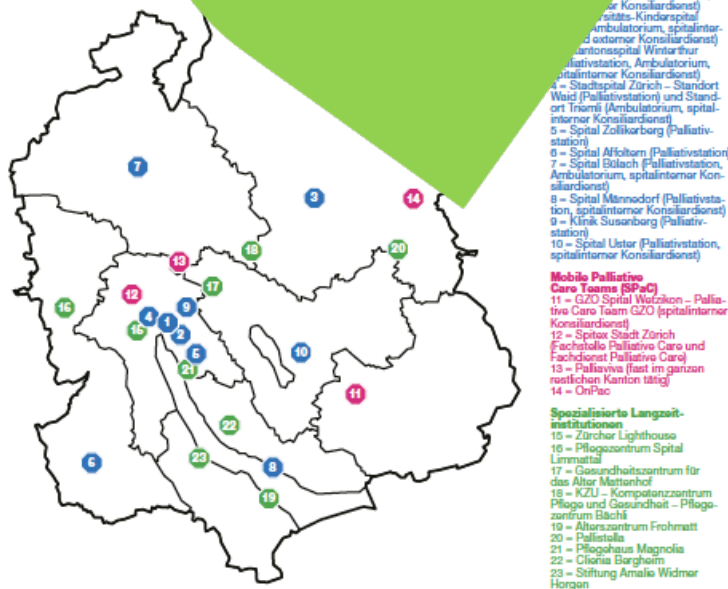
## Kantonsrat will Sterbehilfe in allen Spitälern erlauben



31. März 2026

Der Zürcher Kantonsrat hat sich für Sterbehilfe in allen Alterszentren und Spitälern ausgesprochen. Psychiatrien und Justizvollzugsanstalten bleiben ausgenommen. Ob das Thema an die Urne kommt, ist noch offen.

# Regional Network



- Cooperations with
  - OnPaC
  - Palliaviva
  - Palliative Care GZO Spital Wetzikon
  - SEOP Schaffhausen
  - Pallistella
  - Zürcher Lighthouse
- 150 outpatient Palliative Care consultations

## Activities in our Network



on call duty for  
SPC teams

quality circle  
with SPC teams  
and hospices



## Prospects: a Room with a View



Abo Spital Winterthur

## Privatklinik Lindberg schliesst – Kantonsspital will Flächen übernehmen

Swiss Medical Network verlagert den stationären Betrieb nach Schaffhausen und Zürich. Das Kantonsspital Winterthur plant auf den frei werdenden Flächen Palliativmedizin und Akutgeriatrie.

Aktualisiert: 10.04.2026, 20:15

12 |



Prospects





Thank You for  
your Attention

## *When Psychiatry meets Palliative Care : Insights and Obstacles*

Summer School in Palliative Medicine  
June 25, 2026

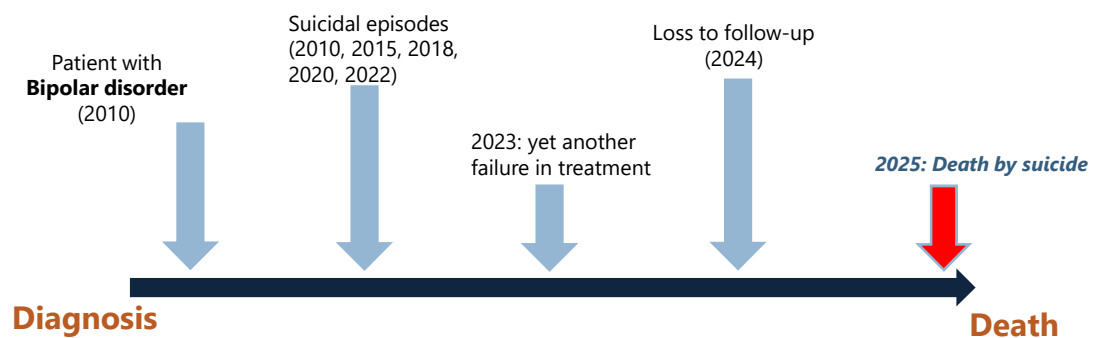
**Dr. Giorgio Maccaferri**

Deputy physician & Medical Senior Lecturer at FBM-UNIL

Head of North Consultation-Liaison Psychiatry Unit  
Psychiatry Department, CHUV



*What would you do in this situation ?*



## Psychiatry in palliative care ? or Palliative Care in psychiatry ?

- Collaboration between Psychiatry and Palliative Medicine is necessary
  - An aging population; complex care needs; psychosomatic conditions
- > 30% of patients in palliative structures have a Psychiatric Disorder
- Lack of validated integrated care models
- Mutual training needs < - -> Stigma

*Mitchell et al., Lancet Oncol, 2011; Trachsel, BMC Psychiatry, 2016;  
Westermair, Frontiers in Psychiatry, 2021; Shalev et al., Current Psych Reports, 2024;  
Shalev et al., Psychosomatics, 2020; Clark et al., J Symptom Manage, 2020*



## What Psychiatry provides to Palliative Medicine

- Expertise in **psychological distress** (anxiety, depression, exacerbated pain, etc.) AND understanding the mechanisms of psychological vulnerability
- More **accurate detection and differential diagnosis** of mental disorders and improved referral **coordination** within the region
- A **complementary pharmacological approach** (refractory states of confusion, behavioral and mood disorders, anxiety disorders)
- Mental health support for healthcare teams and relatives





## What Palliative Medicine provides to Psychiatry

- A broader conception of **quality of life** and total suffering
- An **interdisciplinary approach** that emphasizes support, continuity, and the timing of care
- Reflections on **therapeutic goals** in progressive psychiatric disorders: When to stabilize? When to provide relief? When to accept the natural course of the illness?
- ...



## Understanding Psychiatric Suffering

### Symptoms Level

- Clinical classification
- Psychological distress with bodily signs
- Functional/social impairment

### Vulnerability Level

- Emotional dysregulation
- Increased stress sensitivity
- Slower recovery from stress

### Prognosis

- Episodic
- Chronic
- **Chronically progressive \***

*\* Incomplete remission; Psychiatric comorbidity; Cognitive impairments during free intervals*



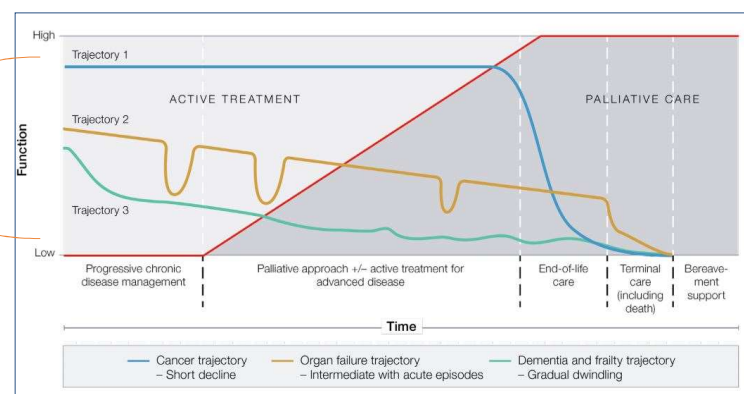
## The issue of Framework in Psychiatry

- Central element of the therapeutic relationship
- Contains and secures
- Impact on relational and pharmacological *compliance*



## Which course for the chronic and progressive psychiatric disorders?

*In Psychiatry ??*

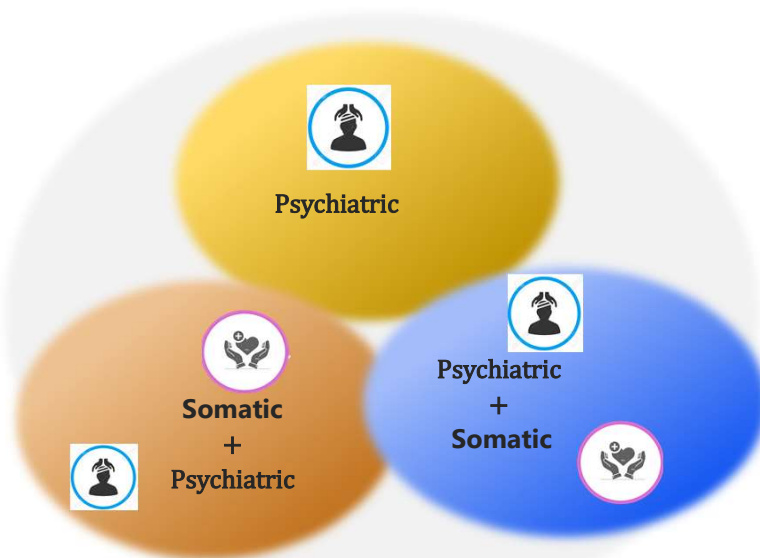


The quality of life continuum

Balfour Mont (1998)

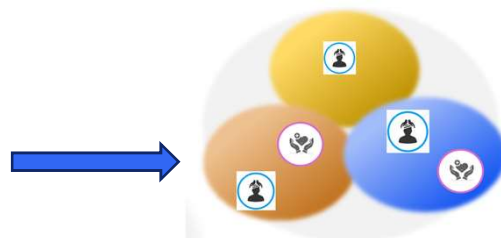


## Interactions between Palliative Care and Psychiatry



**Diagnosis**

**Death**



## Psychiatric conditions in Palliative medicine

- Delirium (up to 88% of Patients)
- Depression (50% of patients, 7–18% suffering a [major depressive episode](#)) DD:  
*Demoralisation syndrome*
- Anxiety and panic disorders
- Suicide
  
- Substance abuse
- Disorders due to psycho-active substances
- Dementia
- ...

Taylor A , et al. Medicine.2020



## The Problem of Death in Psychiatry

- Separate Suicide\* and Assisting Dying from Other Causes of Death
  - Natural/accidental causes, and violent death
  - Asking to die as loss of meaning or taking back control?
  
- \*Suicide risk factors
  - Predictability of Suicidal Models ?
  - Psychiatric illnesses (epidemiology depending on diagnosis)
  - Possible suicidal acts when clinical improvement !

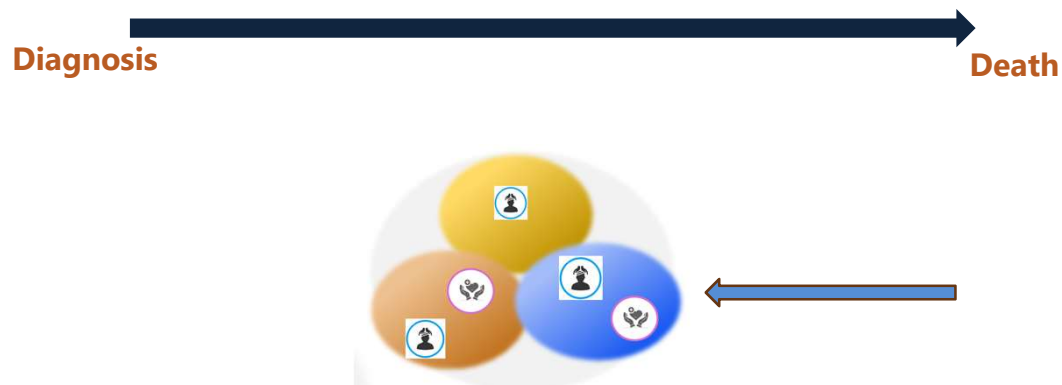


## A death announced? The case of Dialysis discontinuation

- An end of life:
  - Marked by ambivalence
  - Isolating active suicidal behaviour
  - To be prepared together with palliative care
- Choosing to die in order to regain control over one's own choices?
- Addressing the ethical dilemma faced by dialysis clinical staff

---

Maccaferri G.E., Banava E., Duc L., Gamondi C., Fekih Ghorbel Y., Solomon R.A.  
*The end of dialysis: the weariness to carry on.* RMS, 2024



## Psychiatric disorders co-occurring with chronic progressive physical illnesses: Chronic psychoses

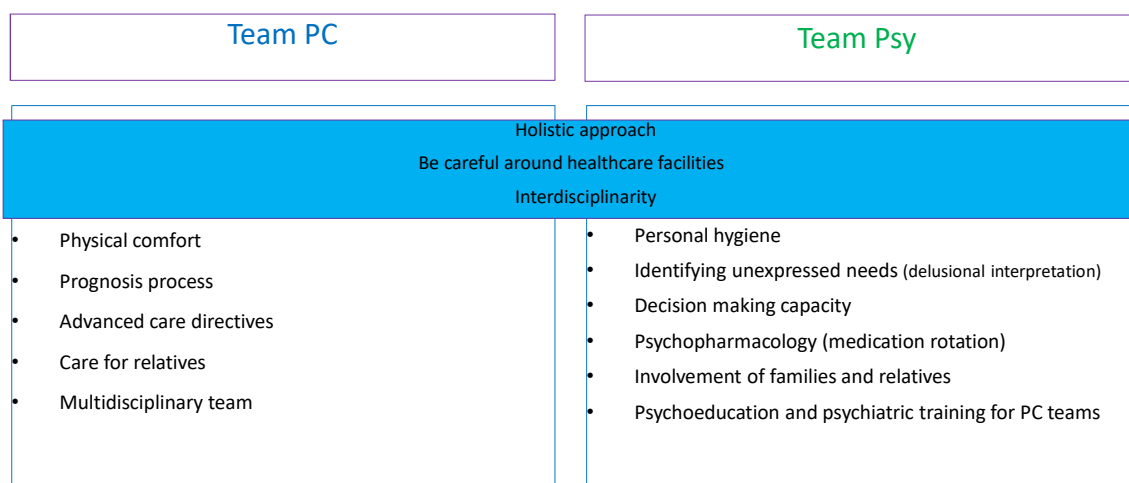
### The « loss of chance » in patients with Schizophrenia

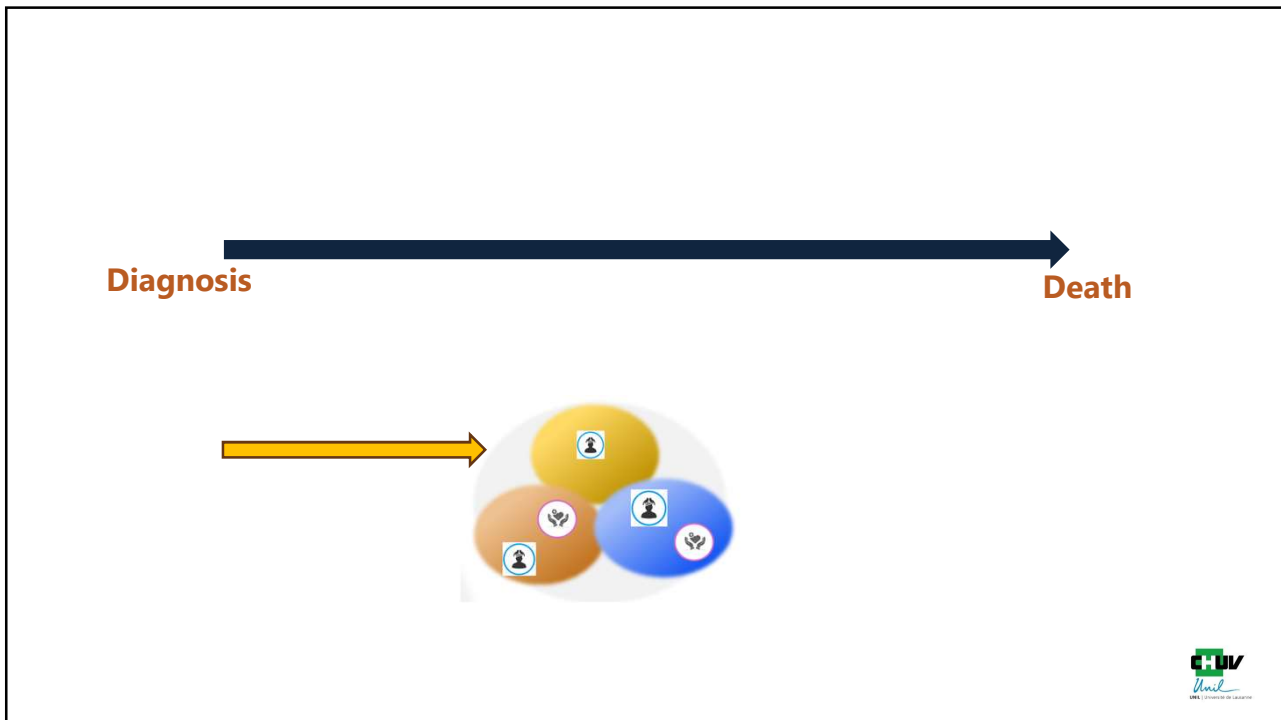
- Risk of premature death before the age of 65 (> 2–3 times)
- Life expectancy reduced by 20%
  - ✓ Suicide, accidents, cardiovascular and respiratory diseases
  - ✓ Reduced access to somatic care
    - ✓ Failure to recognize warning signs
    - ✓ Poor adherence to medication

*Limosin, 2010; Saha et al., 2007; Fors et al., 2007; Nasrallah et al. (CATIE study), 2006*



## Who does what in this situation?





### A few examples

- Anorexia nervosa
- Clozapine-Resistant Schizophrenia
- Persistent Malignant Catatonia
- Treatment-Resistant Mood Disorders (15 % risk of suicide)
- Severe Personality Disorders with chronic clinical instability
- Progressive addictive behaviours with a high risk of mortality

*Maccaferri et al., 2024; Kessler, Maccaferri et al., 2023;  
Trachsel, The Lancet Psych, 2016; ; Hasan et al., 2021; Rush et al., 2006*

## Who does what in this situation?

| Team PC                                                                                                                                                                                                         | Team Psy                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Holistic approach<br>Be careful around healthcare facilities<br>Interdisciplinarity<br>Involvement of families and relatives                                                                                    |                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>• Support for prognosis</li> <li>• Support for the healthcare team</li> <li>• Support for relatives</li> <li>• Advance directives</li> <li>• Physical comfort</li> </ul> | <ul style="list-style-type: none"> <li>• Autonomy <u>vs.</u> Coercion (decision making capacity)</li> <li>• Identifying defence mechanisms</li> <li>• Working on emotional regulation</li> <li>• Psychopharmacology (deprescribing)</li> <li>• Reducing inappropriate Psychiatric admissions</li> <li>• A psychotherapeutic perspective?</li> </ul> |



## Chronic progressives psychiatric disorders = Palliative Psychiatry ?!

- Definition and area of SPMI (*Severe Persistent Mental Illness*):
  - Psychiatric diagnosis, duration of symptoms, disability
  - Focus on quality of life
  - Respect of autonomy
  - Therapeutic relationship
- Challenges:
  - No consensus on indications and palliative care in psychiatry
  - Needs operational definitions, structured clinical protocols
  - Dispelling unfounded fears associated with the withdrawal of care

*Traksel, BMC Psychiatry, 2016; Westermair, Frontiers in Psychiatry, 2021; Elgudin, Ann Palliat Med, 2024; Ruggeri, 2000; Trachsel, 2016; Swiss Academy of Medical Sciences, 2013; WHO, 2014; Myamoto, 2016*





## Organisational challenges and areas for collaboration

- Compartmentalisation of teams -> Medical-psychiatric teams?
- Lack of integrated models -> Drawing inspiration from one another
- Billing restrictions -> How can we ensure these services are properly valued?
- Lack of palliative psychiatric care pathways -> Drawing inspiration from palliative medicine
- Mutual lack of understanding of each other's practices -> More training!



## New CAS in Psychiatry and Palliative Care !

formation continue   [www.formation-continue-unil-epfl.ch](http://www.formation-continue-unil-epfl.ch)



CERTIFICATE OF ADVANCED STUDIES (CAS)

### Psychiatrie et soins palliatifs : clinique de la complexité

**PUBLIC CONCERNÉ**  
Professionnel·le·s – médecins, psychologues et infirmier·ère – impliqué·es dans l'accompagnement de patient·e·s et de leurs proches dans des réalités cliniques de psychiatrie et/ou de soins palliatifs (travaillant dans des services institutionnels, dans les soins à domicile, ou en pratique privée).  
La formation est donnée en français.  
Pour la compréhension du matériel

**ENJEUX**  
La psychiatrie et la médecine palliative jouent un rôle clé dans l'accompagnement des personnes atteintes de maladies chroniques évolutives. Pourtant, ces disciplines sont encore trop souvent cloisonnées, alors que leurs approches se complètent. Face au vieillissement de la population et à l'augmentation des situations cliniques mêlant dimensions somatiques et psychiatriques, il devient essentiel de renforcer les collaborations interdisciplinaires.  
Comment mieux repérer les impacts des troubles psychiatriques sur l'évolution d'une maladie chronique à issue fatale ?  
Et inversement, comment accompagner les troubles psychiques qui émergent dans un contexte de fin de vie ?

### Cursus structure:

- 4 theory modules
- Focus on stress of clinicians
- 1 work experience training in a reverse clinical department !
- CAS University degree





### Key takeaways



The interdependence between the two disciplines in the management of mental and physical health



Difficulties in identifying psychiatric patients



Skills of a palliative care specialist in a psychiatric setting



Thank you!

