CORRESPONDENCE

Palliative Care of Adult Patients with Cancer

by Prof. Dr. med. Claudia Bausewein, PD Dr. med. Steffen T. Simon, Dr. med. Anne Pralong, Prof. Dr. med. Lukas Radbruch, Prof. Dr. med. Friedemann Nauck, and Prof. Dr. med. Raymond Voltz in issue 50/2015

Incorporation of Delirium Prevention in Palliative Medicine

The article by Bausewein et al. successfully unites the multiprofessional aspects of palliative care for adult cancer patients (1). The article discusses not only cancer pain and its drug treatment, but also important concomitant phenomena in palliative care, such as the emergence of depression, as well as communication skills in terminally ill patients.

We are particularly grateful that the subject of delirium at the end of life has been addressed in this context. Delirium in particular is often responsible in clinical routine for the transferal of dying patients to a psychiatric unit. However, the article points out that delirium is a classic concomitant phenomenon in the dying process of cancer patients. The literature also provides indications that the transferal of delirious patients with advanced, life-shortening physical disease to psychiatric units is inappropriate (2). Change of environment as a risk factor, as well as ethical and legal considerations, speak against this approach.

Our working group considers it important to point out that delirium prevention is particularly crucial in the palliative care of cancer patients. The deployment of specially trained nursing staff in the form of specialist delirium liaison nurses can be a beneficial step here (3). Increasing importance should be attached to focusing on delirium prevention in the palliative care of cancer patients in clinical routine. The article in question does much to encourage this move.

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Recommendations Require Critical Appraisal in Individual Cases

Although the S3 guideline on palliative care (1) and the information contained therein are doubtless of great value, the recommendations cannot and should not be adopted without critical appraisal. The best basis for the appropriate care of advanced-cancer patients comprises a thorough diagnostic work-up involving the investigation of an optionally large number of signs and symptoms relevant in oncology, pain medicine, internal medicine, neurology, psychiatry, and dermatology, among other specialties. This provides an appropriate treatment plan aimed at achieving the best possible quality of life for the patient and their relatives.

For example, the recommendation "When opioids are used, accompanying medication to prevent constipation is recommended" is not universally valid for a number of reasons:

- Not all cancer patients are affected by constipation. According to ten studies covering 12 438 cancer patients, diarrhea was present in 7.6% (2).
- Although opioid administration frequently causes constipation, this is not necessarily always the case.
- According to our own observations, combining the opioid tilidine, which was developed and is frequently used in Germany, with naloxone only rarely causes constipation (3). The similar oxycodone–nalaxone combination developed later also reduces the occurrence of constipation (4), thereby improving quality of life.

Therefore, statistical findings should be extrapolated to the individual case only with critical scrutiny, particularly in the end-of-life setting.

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The author declares that no conflicts of interest exist.

In Reply:

We welcome the positive feedback on and recognition of the S3 guideline on palliative care expressed in the correspondence formulated by Professors Kratz and Diefenbacher, as well as by Dr. Wörz.

Kratz and Diefenbacher confirm that recognizing and treating delirium in the dying phase is an important clinical task. They point out that in particular the prevention of delirium is key in palliative care of cancer patients and recommend the use of specially trained nurses. However, the extent to which recommendations on the prevention of postoperative delirium can be extrapolated to the dying phase first needs to be investigated before recommendations can be derived on this basis.

Wörz suggests that the recommendation relating to constipation prevention under opioid therapy is subject to restrictions. Guideline recommendations should never be "adopted without critical assessment": for this reason, there are no key recommendations formulated with "have to, or to be obliged," the strongest level of recommendation is "must." As such, any deviation from these recommendations should be well founded.

The key recommendation on the prevention of constipation is as follows: "In patient with incurable cancer, drug-based prophylaxis *must* be started alongside the use of opioids and be regularly adjusted as needed."

This recommendation applies to the vast majority of patients receiving opioid treatment. One of the few exceptions was mentioned (diarrhea), in the case of which no constipation prophylaxis should be undertaken—this, however, should be regularly monitored in the further course. The absence of constipation in opioid treatment should not, under any circumstances, automatically result in the discontinuation of constipation prophylaxis, but as a rule rather represents the effective prophylaxis of precisely this treatment. This key recommendation is, in our opinion, extremely relevant in clinical routine, since constipation prophylaxis is often forgotten during opioid treatment.

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