Dana-Farber Cancer Institute

Brigham and Women's Hospital
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When is Psychiatric Care Comfort Care?

The Role of the CL Psychiatrist in Transitioning Patients with Serious Mental Illness to Hospice Care

HARVARD MEDICAL SCHOOL

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Background

- "Comfort Care" represents an approach to treatment which prioritizes symptom relief as a patient nears end-of-life (1).
- Each patient's unique medical history, cultural values, and goals for end-of-life should be considered when transitioning from treatments with curative intent to treatment focusing on "Comfort Care" (2).
- For patients with severe mental illness (SMI), deciding what treatments constitute "Comfort Care" is particularly complex as patients and providers seek to avoid recrudescence of SMI while minimizing polypharmacy and medication side effects.
- We describe a case highlighting the role of the CL psychiatrist in guiding psychiatric medication management for patients with SMI and cancer at end-of-life while outlining special considerations to help guide management.

Case Presentation

- Ms. P is a 63-year-old woman with a history of bipolar I disorder (managed with lithium and quetiapine), tobacco use disorder, metastatic non-small cell lung cancer, COPD on home oxygen, and chronic pain who was medically admitted following a flash burn affecting her face, neck, and left hand after lighting a cigarette while wearing oxygen at home.
- Over the course of a prolonged admission, she experienced numerous complications including cardiopulmonary decline and delirium.
- Due to her deteriorating clinical status, she was deemed too ill to receive curative cancer-directed therapy.
- During goals-of-care discussions, Ms. P and her family expressed a wish to prioritize comfort and her code status she was transitioned to "Comfort Measures Only."
- In subsequent weeks, she experienced continued functional decline and confusion which impaired her ability to swallow pills.
- Psychiatry was consulted to assist with psychiatric medication management at the end of life.

Results

- The psychiatry team reviewed Ms. P's history and hospital course with patient, family, and treatment team.
- Her family was hesitant to discontinue Ms. P's medications for bipolar I disorder while also preferring to minimize pill burden.
- Quetiapine was continued at a reduced dose to permit higher doses of sedating pain medications, manage agitation associated with terminal delirium, and help prevent psychiatric decompensation at end-of-life.
- Lithium was not thought to be providing present benefit and was slowly tapered and discontinued to reduce pill burden.
- Over time, Ms. P was no longer able to tolerate oral medications. Quetiapine was discontinued in favor of intravenous Haloperidol targeting agitation and anxiety with goal of maximizing patient comfort at end of life.
- Ms. P died in the hospital several weeks later with family at bedside

Patients with psychiatric illness die from cancer at a rate **30% higher** than the rest of the general population.[1]

Factors to Consider in the Management of SMI in Patients at End-of-Life

Factor	Considerations
Assessing goals for end-of-life	• Identify patient's preference for treatment at end of life, including symptoms and treatments they want prioritized. • Collaborate with family members, primary team, and palliative care
Time Horizon and Prognosis	• Consider onset of action of medications. Usual first-line agents requiring weeks to take effect (e.g. SSRIs or SNRIs) may be less preferred vs agents with more rapid onset
Declining Functional status	• Routes of administration may become unavailable. Psychiatry can assist in switching to other formulations: oral disintegration tablets, liquid formulations, sublingual, subcutaneous, intravenous
Nutritional status	• As nutrition changes, consider adjusting protein-bound medication doses. Lower doses may be effective and decrease side effect risk
Decreased organ function	• Consider adjusting dosage or changing agents to avoid toxicity • e.g. risk of lithium toxicity in cases of worsening renal function.
Psychiatric Decompensation	• Monitor for re-emergence of psychiatric symptoms if long-term medications must be discontinued
Withdrawal Effects and Discontinuation Syndrome	• Monitor if psychiatric medications must be stopped abruptly. • Supportive management may be part of "Comfort Care"

Discussion

- When transitioning patients with SMI to "Comfort Care" in the setting of terminal medical illnesses like cancer, it is critical to understand the patient's preferences and personal values through goals of care conversations.
- Specific factors to consider include time horizon/prognosis, deteriorating functional status, clinical status (nutritional status, decrease organ function), risk of psychiatric decompensation and withdrawal and discontinuation syndrome when de-escalating long term psychiatric medications. (3)

Conclusion

- For patients with SMI, special attention must be paid to the balance between "comfort care" at end-of-life, proper management of chronic psychiatric conditions and thoughtful management of long-term psychiatric medications.
- CL psychiatrists are ideally positioned to manage this balance given their familiarity with the psychiatric effects of medical conditions and the proper management of psychiatric illnesses.

Acknowledgements

- The authors would like to thank the clinical and leadership teams of the Consultation-liaison Psychiatry Fellowship program Psycho-Oncology Track at Brigham and Women's Hospital, Dana-Farber Cancer Institute, and Harvard Medical School.

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