[giorgio.maccaferri@chuv.ch](mailto:giorgio.maccaferri@chuv.ch)



# Physician Group palliative.ch: the year 2025 in summary



**palliative.ch**

**gemeinsam kompetent  
ensemble compétent  
insieme con competenza**

# SUMMARY



- Certification of IdS curricula
- Exam planning and organisation
- Certification of post-graduate institutions for education in palliative medicine
- Credits for continuing education
- Tariffs
- Political “lobbying” in collaboration with palliative.ch
- Consultations on different topics regarding PC



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Palliative.ch:

Corina Wirth

Anja Bernet

### Member Physician Group:

- Eva Balmer
- Eva Bergsträsser
- Christopher Böhlke
- Mirjam Buschor-Bichsel
- Philippe D'Andrès
- Gaby Fuchs
- Samuel Heiniger
- Caroline Hertler
- Barbara Loupatatzis
- Floriana Lurati
- Jürg Streuli
- Petra Vayne-Bossert



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## Palliativmedizin (palliative.ch)

Programm vom 1. Juli 2023



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## Médecine palliative (palliative.ch)

Programme du 1<sup>er</sup> juillet 2023

- Certification of 12 IdS titles
- Until June 30<sup>th</sup>, IdS can ben recognised according to the 2016 programme
- Coordination with palliative.ch to refine the process
- Development and publication of documents on the website for candidates/institutions



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- Since 1.1.2025 passing the exam is mandatory for obtaining the IdS
- 9 candidates were examined in all three language regions in Switzerland
- Coordination with palliative.ch to refine the process
- Development and publication of documents on the website for candidates/institutions



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To Barbara Loupatatzis for leading the exam commission

To all experts😊

To the academic centres in Switzerland for hosting the exams



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- Institutions need to be certified according to the new programme from 1.1.2027
- Certification is ongoing
- Coordination with palliative.ch to refine the process
- Development and publication of documents on the website for institutions



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- Development of a commission that evaluates and approves credits for continuing education in specialised palliative medicine
- Alignment to all other medical specialties in Switzerland in terms of types of credit approval
- Recertification is now required every 5 years (10 credits per year/50 per 5 year)



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- Physicians group representative in the Tariffs group:  
Mirjam Buschor-Bichsel
- TARDOC (as already discussed yesterday with Corina Wirth)
- EFAS consultation ongoing
- Reimbursement complex PC delivery



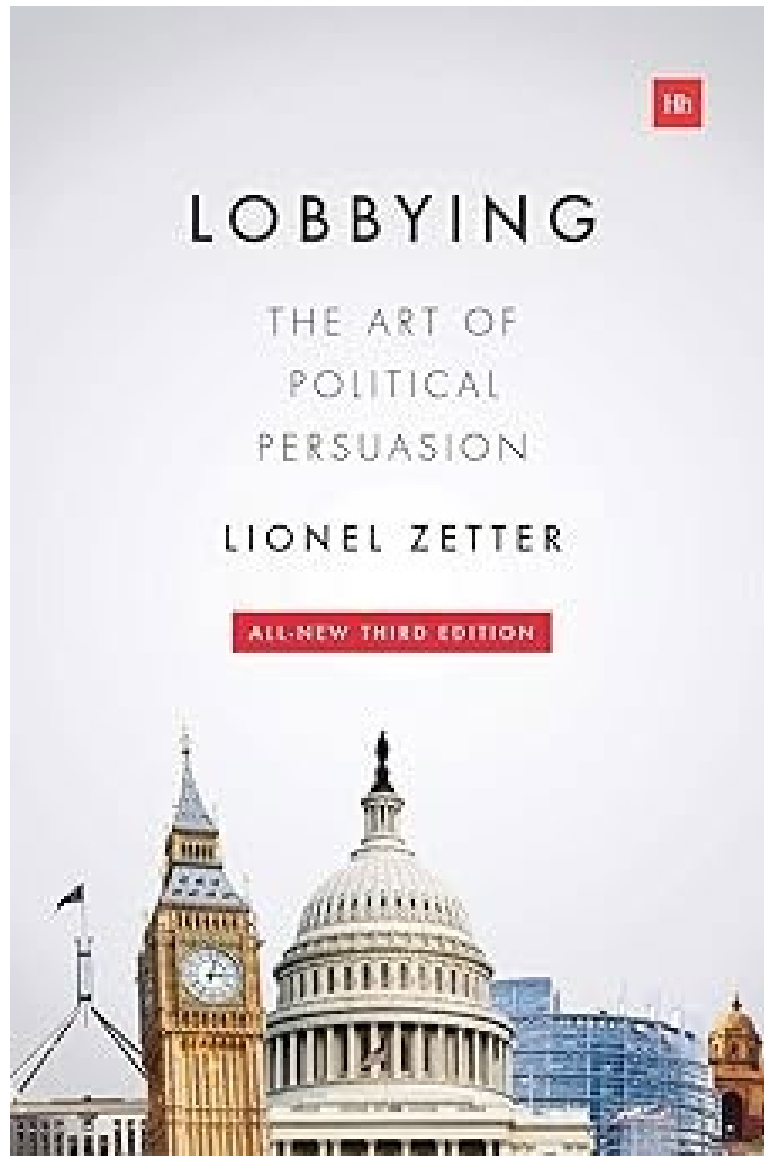
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- In strong collaboration with Palliative.ch
- Advocacy for high-quality specialised PC education and for the role of specialised PC in every care setting
- Supporting visibility amongst other medical societies



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- Consultation procedures on:

- Advance care planning
- Resuscitation measures
- EFAS



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# KETAMIN IN PALLIATIVE CARE

---

Dr. med. Monika Jaquenod-Linder

Konsiliarärztin Palliaviva Kanton Zürich / Palliative Care Stadt Zürich





# KETAMIN IN MY DAILY PRACTICE SINCE 35 YEARS

- Ketamin in anaesthesia, emergency medicine: excellent efficacy
  - Anaesthesia: vulnerable, elderly, frail, unstable or hypovolemic patients; cesarean section
  - Non-fasting patients/children for analog sedation
    - Opioids as an alternative have disadvantages
- Introduction at USZ on wards approximately 20 years ago for complex postoperative/pain patients
- Introduction at Hirslanden Clinic approximately 10 years ago



# KETAMINE IN MY DAILY PRACTICE

- Ketamin as a “pain infusion”: over 30 to 45 minutes, 0.3 to 1 mg/kg of ketamine
- Immediate effects (less pain, next day more energy); lasts 2 to 3 weeks or longer: complex neuroplastic effects are being discussed, less pain for 1 to 3 weeks. “resetting”
  - Neuropathic pain
  - Nociceptive pain
  - Migraine, “fibromyalgia”
  - (Depression, Fatigue)
- Report from a social worker: popular in the scene because it makes the next day better. Nasal microdosing; the only downside is “the Ketamin whole” in the event of an “overdose” in the scene



# KETAMINE IN MY DAILY PRACTICE

## Ketamin as a “pain infusion” - Reports from patients:

Relaxation sets in. I'm lying on a soft surface; it goes beyond the familiar. Hyper-real - something that would never be possible through a body scan.

A cheerful lightness lifts my spirits throughout the entire treatment. Carefree feelings thanks to the anxiolytic effect of the pain infusion.

The sensation of flying in white clouds, in an outer space. Colours blue, yellow, orange. My brain is flooded with real-time data, impressions from within and without. The highly active cognition liberates the mind from everyday concerns.

An expanded world of thought drifts away from my body, until the body is no more.

Is it like dying? Then dying is easy.

# CASE REPORT PALLIATIVE PATIENT

- 35 y patient, metastatic adenocarcinoma of the appendix, diagnosed in 2022 - died in July 2025
- Multiple abdominal surgeries, months-long hospital stays at Hirslanden Clinic due to intestinal leaks, intensive care, high-calorie nutrition, an incredibly strong will to live.
- April 2025, he decided to stay at home; he didn't want to go to the hospital anymore. He is looked after by his wife, mother and Palliaviva. Abdomen with two intestinal fistulas; if they didn't drain, symptoms of subileus developed immediately. An extremely difficult psychosomatic situation. Heavy abdominal pain. A PCA (Picc) was initiated because oral administration was no longer possible.
- PCA was initially filled with morphine, using both continuous infusion and bolus doses; the dose was gradually increased. Pain relief was suboptimal (sandostatin, dexamethasone,...) with 700 mg Morphin i.v.. Ketamine was added with careful dose titration; initially at low doses, psychotropic side effects occurred.

## PCA

Patient: L.R., 35 jährig

Inbetriebnahme :  
Verlaufsblatt Nr.:

☐ i.v

☐ PICC

|                                               |                            |  |  |
|-----------------------------------------------|----------------------------|--|--|
| Datum<br>Zeit                                 | Juli 2026                  |  |  |
| Behältnisgrösse<br>in ml                      | 250 ml                     |  |  |
| Morphin 5 %<br>500 mg/10 ml                   | 5 Amp = 50 ml =<br>2500 mg |  |  |
| Ketalar<br>500 mg/10 ml                       | 5 Amp = 50 ml =<br>2500 mg |  |  |
| NaCl ml 0.9%                                  | 150 ml                     |  |  |
| Reservoir ml<br>(alt/neu)                     | 250 ml                     |  |  |
| Konzentrat mg/ml<br>Morphin<br>Ketamin        | 10 mg/ml<br>10 mg/ml       |  |  |
| Rate mg/h<br>Morphin<br>Ketamin               | 20mg/h<br>20mg/h           |  |  |
| Bolus (B) mg/B<br>Morphin<br>Ketamin          | 7 mg<br>7 mg               |  |  |
| Boli (Minuten)                                | 5 min                      |  |  |
| Boli (Stunde)                                 | 7 x                        |  |  |
| Boli<br>gegeben/versucht<br>auf Null gestellt |                            |  |  |
| NW/SW                                         |                            |  |  |
| Visum                                         |                            |  |  |



# KETAMIN SL-LIMITATION



**Thank you to Manuela Weichelt  
and Ursina Wehrli**

## *Pain management / Palliative care*

Ketamine should only be administered by specialists in palliative medicine or anaesthesiology with experience in the use of ketamine.

In non-palliative situations, administration should be limited to as short as possible (maximum a few days ).



# Summer School Palliative Medicine 2026

Murten, 25.06.2026

## Clinical trials in Palliative care: Ketamine in cancer patients

Caroline Hertler, MD  
Competence Center for Palliative Care  
University Hospital & University of Zurich  
Switzerland



**USZ** Universitäts  
Spital Zürich



**SWISS** NEURO-ONCOLOGY  
SOCIETY



**eano** EUROPEAN ASSOCIATION  
OF NEURO-ONCOLOGY

# Psychedelics

## Hallucinogens, Entheogens

- LSD, Psilocybin

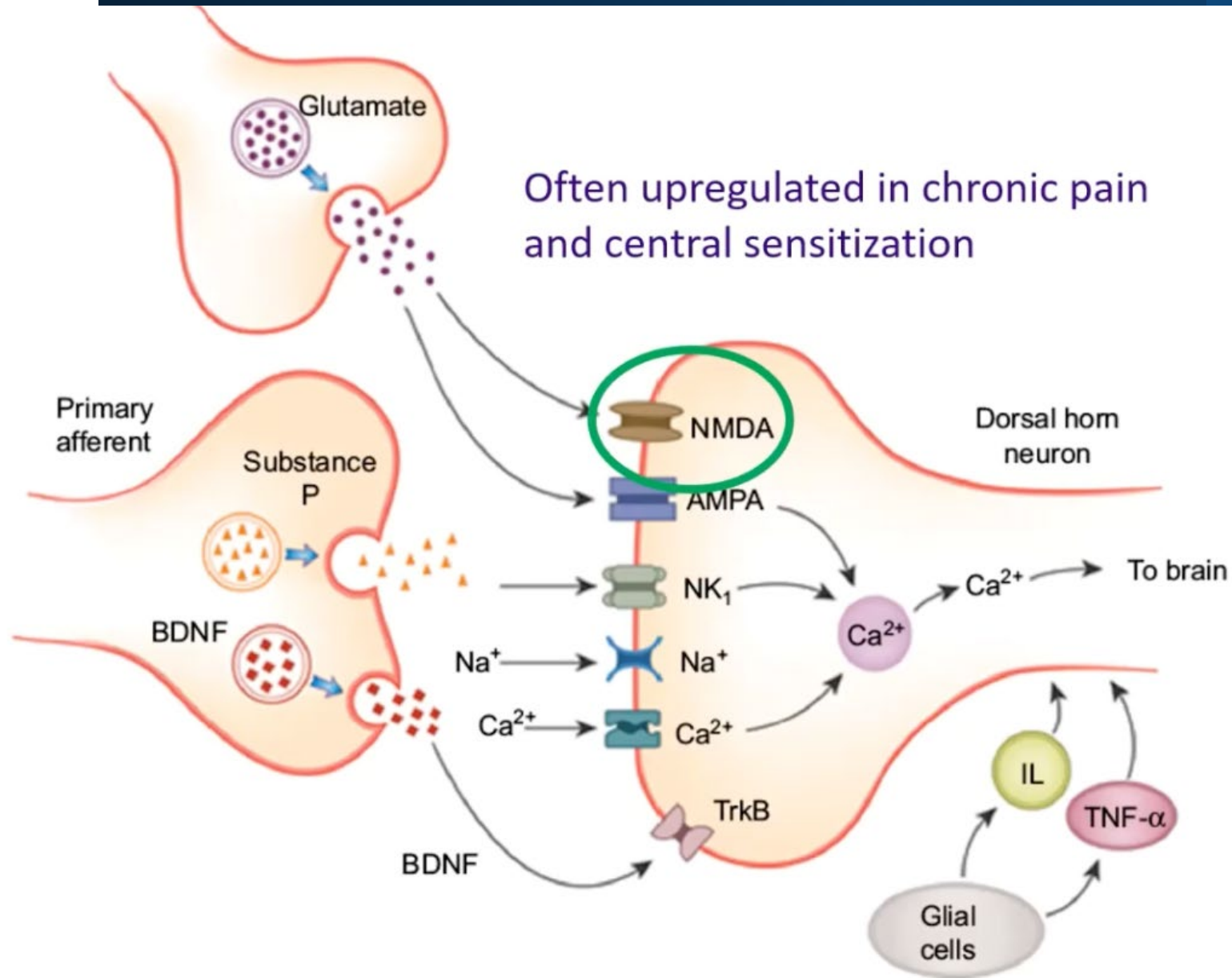
## Empathogens

- MDMA

## Dissociativa

- Ketamin





**Ketamine** = glutamate system

Atypical psychedelic!

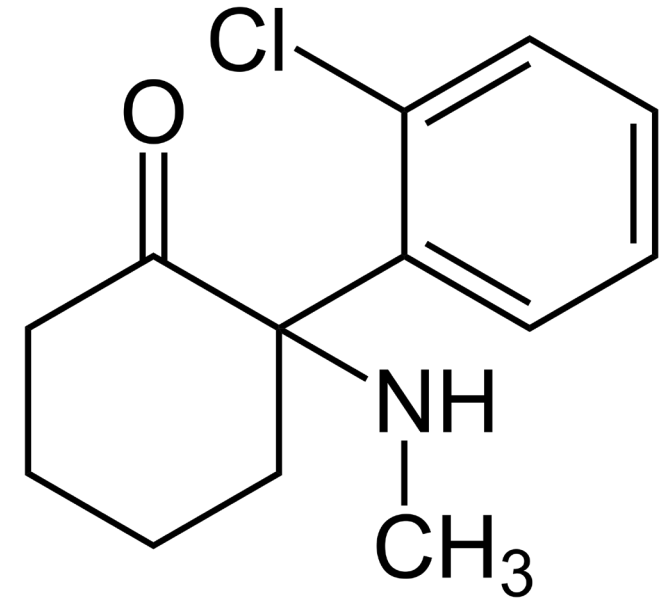
**LSD/Psilocybin** = serotonin receptors

Typical psychedelics

# (S)-Ketamine

N-methyl-D-aspartate (NMDA) antagonist

- Strong, short-lasting analgesic effect
- Strong, rapid-acting antidepressant effect
- Approved by FDA in 1970
- Swissmedic approval for refractory depression (Esketamin) in 2020



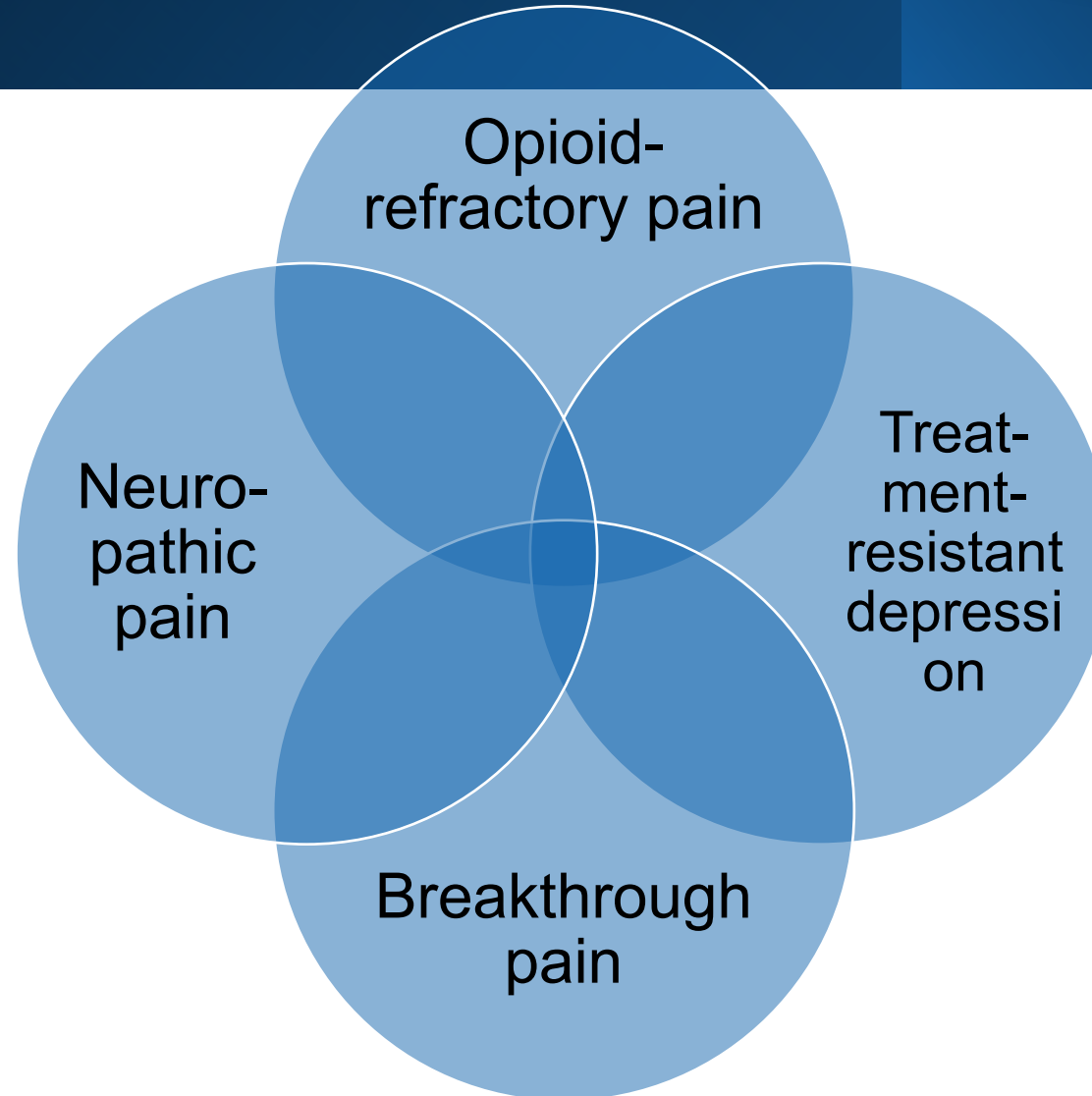
# Indications for ketamine

Approved for:  
Anesthesia

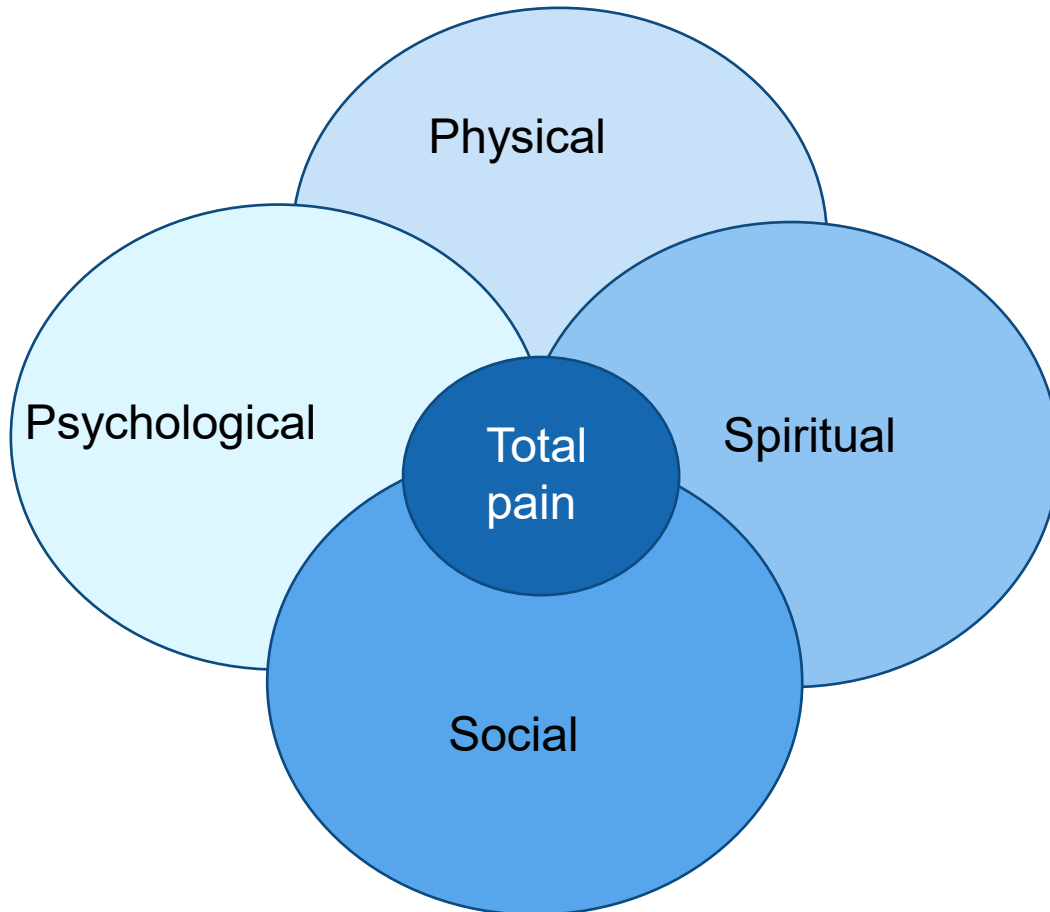
Off-label use:

- Acute and chronic pain
- Depression
- Analgesia/Sedation/Agitation on ICU
- Intubation preparation
- refractory Status epilepticus

# Ketamine use in Palliative Care



# Symptoms in Palliative Care



Palliative patients are burdened by:

- Pain (up to 90%)
- Depression (24.6%)
- Anxiety (9.8%)



Pain



Depression

**Ketamine as an adjuvant to opioids for cancer pain (Review)**

Bell RF, Eccleston C, Kalso EA

- MEDLINE (OVID) to December 2016. We searched CENTRAL (CRSO), Embase (OVID) and two clinical trial registries to January 2017
- Addition of ketamine, given by any route of administration, in any dose, to pre-existing opioid treatment given by any route and in any dose, compared with placebo or active control.
- 3 studies:
  - 2 small with cross-over, 20 and 10 participants, intravenous, add-on to morphine -reduction in pain intensity
  - 1 parallel group design, 185 participants, subcutaneous high doses (500mg) – no difference in pain intensity



# Randomized Controlled Trials

| Studie                           | Patienten                                                             | Intervention                                                         | Ergebnis                                                                          |
|----------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Mercadante et al<br>2000<br>N=10 | Morphine refractory pain<br>90-300mg                                  | Ketamine 0.25mg/kg Bolus<br>Ketamine 0.5mg/kg Bolus<br>Placebo Bolus | Better symptom control with 0.5mg/kg<br>More Side effects<br>(40% Hallucinations) |
| Salas et al<br>2012<br>N=20      | Cancer-related pain<br>NRS $\geq 4/0$ after morphine                  | Ketamine 0.5mg/kg/day followed by 1mg/kg/day after 24h<br>Placebo    | No difference                                                                     |
| Hardy et al<br>2012<br>N=185     | Cancer-associated pain $\geq 3/10$ despite morphine and Co-medication | Ketamin infusion 100mg/day up to 500mg/day<br>Placebo                | No difference in analgesia<br>Side effects more prominent                         |



# Efficacy and Safety of Ketamine to Treat Cancer Pain in



## Adult Patients: A Systematic Review

Jiao Jiao, MS, Jin Fan, MS, Yonggang Zhang, PhD, and Lingmin Chen, PhD

*Department of Anesthesiology (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; The Research Units of West China-Chinese Academy of Medical Sciences (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; School of Acupuncture-Moxibustion and Tuina (J.F.), Chengdu University of Traditional Chinese Medicine, Chengdu, China; Department of Periodical Press and National Clinical Research Center for Geriatrics (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Chinese Evidence-based Medicine Center (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Nursing Key Laboratory of Sichuan Province (Y.Z.), Chengdu, China*

- 35 studies were included, involving 2279 patients with cancer pain.
- Ketamine could significantly reduce pain intensity.
- Subgroup analysis revealed:
  - Ketamine decreased markedly visual analogue scale (VAS) scores in two days after the end of treatment with ketamine
  - Ketamine administrated by patient controlled epidural analgesia (PCEA) was effective.
  - Ketamine could significantly reduce the number of patient-controlled analgesia (PCA) compressions within 24 hours and morphine dosage.
  - Adverse events significantly decreased in the ketamine group, including nausea and vomiting, constipation, pruritus, lethargy, uroschesis, hallucination, and respiratory depression.
  - Ketamine could reduce Hamilton depression scale (HAMD) score and relieve depressive symptoms.

# Efficacy and Safety of Ketamine to Treat Cancer Pain in Adult Patients: A Systematic Review



Jiao Jiao, MS, Jin Fan, MS, Yonggang Zhang, PhD, and Lingmin Chen, PhD  
*Department of Anesthesiology (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; The Research Units of West China-Chinese Academy of Medical Sciences (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; School of Acupuncture-Moxibustion and Tuina (J.F.), Chengdu University of Traditional Chinese Medicine, Chengdu, China; Department of Periodical Press and National Clinical Research Center for Geriatrics (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Chinese Evidence-based Medicine Center (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Nursing Key Laboratory of Sichuan Province (Y.Z.), Chengdu, China*

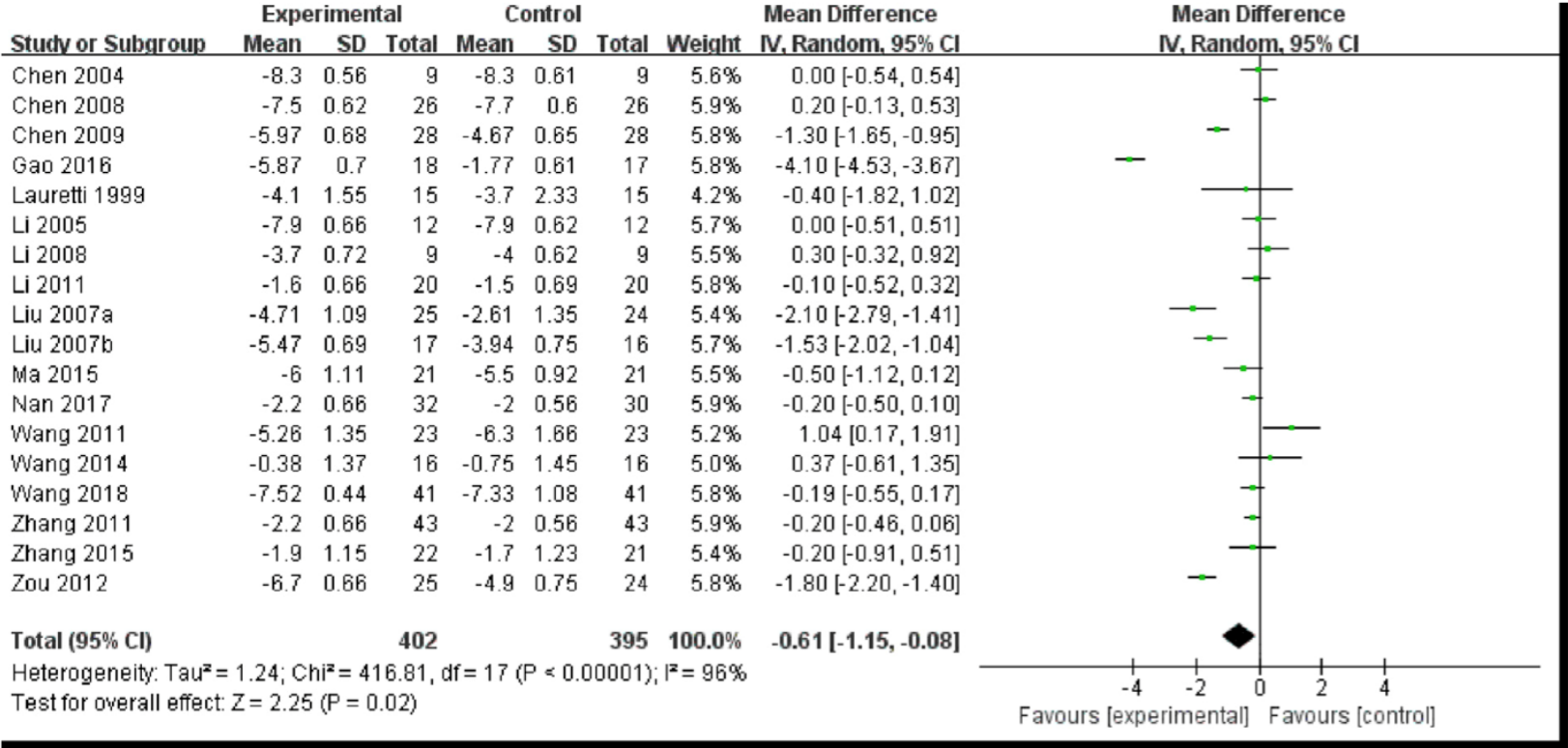


Fig. 2. The forest plot of VAS. 95% CI, 95% confidence interval; IV, inverse variance; SD, standard deviation; VAS, visual analog scale. For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article.

Adult Patients: A Systematic Review

Jiao Jiao, MS, Jin Fan, MS, Yonggang Zhang, PhD, and Lingmin Chen, PhD  
Department of Anesthesiology (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; The Research Units of West China-Chinese Academy of Medical Sciences (J.J., L.C.), West China Hospital, Sichuan University, Chengdu, China; School of Acupuncture-Moxibustion and Tuina (J.F.), Chengdu University of Traditional Chinese Medicine, Chengdu, China; Department of Periodical Press and National Clinical Research Center for Geriatrics (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Chinese Evidence-based Medicine Center (Y.Z.), West China Hospital, Sichuan University, Chengdu, China; Nursing Key Laboratory of Sichuan Province (Y.Z.), Chengdu, China

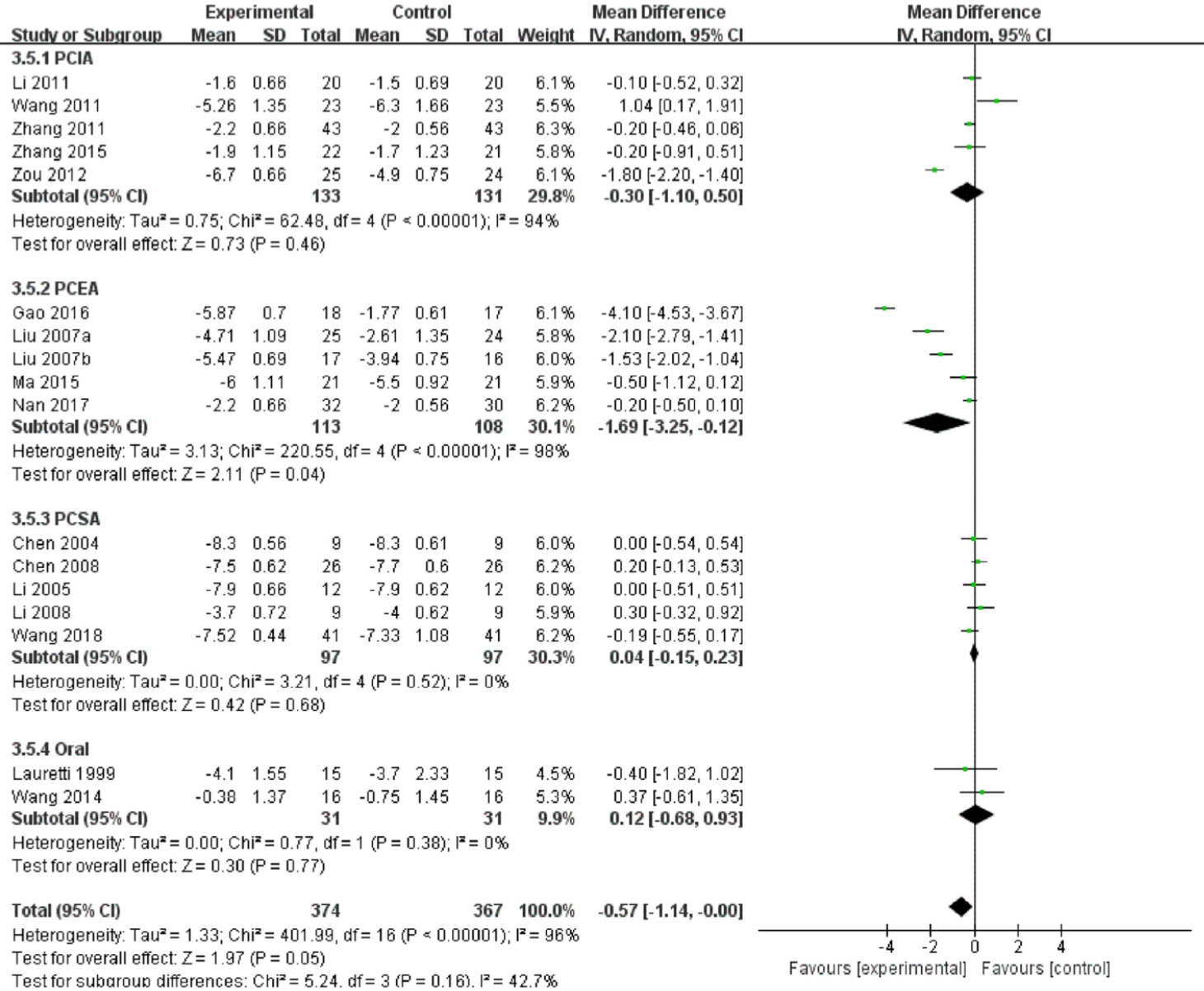


Fig. 5. The subgroups of the administration route. 95% CI, 95% confidence interval; IV, inverse variance; SD, standard deviation. For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article.

# Ketamine for pain – who benefits?

- Studies show heterogeneous results
- Not a first-line drug
- Should be considered for patients as adjuvant treatment when:
  - Refractory pain despite opioid escalation > 300mg oral morphine equivalent
  - Side effects through opioid escalation
  - Allodynia

# The Efficacy of Ketamine in the Palliative Care Setting: A Comprehensive Review of the Literature

[Nathaniel Goldman, BA](#) ✉, [Michael Frankenthaler, MD](#), and [Lidia Klepacz, MD](#) [View all authors and affiliations](#)

[Volume 22, Issue 9](#) | <https://doi.org/10.1089/jpm.2018.0627>

- Eleven studies were included on the topic of ketamine as an antidepressant in the palliative care population.
- Additionally, 5 RCT studies were included on the topic of physical pain in this population.
- Results:
  - All 11 studies, including one RCT, found antidepressant effects of ketamine in this patient population.
  - Ketamine's effect on treating physical pain was mixed with the largest and most recent RCTs suggesting no significant analgesic effect

# Subcutaneous ketamine infusion in palliative patients for major depressive disorder (SKIPMDD)—Phase II single-arm open-label feasibility study

Wei Lee<sup>1,2,3,4\*</sup>, Caitlin Sheehan<sup>5</sup>, Richard Chye<sup>1,2,6,7</sup>, Sungwon Chang<sup>1</sup>, Adam Bayes<sup>7,8</sup>, Colleen Loo<sup>7,8</sup>, Brian Draper<sup>7</sup>, Meera R. Agar<sup>1,7</sup>, David C. Currow<sup>9</sup>

- Participants received weekly subcutaneous ketamine infusion (0.1–0.4mg/kg) over two hours using individual dose-titration design –up to 4 weeks
- 10 participants
- 50% of treated participants achieving  $\geq 50\%$  reduction in baseline Montgomery-Åsberg Depression Rating Scale



# Own research – intranasal ketamine

## **Keta-Care** **Antidepressant and anxiolytic effects of intranasal** **ketamine self-administration in palliative care** **cancer patients: an open-label feasibility study**

|                          |                                                                                                                                                                                         |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Study <u>Type</u> :      | Clinical trial with Investigational Medicinal Product (IMP) according to ClinO Chapter 2                                                                                                |
| Study Categorisation:    | Risk category C according to Chapter 2, Art. 19 of ClinO                                                                                                                                |
| Study Registration:      | ClinicalTrials.gov (NCT06665568); SNCTP (P000006265)                                                                                                                                    |
| Study Identifier:        | Keta-Care                                                                                                                                                                               |
| Sponsor-Investigator:    | PD Dr. med. Caroline Hertler<br>University Hospital Zurich<br>Department of Radiation-Oncology<br>Competence Center Palliative Care<br>Rämistrasse 100<br>CH-8091 Zurich<br>Switzerland |
| Investigational Product: | Study Drug – ketamine hydrochloride                                                                                                                                                     |

# Own research – intranasal ketamine

## **Aim:**

- Assess the feasibility and efficacy of ketamine nasal spray for anxiety and depression in outpatient palliative care cancer patients

## **Design:**

- Patients with Hamilton Anxiety and Depression Scale (HADS) Score > 6

## **Intervention:**

- Self-administration of nasal ketamine (5mg/stroke, max. 50mg)

## **Sub-study:**

- Caregivers of enrolled patients



## STUDY SCHEDULE

HADS  
MADRS  
HAM-A

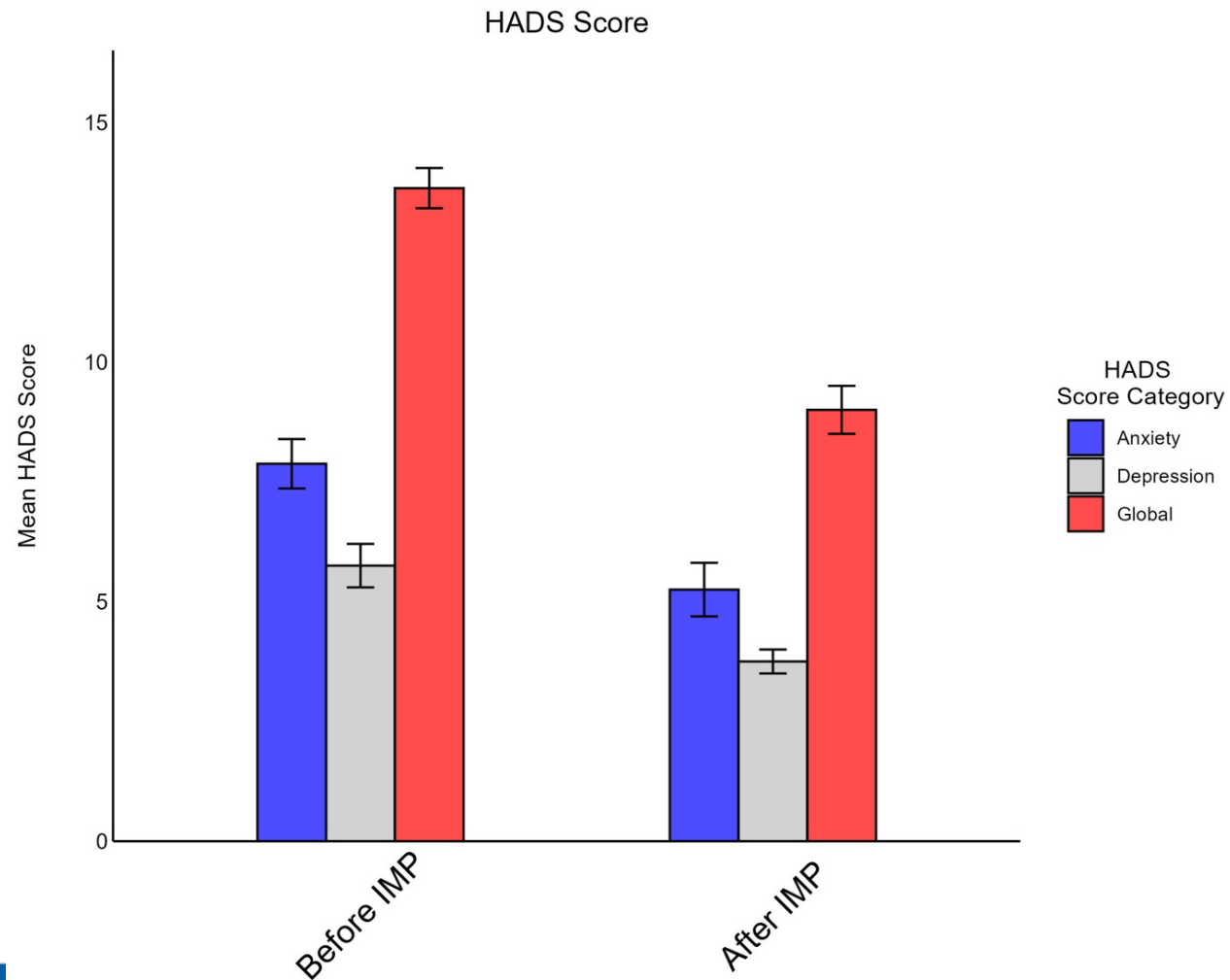
QoL  
Sleep

Burden  
QoL  
Sleep

| Patient                                                           |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
|-------------------------------------------------------------------|--------------------|-----------|----------------------------------------------------|---|---|---|---|---|---|---|-----------------------|--|
| Item                                                              | Before study start |           | Week (+/- 2 days)                                  |   |   |   |   |   |   |   | 90 days (+/- 2 weeks) |  |
|                                                                   | Pre-Screening      | Screening | 1                                                  | 2 | 3 | 4 | 5 | 6 | 7 | 8 |                       |  |
| IPOS                                                              | x                  | x         | x                                                  | x | x | x | x | x | x | x |                       |  |
| Signed informed consent                                           |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Screening blood sample* (chemistry, hematology, liver function)   |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Epidemiological data                                              |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Clinical history                                                  |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| C-SSRS                                                            |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| HADS                                                              |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| MADRS                                                             |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| HAM-A                                                             |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| EORTC-QLQ-C30                                                     |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| IMP administration                                                |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Vitals                                                            |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Patient report of any AE / SAE since last visit                   |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| LOC (AE) & drug effects, CADSS-6                                  |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| PSQI                                                              |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Debriefing                                                        |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Safety visit blood sample (chemistry, hematology, liver function) |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Contact 90 days post final dosing                                 |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Safety reporting period for all AEs / SAEs                        |                    |           | From consent to final IMP administration + 90 days |   |   |   |   |   |   |   | x                     |  |
| Caregiver                                                         |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Item                                                              | Before study start |           | Week (+/- 2 days)                                  |   |   |   |   |   |   |   |                       |  |
|                                                                   | Pre-Screening      | Screening | 1                                                  | 2 | 3 | 4 | 5 | 6 | 7 | 8 |                       |  |
| Signed informed consent                                           |                    | x         | x                                                  | x | x | x | x | x | x | x |                       |  |
| ZBS                                                               |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| CarGoQoL                                                          |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| PSQI                                                              |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |
| Debriefing                                                        |                    |           |                                                    |   |   |   |   |   |   |   |                       |  |

**Figure 1** Study schedule. Asterisk (\*) indicates that Screening blood sample may be skipped if chemistry, hematology and liver function values were already collected <1 month from first scheduled study visit and are available in the patient's medical record.

# First results – study ongoing



**Wie fühlen Sie sich im Moment aufgrund der Substanzwirkung?**  
Setzen Sie einen Strich (|) auf die Linie und einen Kreis (o) bei den Extremen ("überhaupt nicht"/ "extrem"/ "normal").

1. **Irgendeine Wirkung** überhaupt nicht |-----| extrem

2. **Gute Wirkung** überhaupt nicht |-----| extrem

3. **Schlechte Wirkung** überhaupt nicht |-----| extrem

4. **Glücklich** überhaupt nicht |-----| extrem

5. **Angst** überhaupt nicht |-----| extrem

*Article*

## **A Phase II, Open-Label Clinical Trial of Intranasal Ketamine for Depression in Patients with Cancer Receiving Palliative Care (INKeD-PC Study)**

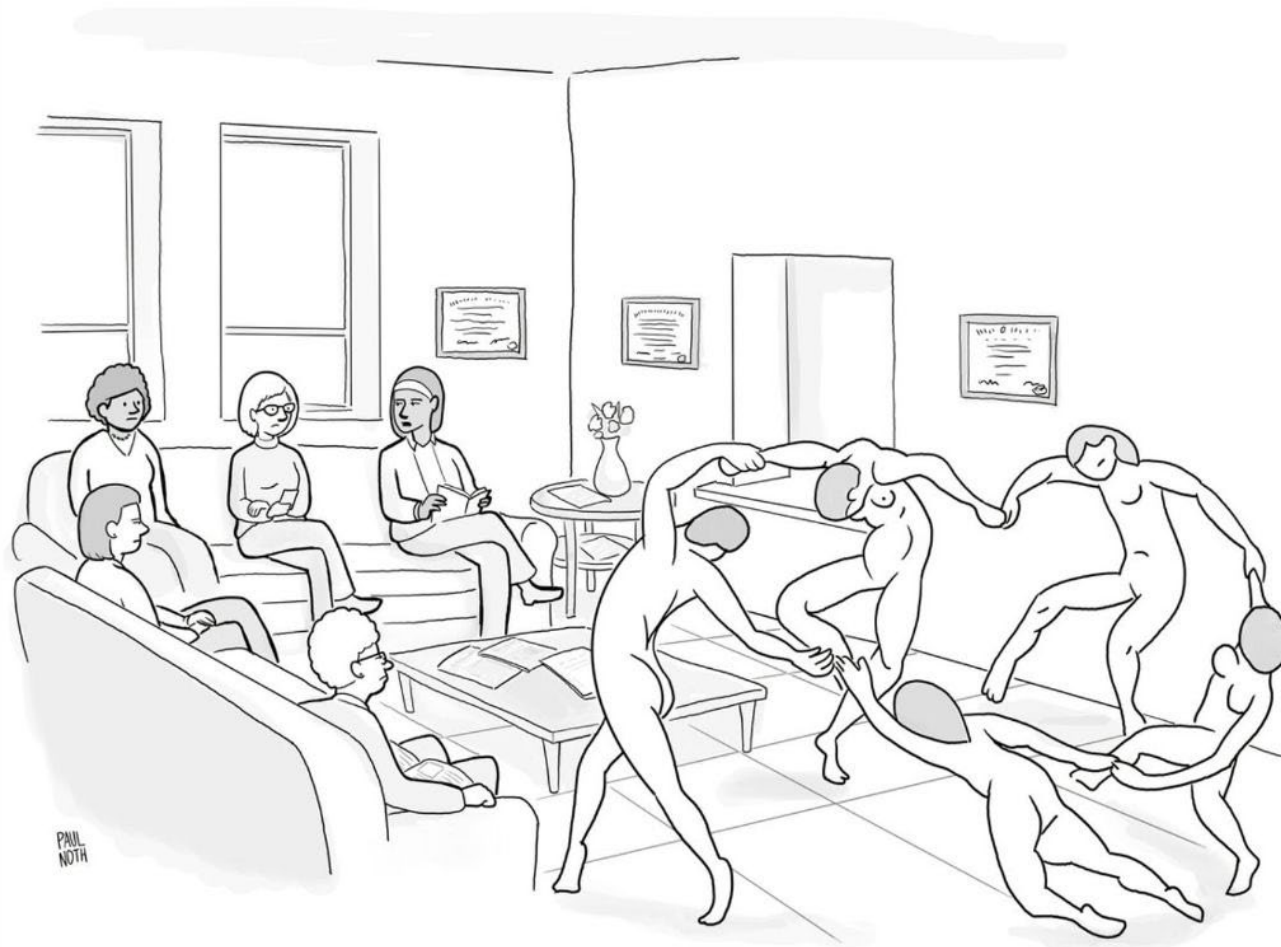
Joshua D. Rosenblat <sup>1,\*</sup>, Froukje E. deVries <sup>2</sup>, Zoe Doyle <sup>1</sup>, Roger S. McIntyre <sup>1</sup>, Gary Rodin <sup>1</sup>,  
Camilla Zimmermann <sup>1</sup>, Ernie Mak <sup>1</sup>, Breffni Hannon <sup>1</sup>, Christian Schulz-Quach <sup>1</sup>, Aida Al Kindy <sup>1</sup>,  
Zeal Patel <sup>1</sup> and Madeline Li <sup>1</sup>

- Participants with advanced cancer with moderate to severe MDD received three flexible doses of intranasal (IN) ketamine (50–150 mg) over a one-week period
- Primary outcome MADRS from baseline to the Day 8 primary endpoint
- 15 participants completed 3 applications
- The Day 8 antidepressant response (MADRS decreased by >50%) and remission (MADRS < 10 on Day 8) rates were high at 70% and 45%, respectively.

# Ketamine in Palliative Care

## Clinical considerations

- So far, the evidence for ketamine in palliative care remains limited by small sample sizes and methodological heterogeneity.
- Response to ketamine appears variable, with some patients responding favorably while others experience no effect. Factors predicting favorable response have not been identified.
- For depression, maintenance dosing strategies and long-term management approaches in serious illness show promising results but require further study



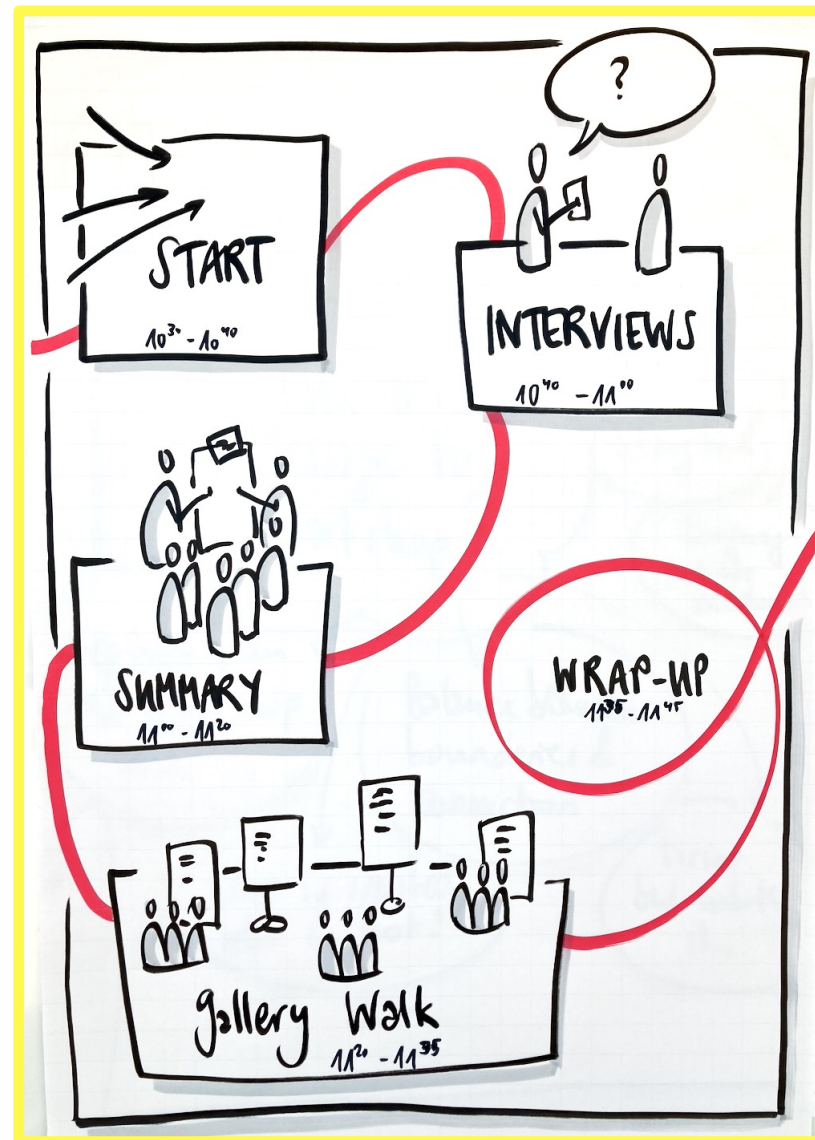
*“So I’m guessing we’re in the placebo group.”*



## Summerschool Palliative Care Documentation of Workshop 2

25.6.26 // 10.30-11.45h // Centre Löwenberg

### PROGRAM



## 9 RESEARCH QUESTIONS

**Workshop 2**  
Challenges in  
interprofessional  
teams  
with  
**Adriana  
Burgstaller**  
palliative.ch  
gesundheitssystem  
entwicklung  
beratung  
schulung

What has been your  
biggest gain from  
interprofessional  
collaboration?

What has been your  
largest pain point in  
interprofessional  
collaboration?

How can we live the core  
idea of interprofessional  
collaboration in the  
future?

What changes when new  
roles (such as physician  
associates) are  
introduced?

What helps you  
personally to stay open  
toward different  
perspectives?

When was the last time  
another profession  
changed your mind about  
a patient?

What might other professions  
find most challenging about  
working with us?  
What might they wish for  
from us?

What small change would  
make the biggest  
difference in your daily  
interprofessional work?

What did you have to  
unlearn in order to work  
well in an  
interprofessional team?

## INTERVIEWS





## SUMMARY IN SMALL GROUPS





## RESULTS - Questions 1-3

What has been your biggest gain from interprofessional collaboration?

Shift in perspectives:  
opening up  
humility  
Shared responsibility  
Validation of capacities of others

What has been your largest pain point in interprofessional collaboration?

- ▷ Unwillingness to take a leadership role   
 gap to responsibility
- ▷ Definition of boundaries of roles + competences
- ▷ Missing trust
- ▷ Different communication style, attitude + respect
- ▷ time consuming interfaces/communication because of different needs
- ▷ Lacking resources within other professions
- ▷ Lacking understanding of the availability of the physician

What small change would make the biggest difference in your daily interprofessional work?

THINKING THE INTERPROF. TEAM IN A BROADER WAY

facility management

cook

reception

hôtellerie

ENHANCING RELATIONSHIPS

informal time together

see the other as a person, not only his/her profession

definition/understanding of roles and competences

understanding

respect

+ trust

ACCESS TO INFORMATION

notes, documentation: in the same "place"

broader input options?

meetings

## RESULTS - Questions 4-6



What might other professions find most challenging about working with us? What might they wish for from us?

- More humility (from palliative care)!*
- Hierarchy in decision making in interprof. Team
  - Medical view over holistic view
  - Communication quantity & quality *listening*
- *Make space and autonomy*
- *Clarify the rules (as consultants)*

How can we live the core idea of interprofessional collaboration in the future?

- reimbursement
- communication skills
- Schedule for <sup>systematic</sup> meetings &
- supervision / coaching
- make it attractive i.e. "goals should be defined"



## RESULTS - Questions 7-9

What changes when new roles (such as physician associates) are introduced?

- group dynamics
- <sup>new</sup> "old" points of view being questioned/alternative
- team goes through adaptation phase
- Definition { competencies borders
- team need to be rebalanced
- fear of change
- Cautionness

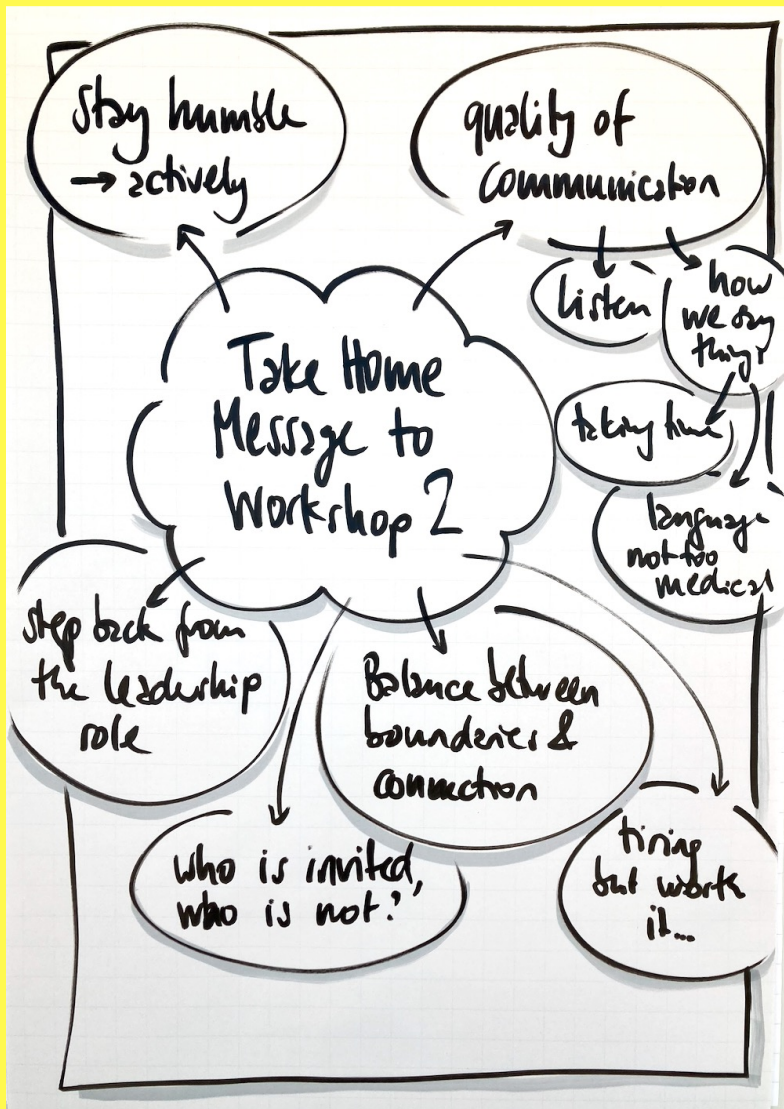
What did you have to unlearn in order to work well in an interprofessional team?

- adapt the language
- adapt the work pace
- accept to not having the lead / not taking all the responsibilities
- being comfortable with not having all the answers
- let go of the desire for consensus
- not sticking to your own opinion / ~~knowledge~~ knowledge
- taking different opinions personal

When was the last time another profession changed your mind about a patient?

- this happens frequently
- any profession
- helps to lightening blind spots
- can influence decision making

## YOUR TAKE HOME MESSAGE



THANK YOU VERY MUCH AND ALL THE BEST

ADRIANA

# Self-Care for Palliative Care Professionals

## Palliative Summer School 2026

Regula Saner – Basel  
eidg. anerk. Psychotherapeutin  
[www.zentrum-für-achtsamkeit.ch](http://www.zentrum-für-achtsamkeit.ch)



Mindful

1

 **Stanford** | WellMD  
MEDICINE | Center

## 2016 Physician Wellness Survey Full Report 2016

**Culture of Wellness**

- Perceived Appreciation
- Personal/Organization Values Alignment
- Peer Supportiveness
- Perceived Support from Leadership
- Control of Schedule

**Efficiency of Practice**

- Efficiency of the Electronic Medical Record

**Personal Resilience**

- Self-Compassion
- Sleep-Related Impairment
- Meaningfulness of Clinical Work

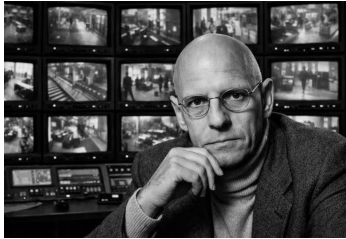



2



## SELF-CARE

## The 1970s



Michel Foucault  
Philosopher, France

Self-Care ≠ modern routine of pampering or wellness.  
it's hard work.  
it shapes the self, the identity, the desires and actions

Self-Reflection → Self-Knowledge → Self-Care

Journaling  
Meditation  
Mentorship

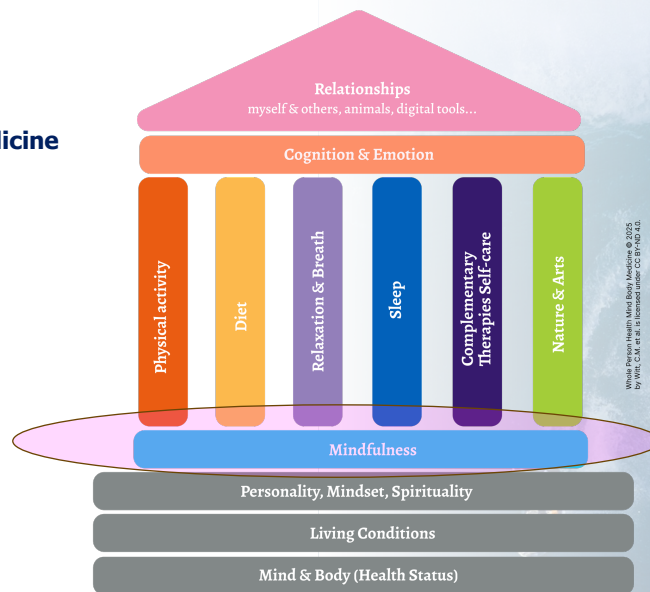
Seeking out wise friends or guides to help you uncover the truth about yourself without submitting blindly to an authority figure.



3

## Big Picture of Self-Care

**Temple of MindBodyMedicine**  
University Hospital Zurich  
Prof. Claudia Witt et al.



4

## STRESS / MINDFULNESS 1970s/1980s

### Stress Theory



Hans Selye  
Endocrinologist

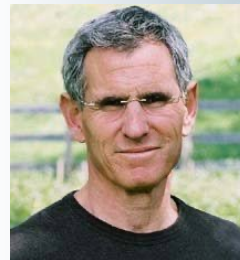
Richard Lazarus  
Psychologist



### MBSR

Mindfulness Based Stress Reduction  
8-week program

Meditation, Insight-Training and Self-Reflection

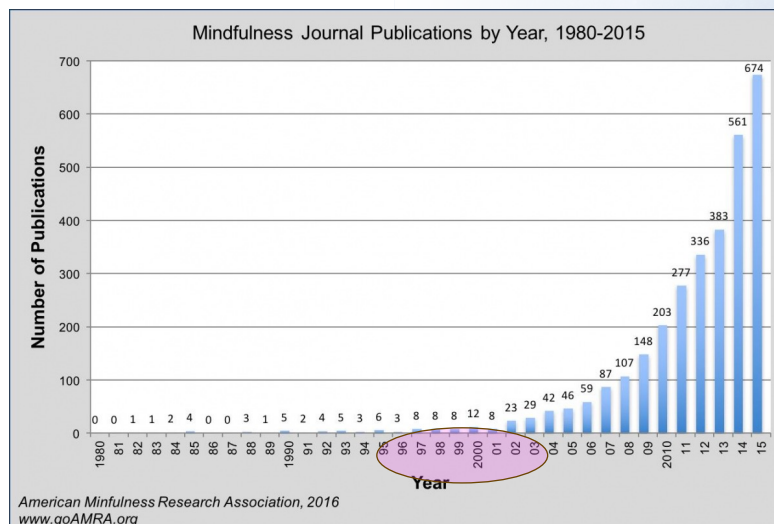


Jon Kabat Zinn



5

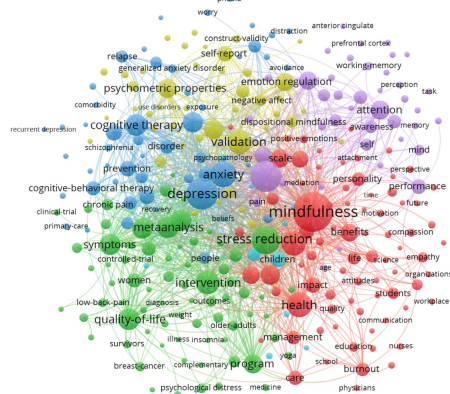
## MINDFULNESS The 1990s



6

## MINDFULNESS

### Trends of Research on Mindfulness: A Bibliometric Study of an Emerging Field, 2024 *Trends in Psychol.* 32, 466–479 (2024)



Publications versus Year

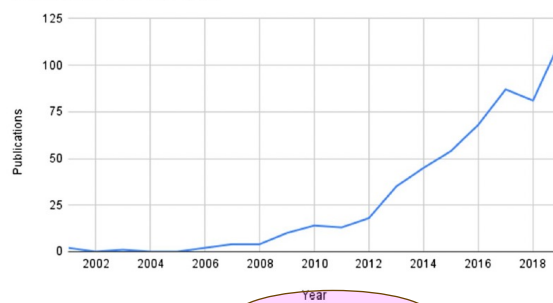


Fig. 5 The analysis of articles published with "randomized controlled trial" in the abstracts and the relation to the year of publication



7

## What is Mindfulness?

Jon Kabat-Zinn:

Mindfulness is awareness that arises through paying attention, on purpose, in the present moment, non-judgementally in the service of self-understanding and wisdom."

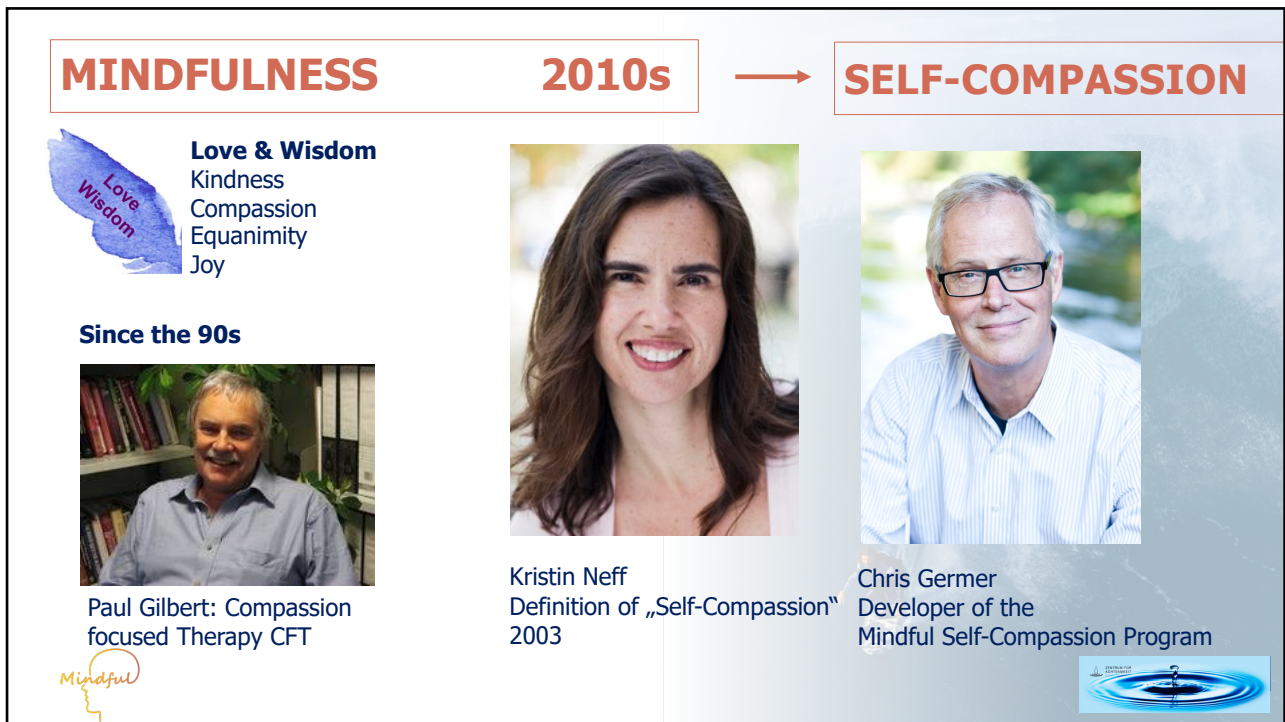
### Love & Wisdom

Kindness  
Compassion  
Equanimity  
Joy



8





9

## How do you treat a friend?






10

# The Practice of Self-Compassion & Compassion

## FORMAL DEFINITION OF SELF-COMPASSION



Loving – Connected – Presence

**Tender Self Compassion** (“being with”): comfort, connect, validate  
**Fierce Self-Compassion** (“taking action”): protect, provide, motivate



11

## Mindful Self Compassion Break



Loving – Connected – Presence

### Mindfulness

- „This is...” or...

### Common Humanity

- „Others would feel the same way” or...

### Kindness

- „Stay connected & kind to yourself...” or
- „You can do it!” or
- “Please not yet...” or....



12

## The difference between Empathy and Compassion



**Matthieu Richard**



13

## The difference between Empathy and Compassion



**Tanja Singer & Matthieu Richard**



14



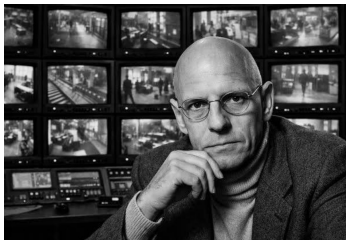
## Mindful Self Compassion with Equanimity

Everyone is on their own life journey.  
I am not the cause of this person's suffering,  
nor is it entirely within my power to make it  
go away,  
even though I wish I could.  
Moments like these can be difficult to bear,  
yet I may still try to help if I can.



15

## SELF-CARE



Michel Foucault  
Philosopher, France

## The 1970s

Self-Care ≠ modern routine of pampering or wellness.  
it's hard work.  
it shapes the self, the identity, the desires and actions

Self-Reflection → Self-Knowledge → Self-Care

Journaling  
Meditation  
Mentorship



16

I've learned that people  
will forget  
what you said,  
they will forget  
what you did,  
but they will never  
forget how you made  
them feel.



Maya Angelou



17

## RESSOURCES

### **Meditations:**

Regula Saner: <https://www.zentrum-fur-achtsamkeit.ch/ressourcen/>

Chris Germer: <https://chrisgermer.com/meditations/>

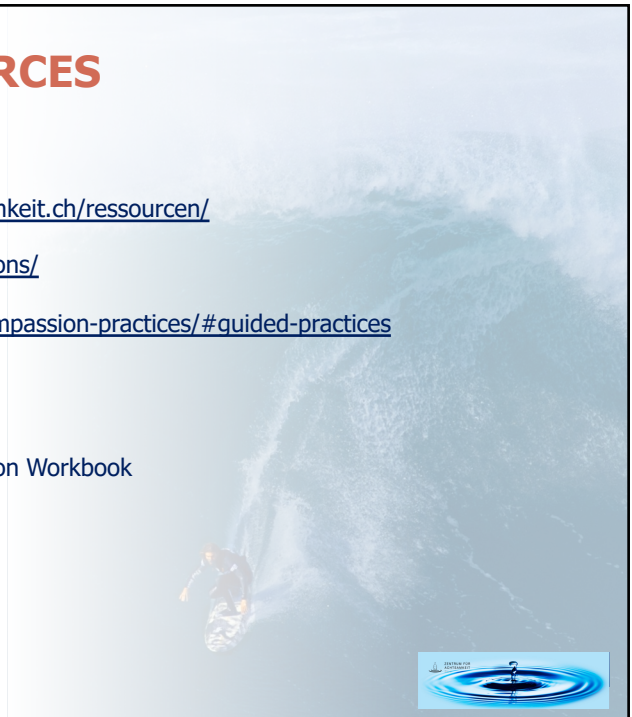
Kristin Neff: <https://self-compassion.org/self-compassion-practices/#guided-practices>

### **Books:**

Michel Foucault: The History of Sexuality

Kristin Neff: Self-Compassion

Christopher Germer: The Mindful Self-Compassion Workbook



18



19

# How to implement care for the frail elderly in and out palliative care setting



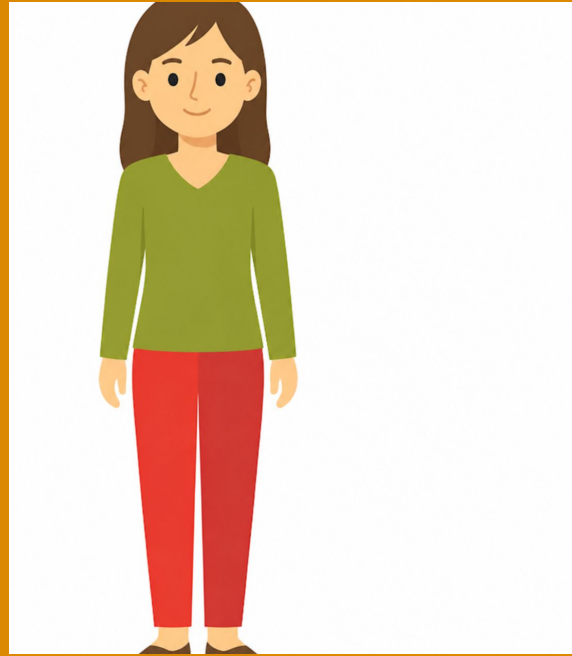
HUG



UNIVERSITÉ  
DE GENÈVE

Sophie Pautex  
Palliative Medicine division  
Dpt Readaptation and Geriatric

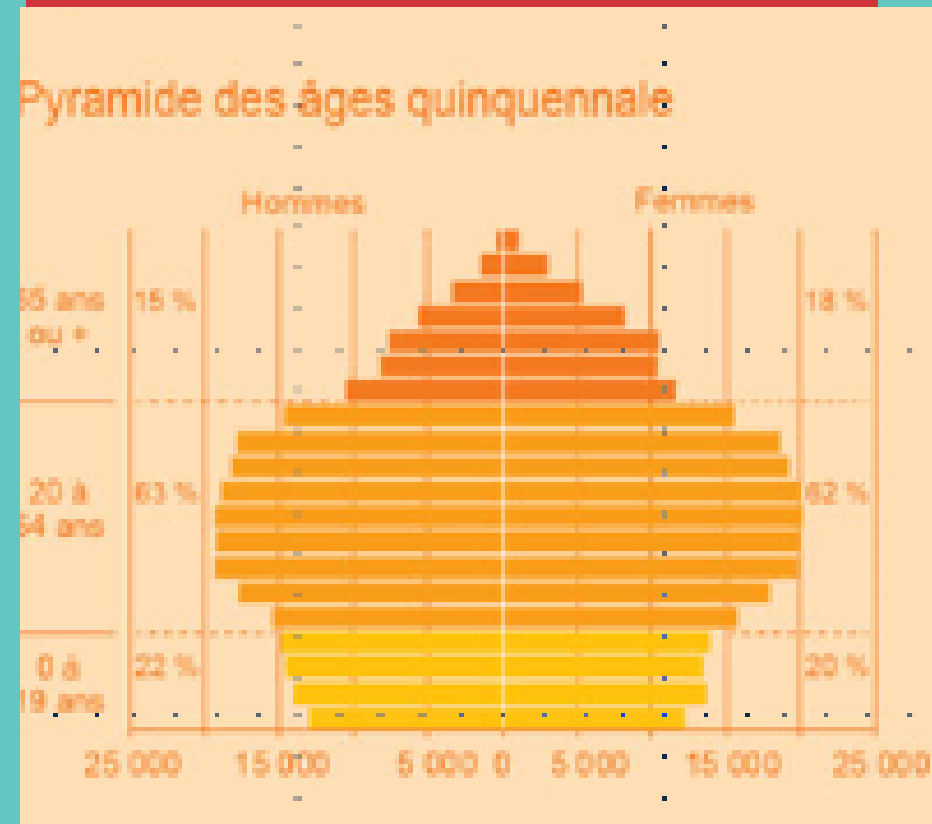
# Agenda



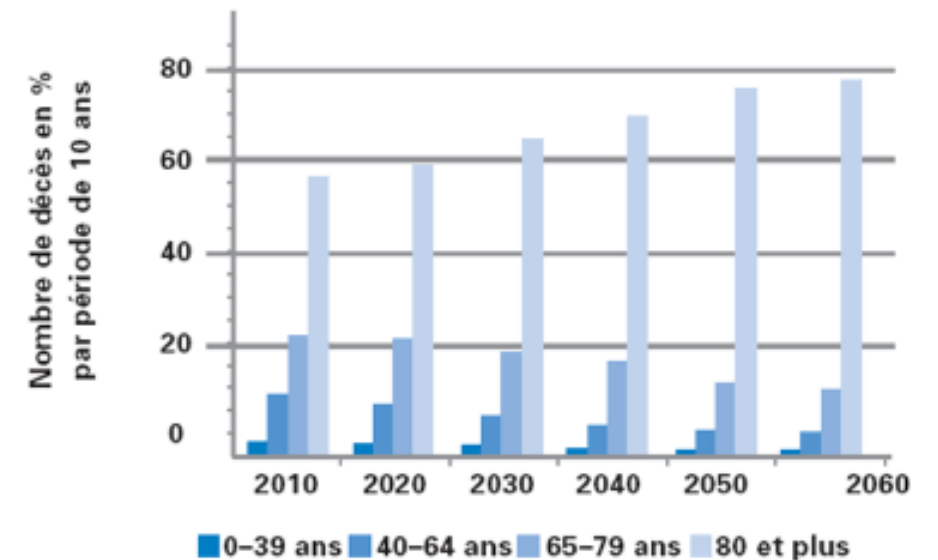
Is it your problem?  
Patients Mrs A et Mr B  
What is different with Mrs B  
What are the needs of Mrs B?  
How to integrate PC?  
Conclusion



# IS IT YOUR PROBLEM?

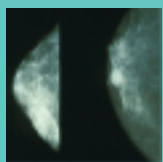


**Fig. 3 : Evolution des décès par âge 2010-2060**



Source : Office fédéral de la statistique (OFS)

# Mrs A, 42 years old



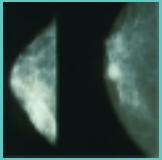
**Metastatic  
Breast cancer**



**Married  
3 children**



# Mrs B, 82 years old



- Metastatic breast cancer
- Respiratory disease: COPD gold IV
- Cardiac disease: heart failure D (ischemic and rhythmic)
- Diabetes II with many complications
- Gait instability and several falls, no recent fracture
- Weight loss with reduced appetite
- 3 pneumonia last year with 3 hospitalisations
- Loneliness, depression?
- Cognitive impairment : she need help for IADLs

**Married**  
**3 children**





# MAIN CHARACTERISTICS



**MULTIMORBIDITIES**



**DEMENTIA**

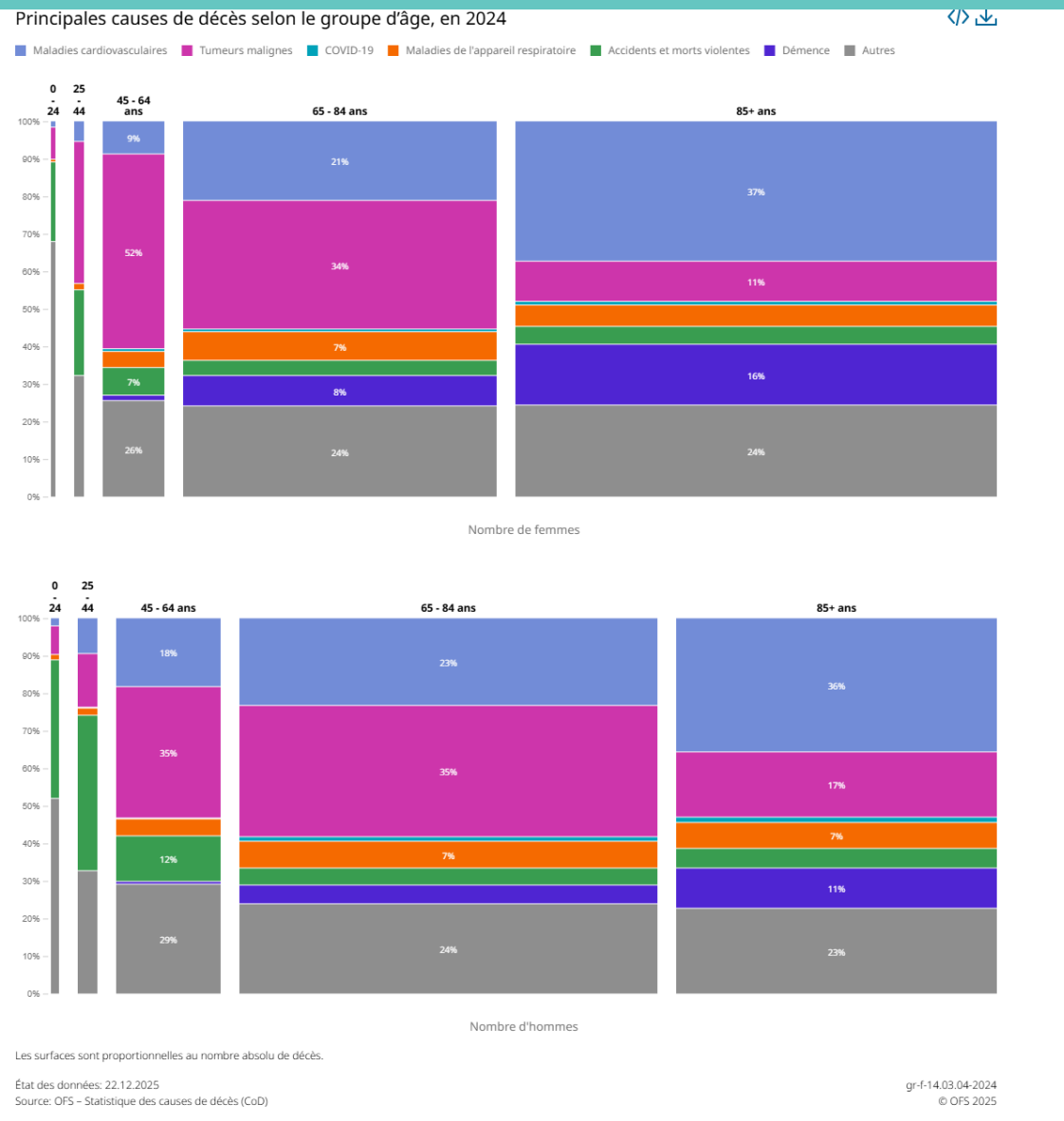
DISEASE COGNITIVE IMPAIRMENT BPSD



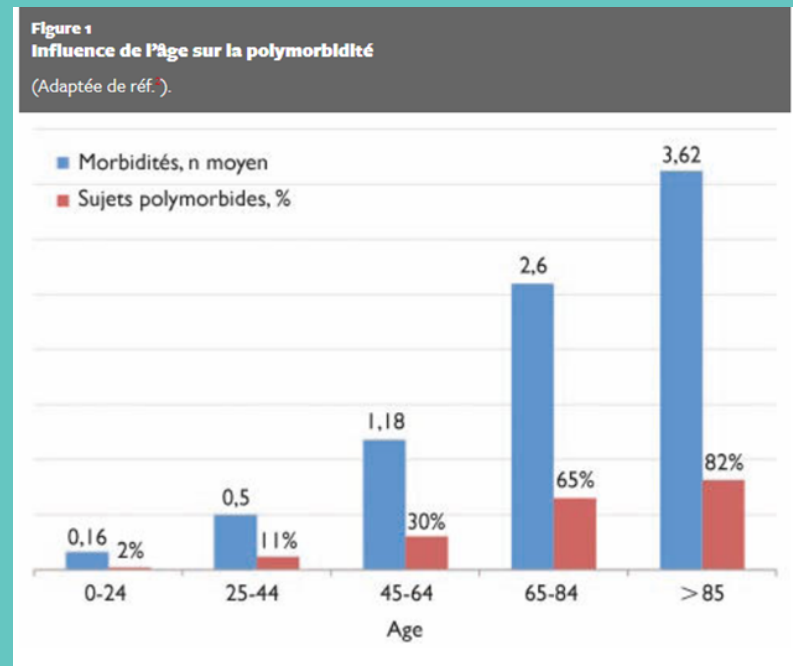
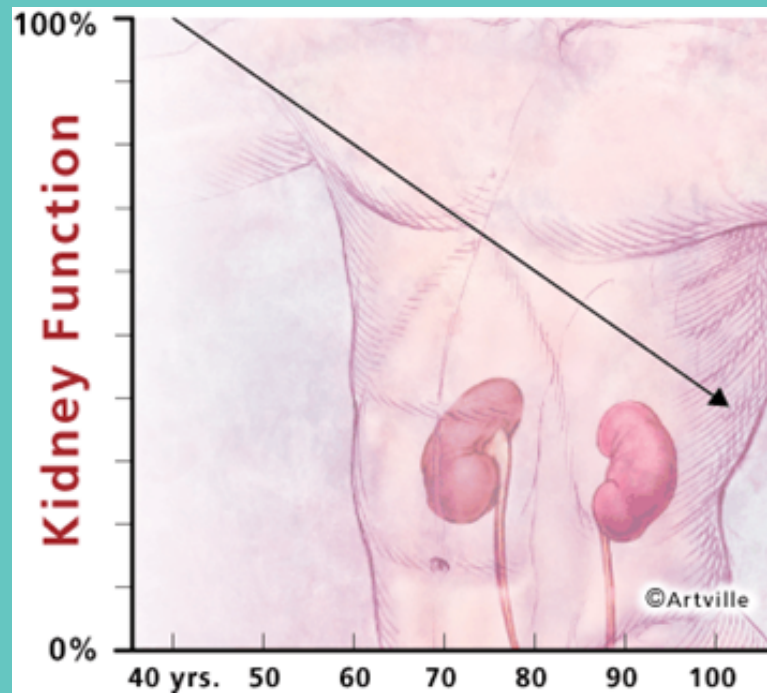
**FRAILITY**



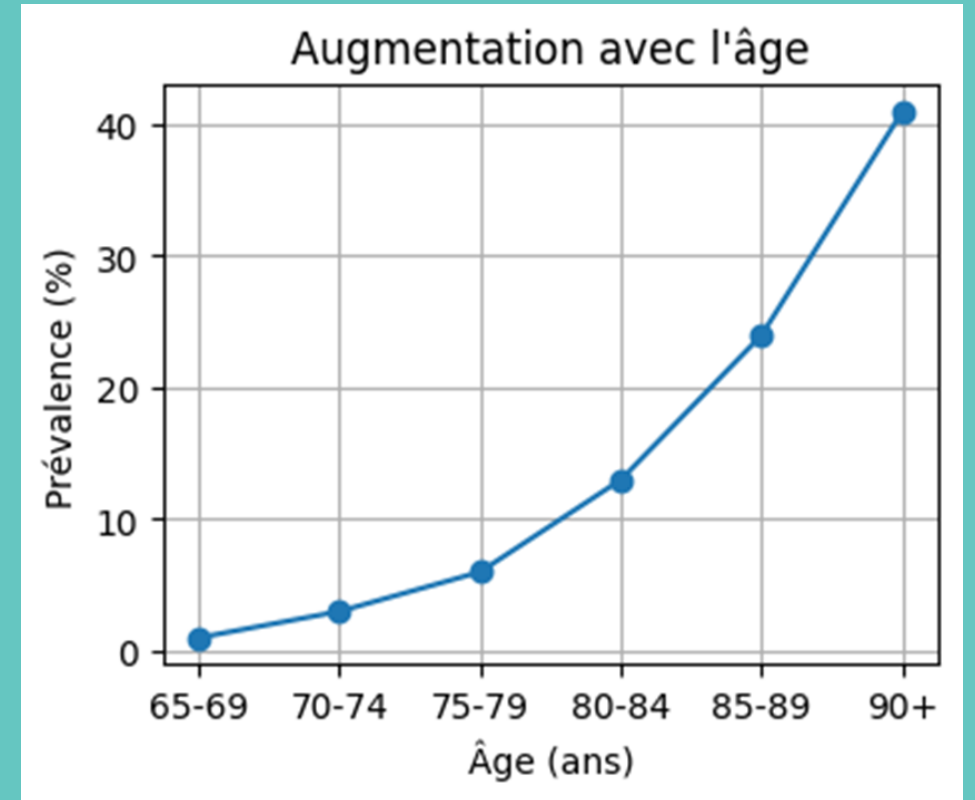
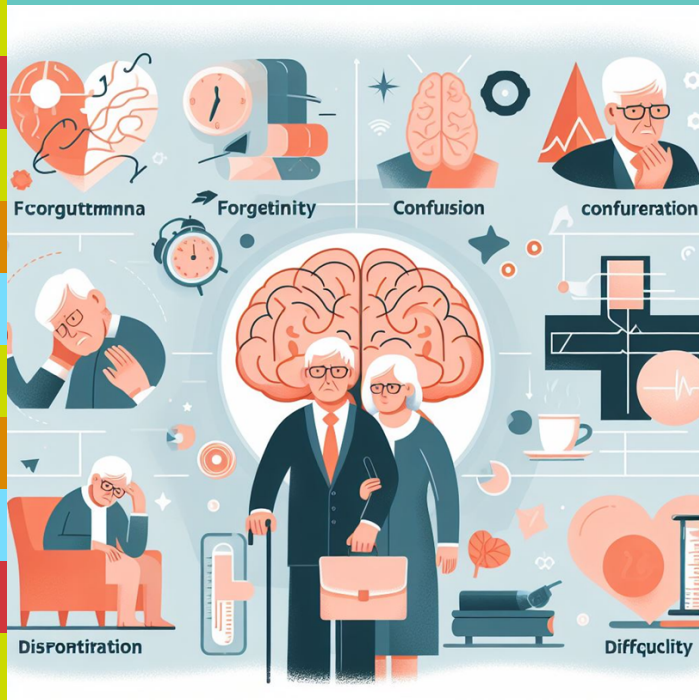
**UNCERTAINTY**



# MULTIMORBIDITIES



# COGNITIVE IMPAIRMENT



Références : Alzheimer Suisse ; OFSP .

# FRAILITY

Frailty is a clinical state of increased vulnerability resulting from age-related decline across multiple physiological systems, which reduces an individual's ability to cope with stressors and increases the risk of adverse outcomes such as falls, disability, hospitalization, and death.

Kenneth Rockwood, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489–495. doi:10.1503/cmaj.050051

## CLINICAL FRAILITY SCALE

|                                                                                     |          |                                         |                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------|----------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>1</b> | <b>VERY FIT</b>                         | People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.                                                                                                                                                                                       |
|  | <b>2</b> | <b>FIT</b>                              | People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.                                                                                                                                                                   |
|  | <b>3</b> | <b>MANAGING WELL</b>                    | People whose medical problems are well controlled, even if occasionally symptomatic, but often not regularly active beyond routine walking.                                                                                                                                                                            |
|  | <b>4</b> | <b>LIVING WITH VERY MILD FRAILITY</b>   | Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.                                                                    |
|  | <b>5</b> | <b>LIVING WITH MILD FRAILITY</b>        | People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework. |
|  | <b>6</b> | <b>LIVING WITH MODERATE FRAILITY</b>    | People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.                                                                                                     |
|  | <b>7</b> | <b>LIVING WITH SEVERE FRAILITY</b>      | Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).                                                                                                                                                      |
|  | <b>8</b> | <b>LIVING WITH VERY SEVERE FRAILITY</b> | Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.                                                                                                                                                                                       |
|  | <b>9</b> | <b>TERMINALLY ILL</b>                   | Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. Many terminally ill people can still exercise until very close to death.                                                                                              |

### SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

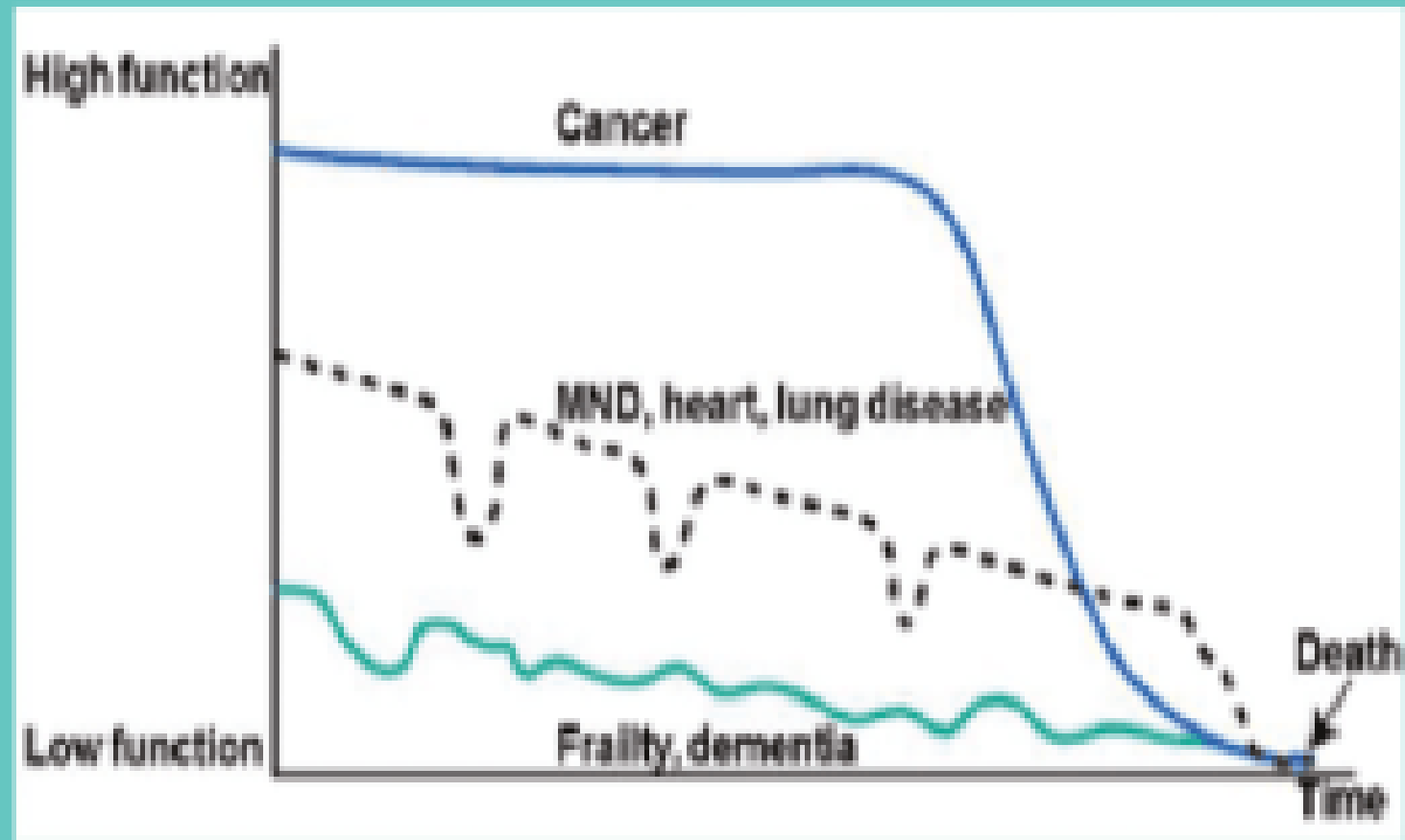
In very severe dementia they are often bedfast. Many are virtually mute.

Clinical Frailty Scale  
©2005–2020 Rockwood,  
Version 2.0 (EN). All rights reserved. For permission:  
[www.geriatricmedicine.ca](http://www.geriatricmedicine.ca)  
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

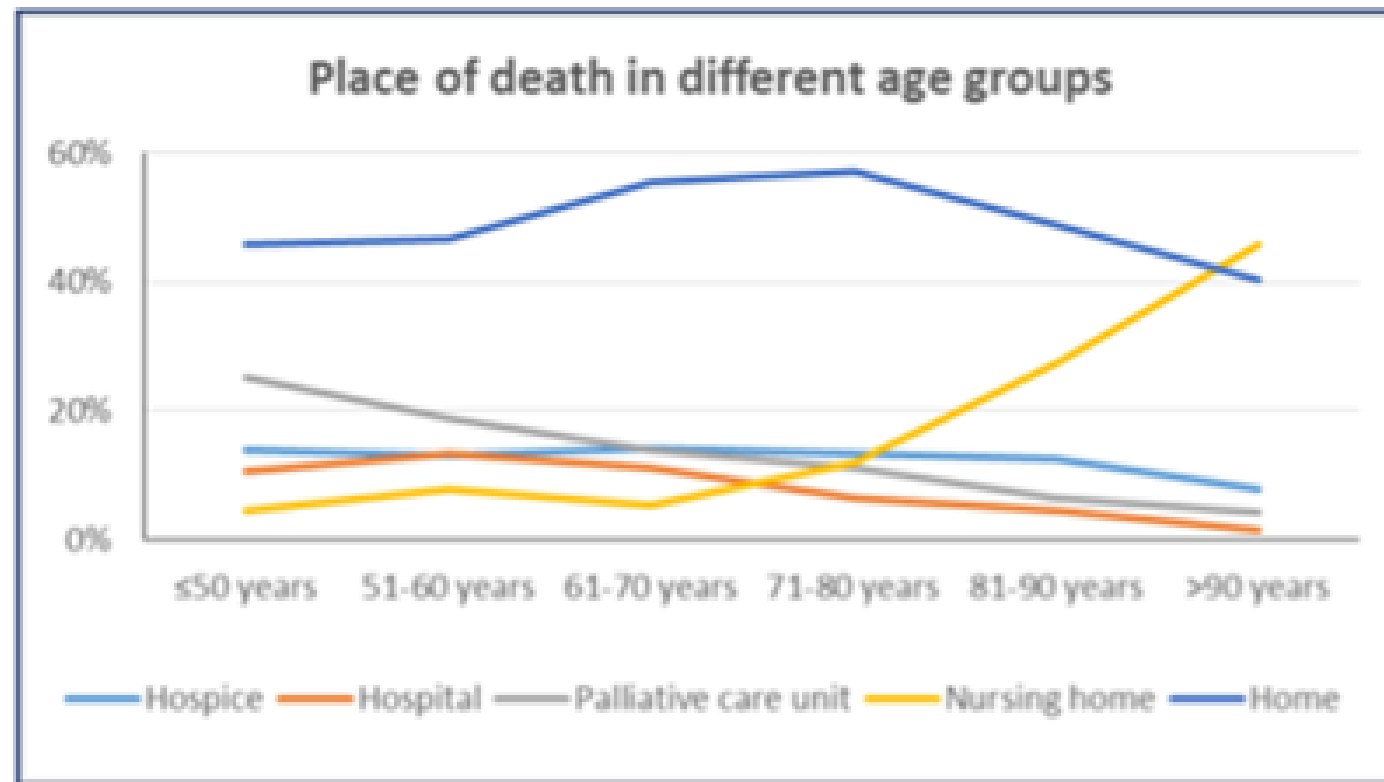




# TRAJECTORIES



# PLACE OF DEATH



**Figure 2.** Place of death in relation to age

Age-dependent differences in utilization of  
palliative care and place of death  
S. M. Trianti, M. Panhofer, L. Sossalla  
Leipziger Palliativgesellschaft, Leipzig, Germany



## White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care

Palliative Medicine  
2014, Vol. 28(3) 197-209  
© The Author(s) 2013  
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sagepub.co.uk/journalsPermissions.nav  
DOI: 10.1177/0269216313493685  
pmj.sagepub.com  
SAGE

Jenny T van der Steen<sup>1</sup>, Lukas Radbruch<sup>2</sup>, Cees MPM Hertogh<sup>1</sup>,  
Marika E de Boer<sup>1</sup>, Julian C Hughes<sup>3</sup>, Philip Larkin<sup>4</sup>,  
Anneke L Francke<sup>1,5</sup>, Saskia Jünger<sup>6</sup>, Dianne Gove<sup>7</sup>, Pam Firth<sup>8</sup>,  
Raymond TCM Koopmans<sup>9</sup> and Ladislav Volicer<sup>10</sup> on behalf of the  
European Association for Palliative Care (EAPC)

# Uncertainty

Prognosis

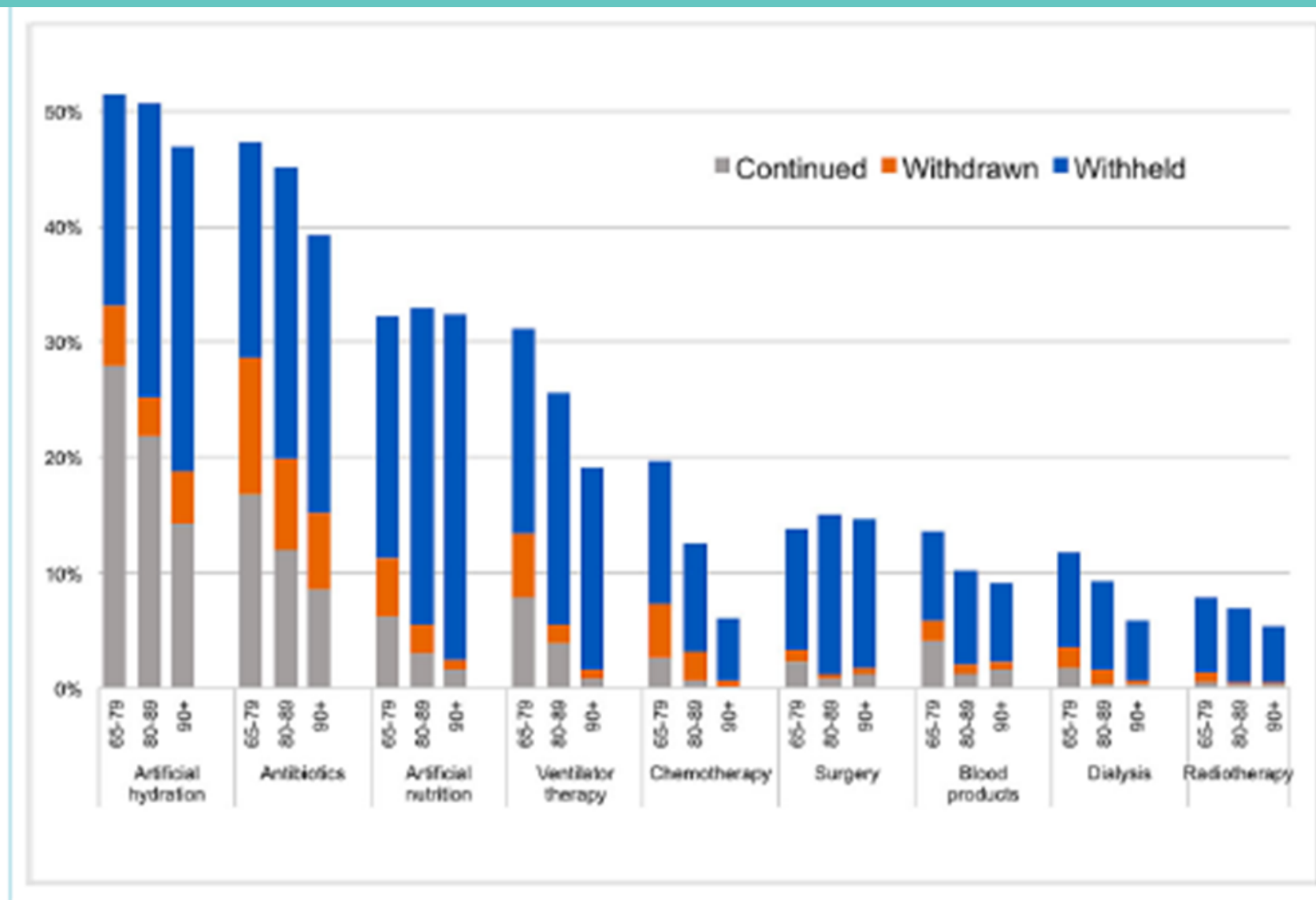
Anticipation

Feeding

Antibiotics

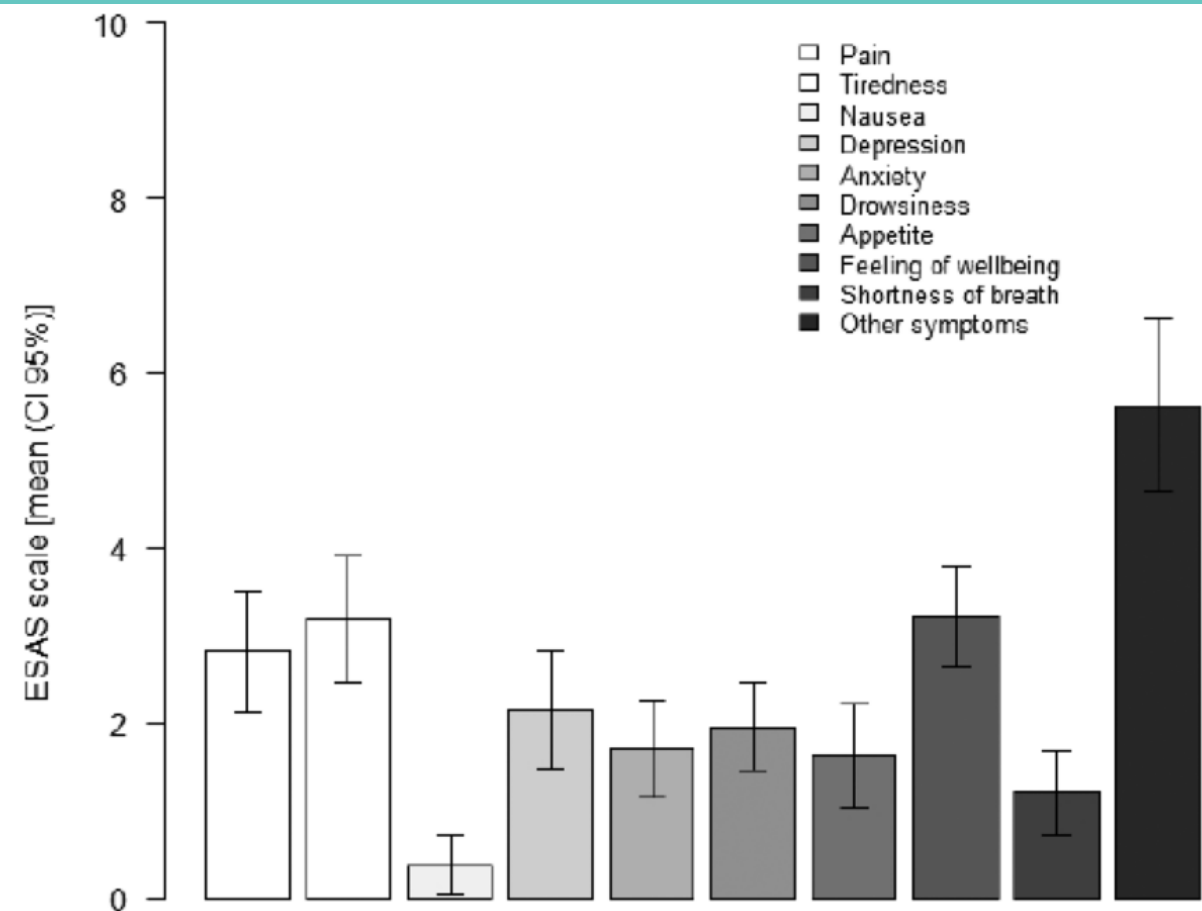
Best care place

# DECISION MAKING



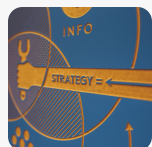
Hug, K. Med Wkly 2020

# NEEDS OF OLDER PATIENT

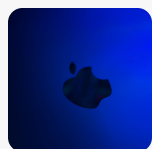


**Fig. 2.** Overall Edmonton Symptom Assessment Scale: mean (95% CI) by symptom.

# HOW TO INTEGRATE



TO COLLABORATE



TO ADAPT OUR INTERVENTION

- needs - decision making - relatives



TO EDUCATE



TO DO RESEARCH

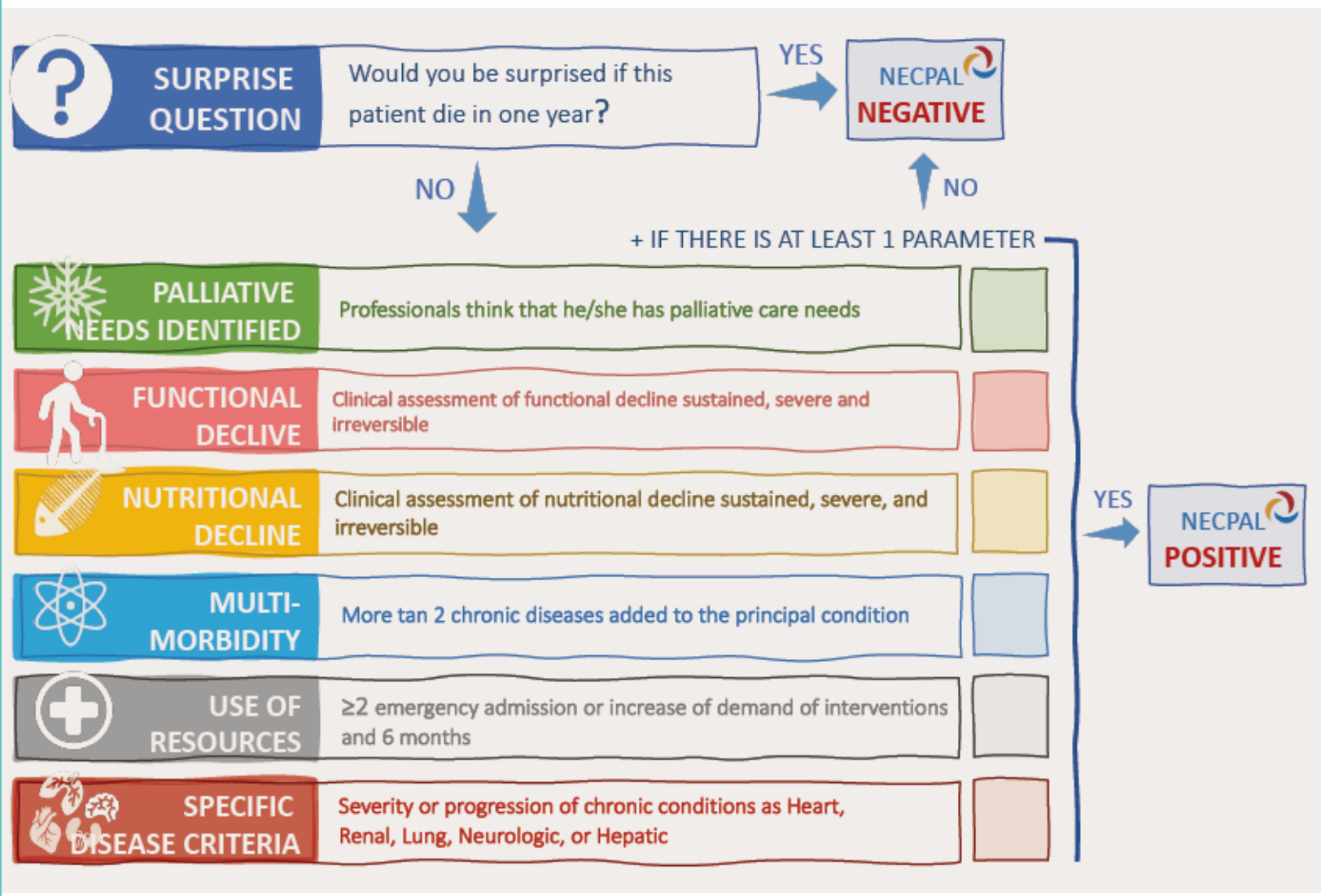
## A European Association for Palliative Care White Paper defining an integrative palliative, geriatric, and rehabilitative approach to care and support for older people living with frailty and their family carers: a 28-country Delphi study and recommendations

Lieve Van den Block,<sup>a,b,\*</sup> Kim de Nooijer,<sup>a,b</sup> Sophie Pautex,<sup>c</sup> Lara Pivodic,<sup>a,b</sup> Nele Van Den Noortgate,<sup>d</sup> Caroline Nicholson,<sup>e</sup> Katarzyna Szczercińska,<sup>f,g</sup> Sandra Martins Pereira,<sup>h</sup> Rebecca Tiberini,<sup>i</sup> Barbara Hanratty,<sup>j</sup> and Rose Miranda<sup>a,b</sup>



# SCREENING

## NECPAL TOOL VERSION 4.0 2021



Gomez-Batiste X, Martinez-Munoz M, Blay C, et al 2013;3(3):300–8.



# ASSESSMENT OF NEEDS

## NEEDS ASSESSMENT TOOL : PROGRESSIVE DISEASE (NAT: PD)

COMPLETE ALL SECTIONS

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

PATIENT/ADDRESS LABEL

### SECTION 1: PRIORITY REFERRAL FOR FURTHER ASSESSMENT

|                                                                                                      | Yes | No | If dotted boxes are ticked, consider assessment by SPCS |
|------------------------------------------------------------------------------------------------------|-----|----|---------------------------------------------------------|
| 1. Does the patient have a caregiver readily available if required?                                  |     | +  |                                                         |
| 2. Has the patient or caregiver requested a referral to a specialist palliative care service (SPCS)? | +   |    |                                                         |
| 3. Do you require assistance in managing the care of this patient and/or family?                     | +   |    |                                                         |

### SECTION 2: PATIENT WELLBEING (Refer to the prompt sheet for assistance)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Level of Concern |                |             | Action Taken     |                                   |                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------|-------------|------------------|-----------------------------------|-----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | None             | Some/Potential | Significant | Directly managed | Managed by other care team member | Referral required (complete referral section below) |
| 1. Is the patient experiencing unresolved physical symptoms (including problems with pain, breathlessness, sleeping, appetite, bowel, fatigue, nausea, oedema or cough)?                                                                                                                                                                                                                                                                                                    |                  |                |             |                  |                                   |                                                     |
| 2. Does the patient have problems with daily living activities?                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                |             |                  |                                   |                                                     |
| 3. Does the patient have psychological symptoms that are interfering with wellbeing or relationships?                                                                                                                                                                                                                                                                                                                                                                       |                  |                |             |                  |                                   |                                                     |
| 4. Does the patient have concerns about how to manage his/her medication and treatment regime?                                                                                                                                                                                                                                                                                                                                                                              |                  |                |             |                  |                                   |                                                     |
| 5. Does the patient have concerns about spiritual or existential issues?                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                |             |                  |                                   |                                                     |
| 6. Does the patient have financial or legal concerns that are causing distress or require assistance?                                                                                                                                                                                                                                                                                                                                                                       |                  |                |             |                  |                                   |                                                     |
| 7. Does the patient have concerns about his/her sexual functioning or relationship?                                                                                                                                                                                                                                                                                                                                                                                         |                  |                |             |                  |                                   |                                                     |
| 8. From the health delivery point of view, are there health beliefs, cultural or social factors involving the patient or family that are making care more complex?                                                                                                                                                                                                                                                                                                          |                  |                |             |                  |                                   |                                                     |
| 9. Does the patient require information about: (tick any options that are relevant) <input type="checkbox"/> The diagnosis <input type="checkbox"/> The prognosis <input type="checkbox"/> Treatment options <input type="checkbox"/> Medical/health/support services <input type="checkbox"/> Financial/legal issues <input type="checkbox"/> Social/emotional issues <input type="checkbox"/> Advance directive/resuscitation order <input type="checkbox"/> Other: _____ |                  |                |             |                  |                                   |                                                     |

COMMENTS: \_\_\_\_\_

### SECTION 3: ABILITY OF CAREGIVER OR FAMILY TO CARE FOR THE PATIENT (Refer to the prompt sheet for assistance)

| Who provided this information? (please tick one)<br><input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Both                                                                                                                                                                                                                                                                                                                                                   | Level of Concern |                |             | Action Taken     |                                   |                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------|-------------|------------------|-----------------------------------|-----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | None             | Some/Potential | Significant | Directly managed | Managed by other care team member | Referral required (complete referral section below) |
| 1. Is the caregiver or family distressed about the patient's physical symptoms?                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                |             |                  |                                   |                                                     |
| 2. Is the caregiver or family having difficulty providing physical care?                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                |             |                  |                                   |                                                     |
| 3. Is the caregiver or family having difficulty coping?                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |                |             |                  |                                   |                                                     |
| 4. Is the caregiver or family having difficulty managing the patient's medication and treatment regime?                                                                                                                                                                                                                                                                                                                                                                                                 |                  |                |             |                  |                                   |                                                     |
| 5. Does the caregiver or family have financial or legal concerns that are causing distress or require assistance?                                                                                                                                                                                                                                                                                                                                                                                       |                  |                |             |                  |                                   |                                                     |
| 6. Is the family currently experiencing problems that are interfering with their functioning or inter-personal relationships, or is there a history of such problems?                                                                                                                                                                                                                                                                                                                                   |                  |                |             |                  |                                   |                                                     |
| 7. Does the caregiver require information about: (tick any options that are relevant) <input type="checkbox"/> The diagnosis <input type="checkbox"/> The prognosis <input type="checkbox"/> Treatment options <input type="checkbox"/> Medical/health/support services <input type="checkbox"/> Financial/legal issues <input type="checkbox"/> Social/emotional issues <input type="checkbox"/> Advance directive/resuscitation order <input type="checkbox"/> What to do in event of patient's death |                  |                |             |                  |                                   |                                                     |

COMMENTS: \_\_\_\_\_

### SECTION 4: CAREGIVER WELLBEING (Refer to the prompt sheet for assistance)

| Who provided this information? (please tick one)<br><input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Both                                  | Level of Concern |                |             | Action Taken     |                                   |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------|-------------|------------------|-----------------------------------|-----------------------------------------------------|
|                                                                                                                                                                                        | None             | Some/Potential | Significant | Directly managed | Managed by other care team member | Referral required (complete referral section below) |
| 1. Is the caregiver or family experiencing physical, practical, spiritual, existential, sexual or psychological problems that are interfering with their own wellbeing or functioning? |                  |                |             |                  |                                   |                                                     |
| 2. Is the caregiver or family experiencing grief over the impending or recent death of the patient that is interfering with their own wellbeing or functioning?                        |                  |                |             |                  |                                   |                                                     |

COMMENTS: \_\_\_\_\_

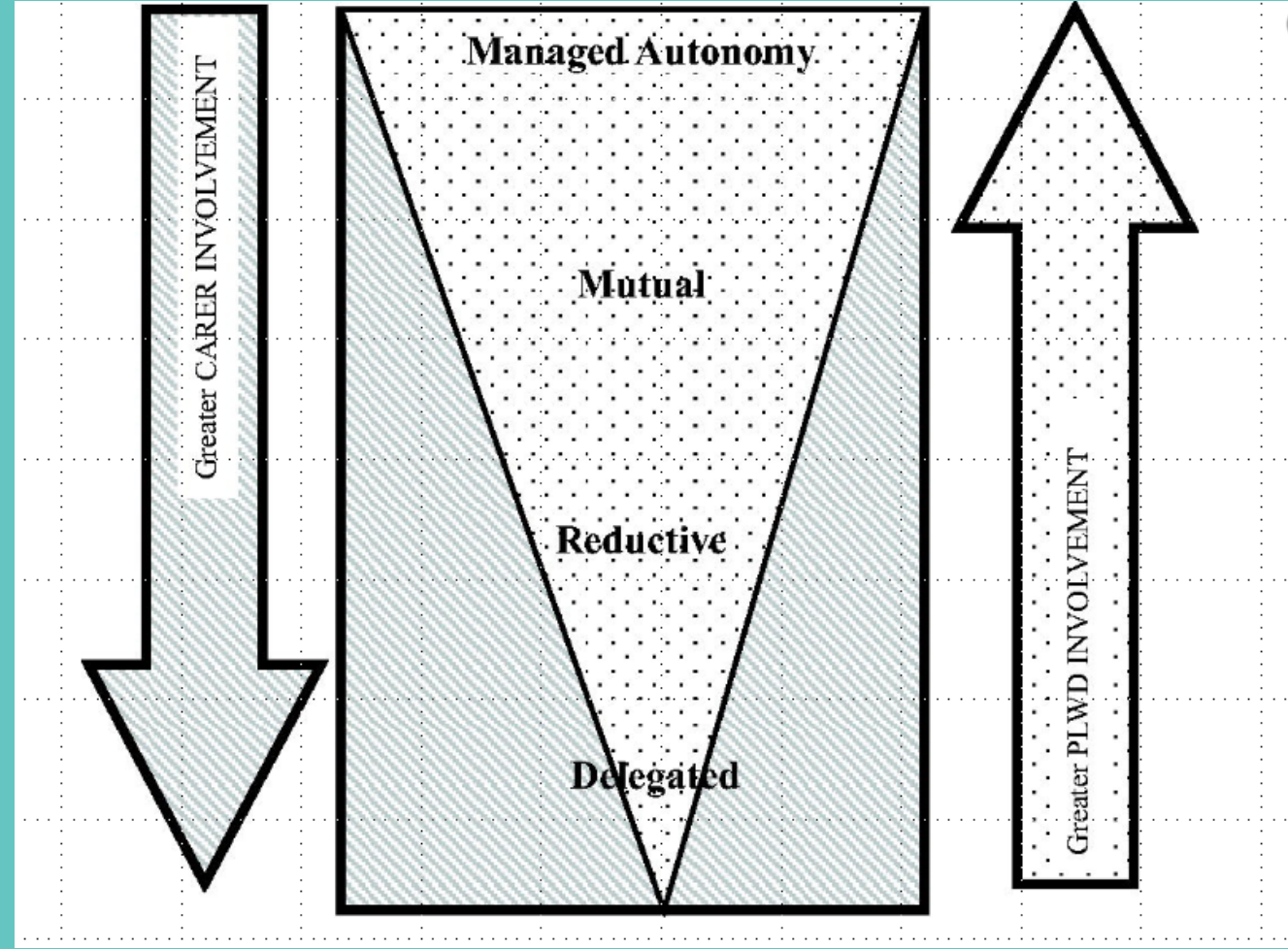
We need to adapt and to have time, because patients have difficulties

- To accurately process and produce language
- To focus attention
- To hold the information
- To organize and formulate thought

# Management BPSD

|                                                       |                                                                                                                                                                                                                                           |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Assessment of causes</b>                           | Identify and treat potentially reversible factors such as pain, delirium, infection, constipation, urinary retention, dehydration, sleep disorders, sensory impairment, or medication adverse effects.                                    |
| <b>Non-pharmacological interventions (first-line)</b> | Use person-centered care, environmental modification, structured activities, music therapy, sensory stimulation, behavioral approaches, and caregiver support.                                                                            |
| <b>Risk and safety management</b>                     | Assess risk of harm to self or others and implement proportionate safety measures while avoiding restraints whenever possible.                                                                                                            |
| <b>Pharmacological treatment</b>                      | Consider only for severe agitation, aggression, or psychosis causing significant distress or danger and when non-pharmacological interventions have failed. Use the lowest effective dose for the shortest duration and review regularly. |
| <b>Multidisciplinary approach</b>                     | Involve physicians, nurses, psychologists, occupational therapists, social workers, and family caregivers.                                                                                                                                |

# CAPACITY DECISION MAKING



*Bhatt, J "Aging & Mental Health 2020*

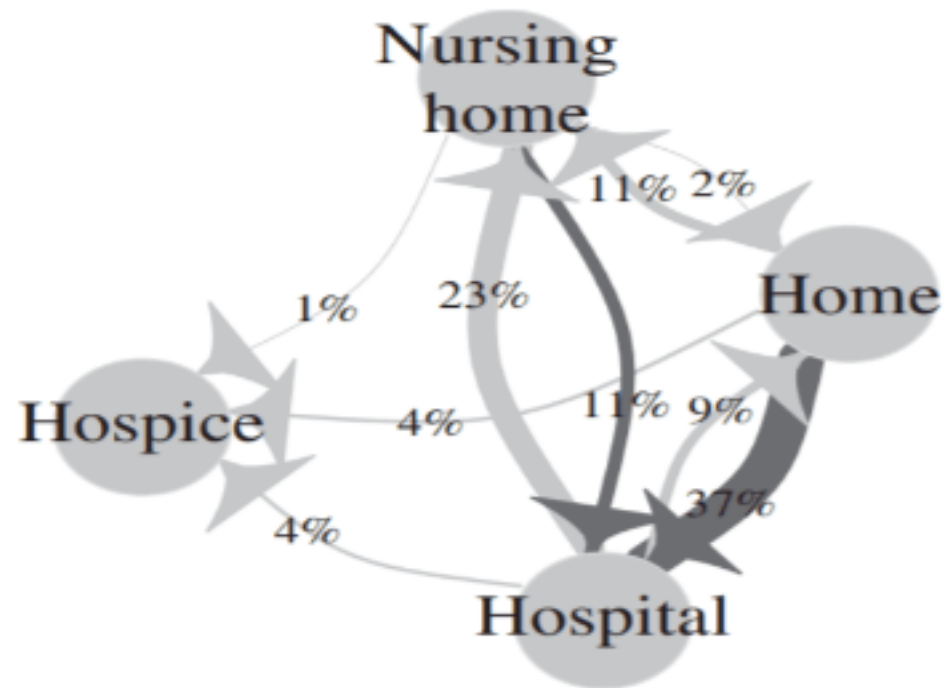
# LONG TERM CARE FACILITIES

|                             |                                                                                                    |
|-----------------------------|----------------------------------------------------------------------------------------------------|
| <b>Individual level</b>     | Lack of staff training in palliative care                                                          |
| <b>Individual level</b>     | Difficulty identifying residents requiring a palliative approach                                   |
| <b>Individual level</b>     | Challenges related to dementia and symptom assessment                                              |
| <b>Individual level</b>     | Poor communication skills for advance care planning and end-of-life discussions                    |
| <b>Organizational level</b> | Insufficient staffing and time                                                                     |
| <b>Organizational level</b> | Limited physician involvement                                                                      |
| <b>Organizational level</b> | Limited access to specialist palliative care support                                               |
| <b>Organizational level</b> | Organizational cultures focused on custodial or curative care rather than palliative care          |
| <b>Organizational level</b> | Lack of leadership support and sustainable implementation strategies                               |
| <b>System level</b>         | Inadequate integration between long-term care facilities and healthcare services                   |
| <b>System level</b>         | Limited reimbursement and financial incentives for palliative care                                 |
| <b>System level</b>         | Absence of national policies, standards, or quality indicators supporting palliative care in LTCFs |
| <b>System level</b>         | Societal misconceptions about palliative care and reluctance to discuss death and dying            |

19/01/2018

Présentation pour conférence

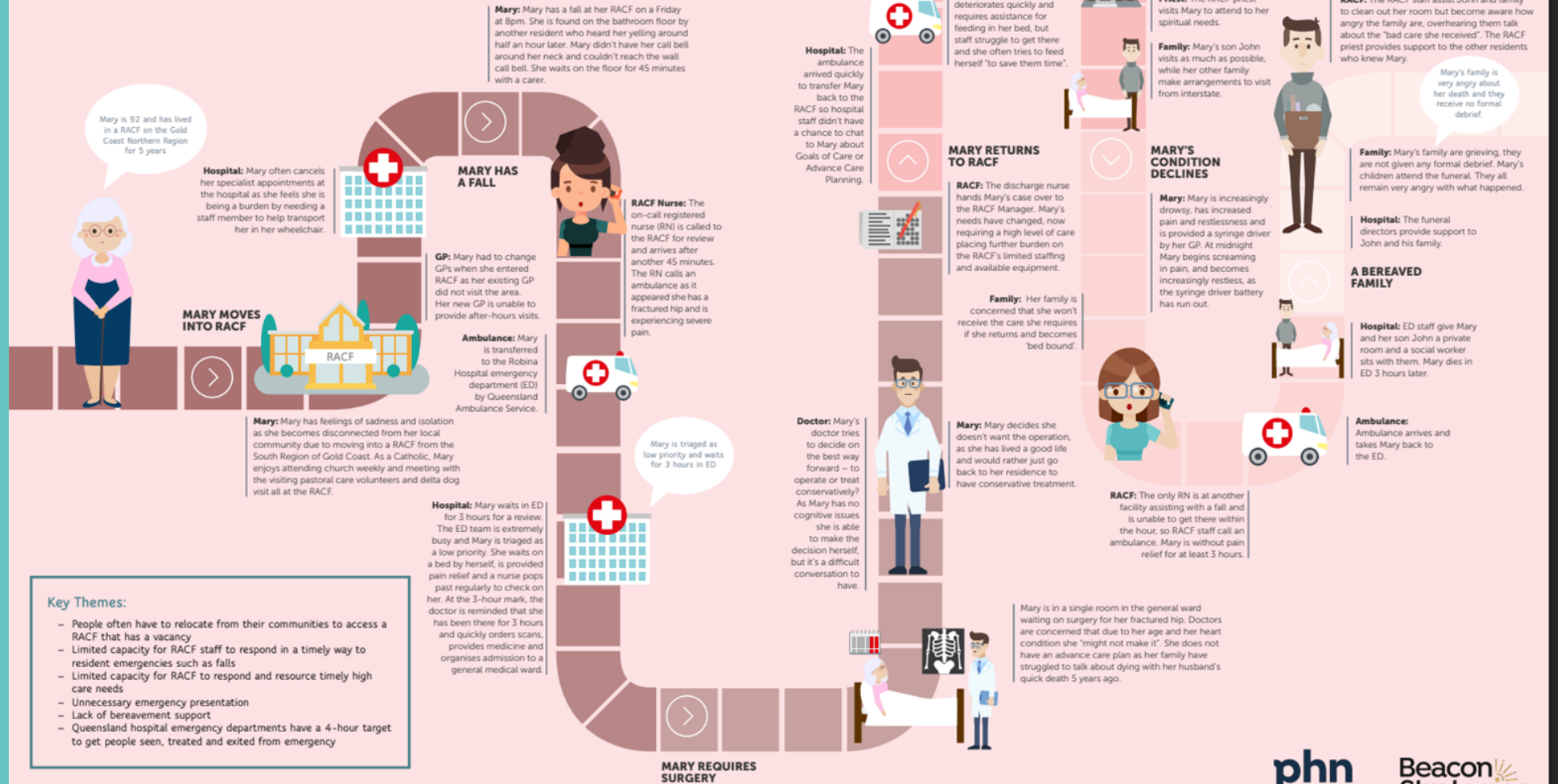
# NETWORK



**FIG. 1.** Graph of transfers of end-of-life patients with the edges (arrows) representing the proportion of frequent referrals (often/very often) one to three weeks before death for each pathway.

*S Glezendanner J Palliat Med 2018*

Brisbane, while the others live interstate. Mary's husband died 5 years ago, after which she decided with the help of her family to move into a Residential Aged Care Facility (RACF). Mary suffers from heart failure and several other co-morbid conditions. She requires some support to shower and needs a wheelchair to move long distances. She was previously active with a local craft group but hasn't seen them since moving into the RACF.



## Key Themes:

- People often have to relocate from their communities to access a RACF that has a vacancy
- Limited capacity for RACF staff to respond in a timely way to resident emergencies such as falls
- Limited capacity for RACF to respond and resource timely high care needs
- Unnecessary emergency presentation
- Lack of bereavement support
- Queensland hospital emergency departments have a 4-hour target to get people seen, treated and exited from emergency



# ADVANCE CARE PLANNING

## Projet de soins anticipé dans les établissements médico-sociaux

### Guide de mise en œuvre



| 1. Entretien d'admission avec le ou la résident.e et éventuellement avec ses proches                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>– Capacité de discernement du ou de la résident.e en matière de ProSA?</li> <li>– Existence de documents de ProSA sur la volonté exprimée/les valeurs personnelles?</li> <li>– Représentant.e thérapeutique déjà désigné.e?</li> </ul>                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 2. Processus de conseil avec le ou la résident.e ou son ou sa représentant.e thérapeutique                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>A Dialogue infirmier ProSA</b> <ul style="list-style-type: none"> <li>– sur les directives anticipées</li> <li>– sur la situation de vie actuelle</li> <li>– sur le degré d'intensité de traitement (préssumé) souhaité</li> </ul> <p>Un compte-rendu est rédigé.</p>                                                                                                                                                                                                                                                                              | <b>B Entretien de conseil ProSA</b> <ul style="list-style-type: none"> <li>– sur les directives anticipées</li> <li>– sur la situation de vie actuelle</li> <li>– sur les valeurs personnelles actuelles ou présumées</li> <li>– sur le degré d'intensité de traitement (préssumé) souhaité</li> </ul> <p>Un compte-rendu est rédigé.</p>                                                                                                                                                                                                            |
| 3. Prise de décision avec le ou la résident.e ou avec son ou sa représentant.e thérapeutique                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>A Proposition</b> <p>L'infirmier.ère discute du compte-rendu du dialogue et fait une proposition pour le degré d'intensité de traitement. Le cas échéant, les directives anticipées sont actualisées. La proposition – non signée – est soumise à un.e médecin.</p> <p><b>Fixation du choix par un.e médecin</b></p> <p>Le ou la médecin de famille ou d'EMS discute de la proposition et détermine le degré d'intensité de traitement.* Signature commune du document fixant le choix. Au besoin, un plan de médication d'urgence est établi.</p> | <b>B Fixation du choix</b> <p>Le ou la conseillère en ProSA discute du compte-rendu de l'entretien et fixe le degré d'intensité de traitement.* Le cas échéant, les directives anticipées sont actualisées. Signature commune du document fixant le choix, qui est transmis au ou à la médecin.</p> <p><b>Validation par un.e médecin</b></p> <p>Le ou la médecin de famille ou d'EMS reçoit le document fixant le degré d'intensité de traitement* pour validation et signature. Au besoin, il ou elle établit un plan de médication d'urgence.</p> |
| 4. Transmission de l'information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"> <li>– Informer l'équipe de soins et d'accompagnement ainsi que le ou la représentant.e thérapeutique.</li> <li>– Au besoin proposer un entretien avec les proches pour partager plus largement les décisions prises.</li> </ul>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. Utilisation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p>Le document sur le degré d'intensité de traitement est consulté dans une situation (d'urgence) où les souhaits actuels ou présumés en matière de traitement ne peuvent pas être discutés. Ce formulaire de ProSA est remis au ou à la médecin traitant.e ou au personnel du service de secours.</p>                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 6. Réévaluation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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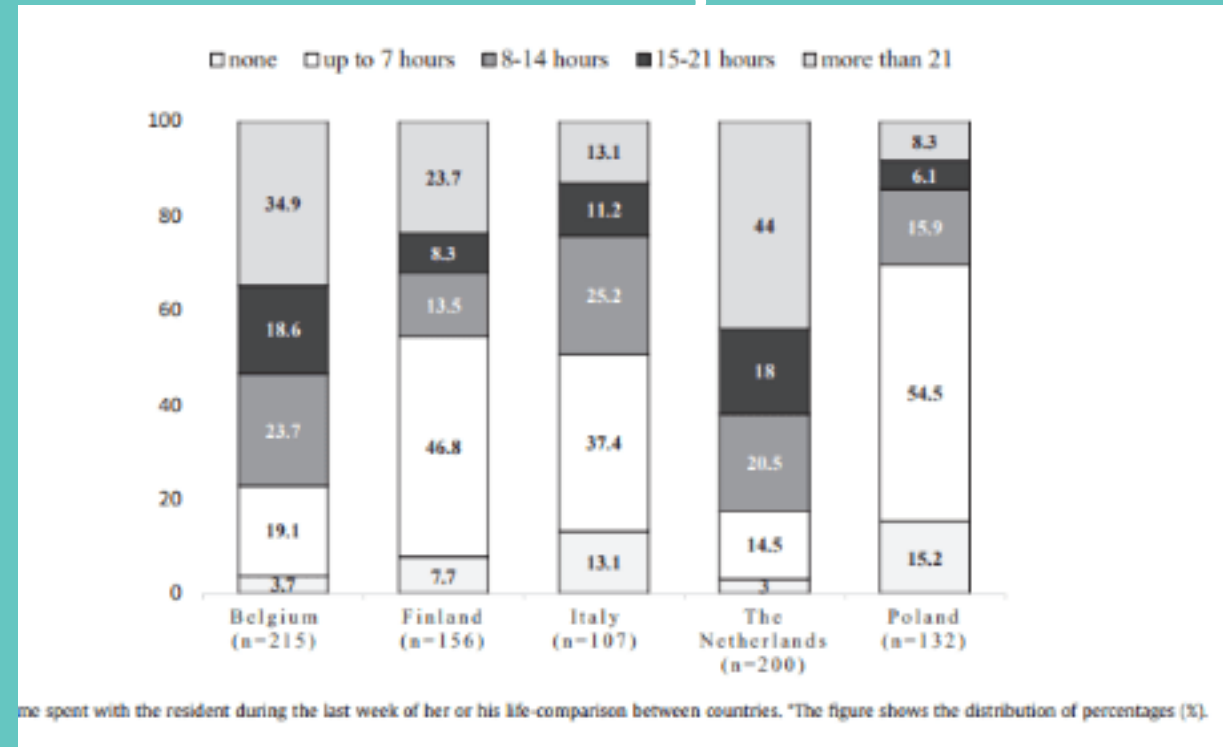
Original Study

## Engagement of Relatives in End-of-life Care of Residents in Long-Term Care Facilities: A Cross-Sectional Study in 5 EU Countries

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Lieke Van den Block MSc, PhD<sup>b</sup>, Tinne Smets MSc, PhD<sup>b</sup>,  
Nele Van Den Noortgate MD, PhD<sup>c</sup>, Harriet Finne-Soveri MD, PhD<sup>d</sup>,  
Giovanni Gambassi MD, PhD<sup>e,f</sup>, Bregje D. Onwuteaka-Philipsen PhD<sup>g</sup>,  
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<sup>f</sup>Stacy Karson Medical College, Thomas Jefferson University, Philadelphia, PA, USA  
<sup>g</sup>Amsterdam UMC, Vrije Universiteit Amsterdam, Department of Public and Occupational Health, Expertise Center for Palliative Care Amsterdam UMC, Amsterdam, the Netherlands  
<sup>h</sup>Geriatrics, Outpatient Department, University Hospital, Kraków, Poland

communication ?





**Table 4**  
Subgroup analysis for people with/without dementia.

|                                            |                                                   | Hospital transfer<br>OR (95% CI) | p-<br>value  |
|--------------------------------------------|---------------------------------------------------|----------------------------------|--------------|
| No dementia, or mild<br>dementia (n = 199) | Strong and supportive<br>relationship with family | 1.01(0.37 to<br>2.72)            | 0.986        |
|                                            | AD for not hospitalizing                          | 0.50 (0.16<br>to 1.61)           | 0.368        |
| Moderate dementia (n =<br>413)             | Strong and supportive<br>relationship with family | 1.14 (0.64<br>to 2.04)           | 0.649        |
|                                            | AD for not hospitalizing                          | 0.53 (0.24<br>to 1.15)           | 0.109        |
| Advanced dementia (n =<br>262)             | Strong and supportive<br>relationship with family | 1.41 (0.61<br>to 3.27)           | 0.426        |
|                                            | AD for not hospitalizing                          | <b>0.30 (0.09<br/>to 0.96)</b>   | <b>0.043</b> |

Controlling for age, sex, marital status, hypertension, stroke, cancer, chronic heart disease, falls last 30 days, and pain.

AD, advanced directive; OR, odds ratio; CI, confidence interval.

idé ou empêché notre capacité  
entre nous ?

s uns avec les autres.

## CLINICAL TRIAL article

Front. Pain Res., 24 May 2023  
 Sec. Pharmacological Treatment of Pain  
 Volume 4 - 2023 |  
<https://doi.org/10.3389/fpain.2023.1108832>

This article is part of the Research Topic  
 Cannabis and Cannabinoid Formulations in Pain Management  
[View all 5 Articles >](#)

## Medical cannabinoids for painful symptoms in patients with severe dementia: a randomized, double-blind cross-over placebo-controlled trial protocol

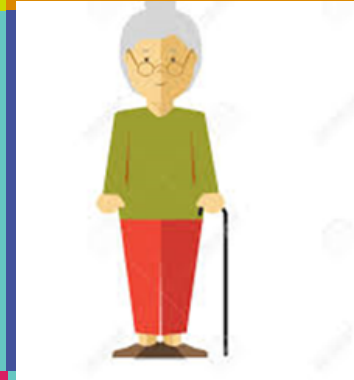
Federica Bianchi<sup>1,2\*</sup> Sophie Pautex<sup>2,3</sup> James Wampfler<sup>4</sup> François Curtin<sup>1,4</sup>  
 Youssef Daali<sup>1,4,5</sup> Jules Alexandre Desmeules<sup>1,5</sup> Barbara Broers<sup>1,6</sup>



Pautex S., Front Aging Neurosci. 2022 29;14:957665.

# THM

- Frailty, multimorbidity, cognitive impairment and uncertainty drive care needs.
- Systematic assessment of symptoms, function and psychosocial concerns is essential.
- Communication and decision-making must be adapted to cognitive impairment.
- Collaboration between geriatrics, palliative care, primary care and LTCF is crucial.
- Future priorities: screening, needs assessment, education, networks and research.





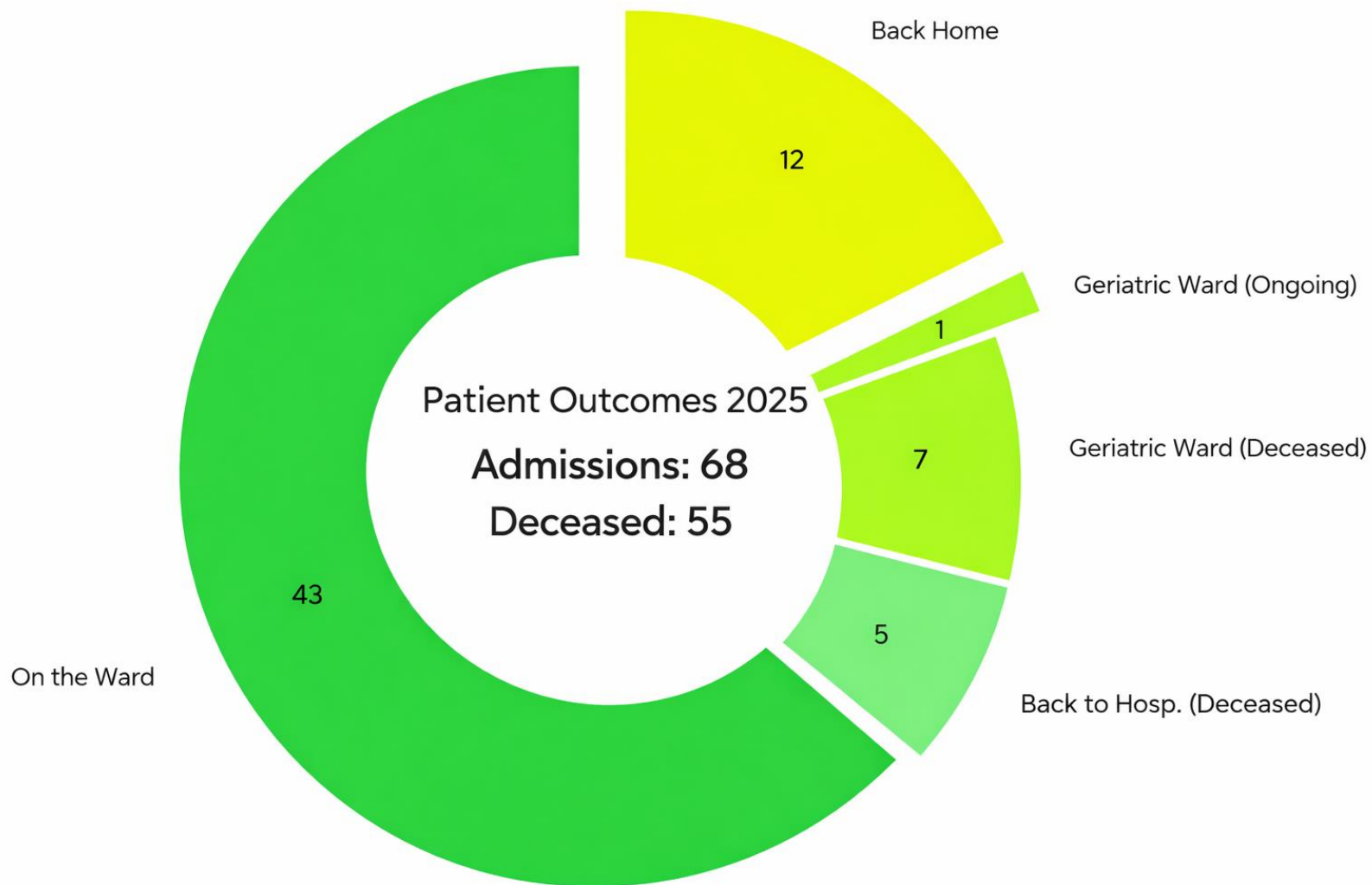
# Recommendations for a smooth transition

From a hospital to a specialised Palliative Care ward in a care home



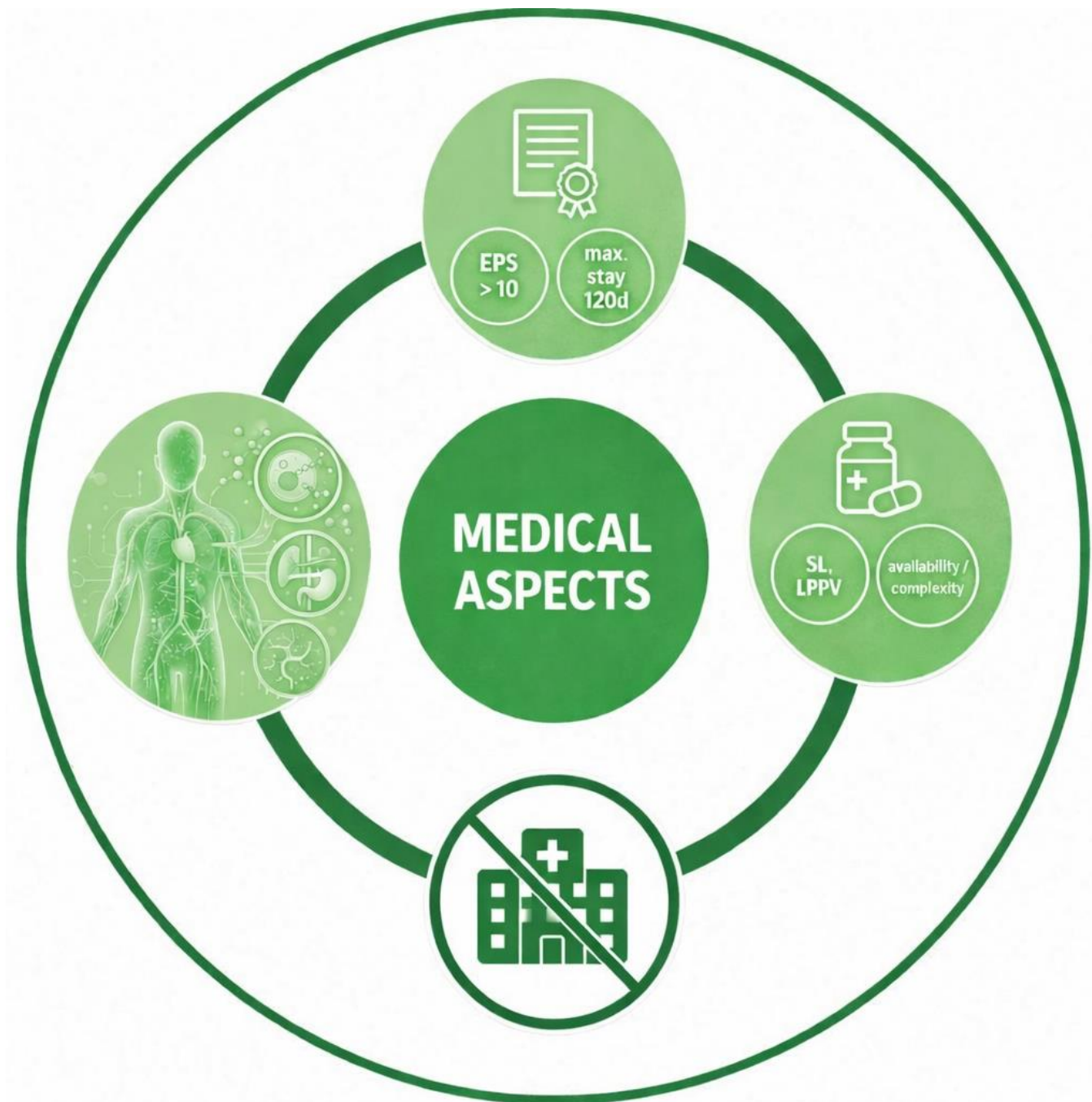
We might hope for:





## General Information







**48yo, f, advanced cancer of the stomach with Krukenberg metastases, 05/24**

**Admission:** 10/25, Thursday

**Topics:** significant abdominal pain (oral opioids), nausea, intermittent bowel obstruction, PleurX system, Port a cath, electrolyte dysbalance, cachexia / husband, 2 children (10, 12yo), discharge idea: home "after ..."

**Discharge plans hospital:**

- daily Radiotherapy, ongoing oncological treatment
- 1.5l iv fluids (port a cath)
- Blood sample coming Monday: Sodium

## Case

Ad 2)

- Fortführen der intravenösen Rehydrierung mit 1.5 Liter Kristalloidlösung / 24h bis und mit Montag 03.11.
  - Nach hausinterner Verfügbarkeit sowohl Ringerfundin wie auch NaCl 0.9% möglich
- Wir bitten um eine laborchemische Verlaufskontrolle der Serumnatriämie am Montag 03.11.25, bei Werten von > 130 mmol/l, kann die intravenöse Flüssigkeitssubstitution sistiert werden.

# Take home

